Uttlesford District Council

UTTLESFORD COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the deaths of Deborah & Michael

July 2015

Independent Chair and Author of Report: Althea Cribb

Associate Standing Together Against Domestic Violence

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STANDING together against domestic violence

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This report of a DHR examines agency responses and support given to Deborah and Michael, residents of Uttlesford, prior to the point of their deaths in July 2015.

1.1.3 The review will consider agencies contact/involvement with Deborah, Michael and the perpetrator Ryan from 1 January 2003 (see 1.6.3) to the date of the homicide.

1.1.4 The key purpose for undertaking DHRs 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.

1.1.5 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.6 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.2 Outline of the circumstances that led to a DHR

1.2.1 At 11pm on the date of the homicide, Essex Police received a 999 call from a man who stated that there had been a murder, and gave the address. Police attended and found Ryan in an alley close to the stated address with blood on his hands and carrying a carrier bag. When asked where the blood was from, he indicated the address.

1.2.2 Officers entered the address and discovered Deborah, who was pronounced deceased immediately, and Michael, who was pronounced deceased at the scene following unsuccessful attempts by the attending paramedics to resuscitate him.

1.2.3 An officer observed Ryan laughing, and given the circumstances, arrested him.

1.2.4 Deborah was the mother of Ryan. Michael was a good friend of Deborah who often visited her (according to some information submitted to the DHR, they were intimate partners).

1.2.5 Ryan was convicted after trial of both homicides on 13 May 2016. He was sentenced to life imprisonment with a minimum term of 32 years.

1.2.1 The Review Panel expresses its sympathy to the families and friends of Deborah and Michael for their loss and thanks them for their contributions and support for this process.

1.3 Timescales

1.3.1 The Uttlesford CSP, in accordance with the Revised Statutory Guidance for DHRs (March 2013), commissioned this DHR.

1.3.2 Essex Police notified Uttlesford CSP that the case should be considered as a DHR. The Uttlesford CSP made a decision to conduct a DHR, and having agreed to undertake a review, the Home Office was notified of the decision in writing.

1.3.3 Standing Together Against Domestic Violence was commissioned to provide an independent chair for this DHR in October 2015. The first meeting of the Review Panel was held on 10 December 2015. There were five subsequent meetings in February, April, July and September 2016, and in June 2017. The report was handed to the Uttlesford Community Safety Partnership in October 2017.

1.3.4 Home Office guidance states that the DHR should be completed within six months of the initial decision to establish one. Standing Together were appointed to deliver the DHR in October 2015; there was then a delay to the start of the DHR, as the first meeting had to be postponed to ensure that all relevant agencies could attend. The DHR was subsequently delayed due to some agencies submitting their Individual Management Reviews late, and the DHR becoming aware of some agencies' involvement late in the process. There were initially ten agencies to submit IMRs; by the end of the process 24 agencies had submitted an IMR or information.

1.3.5 The Review Panel agreed to put the process on hold in September 2016 following the commissioning of the Independent Mental Health Investigation, to allow for that to progress to the point where findings could be shared between the DHR and the Investigation, to support the learning for both. This was

because Ryan's receipt of mental health care was such a significant factor in the learning for this case. The Investigation was due to be completed within six months but was delayed, with the final report being sent to the DHR Chair in October 2017. Once received, the Overview Report and Executive Summary were amended and the process concluded as quickly as possible.

1.4 Confidentiality

1.4.1 The independent chair has made every effort to anonymise the individuals in this review.

1.4.2 Pseudonyms were chosen for the individuals in the case, and these were checked with those family members involved in the review.

1.5 Dissemination

1.5.1 Prior to publication, the following reviewed the Overview Report:

(a) Deborah's family members who had been involved in the review
(b) Review Panel
(c) Uttlesford CSP
(d) Essex County Council Domestic Abuse Partnership Manager

1.5.2 The above list will also receive confirmation of the publication of the DHR, with details of where to access it.

1.5.3 In addition, the details of the published report will be sent to:

(a) Essex Police and Crime Commissioner
(b) Essex Southend and Thurrock Domestic Abuse Strategic Board
(c) East Hertfordshire CSP
(d) Hertfordshire Domestic Abuse Partnership
(e) Essex MAPPA Strategic Management Board
(f) Hertfordshire MAPPA Strategic Management Board

1.6 Terms of Reference

1.6.1 The full Terms of Reference are included at Appendix 1. This review aims to identify the learning from Deborah's, Michael's and Ryan's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 The Review Panel comprised agencies from Uttlesford, as the victims and perpetrator were living in that area at the time of the homicide. Agencies from East Hertfordshire were also included as the perpetrator had previously lived there. Agencies were contacted as soon as possible after the DHR was

established to inform them of the review, their participation and the need to secure their records.

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

1.6.4 At the first meeting the chair and Review Panel discussed those issues particularly pertinent to this review, which were identified as: familial domestic abuse; drug and alcohol use; risk management and the Multi-Agency Risk Assessment Conference (MARAC); and mental health.

1.6.5 As a result, Safer Places were invited to be part of the review due to their expertise in local domestic abuse services even though they had not been previously aware of the individuals involved. This was in addition to the expertise provided by the existing Review Panel members from drug and alcohol and mental health agencies.

1.7 Methodology and Contributors to the DHR

1.7.1 The report makes reference to the term domestic violence. The cross-government definition of domestic violence and abuse (amended March 2013) is included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

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

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

for independence, resistance and escape and regulating their everyday behaviour.

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

1.7.2 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.7.3 The approach adopted was to seek Individual Management Reviews (IMRs) and chronologies of contact from all organisations and agencies that had contact with Deborah, Michael and/or Ryan over the Terms of Reference time period. Whether they had contact was established at the first meeting, through letters and telephone calls to those not in attendance, and through the information provided in agency IMRs following their submission to the DHR.

1.7.4 The following agencies reviewed their files and notified the Review Panel that they had no involvement with Deborah, Michael or Ryan and therefore had no information for an IMR:

(a) Essex County Council Children's Social Care Services
(b) Essex County Council Adult Services
(c) Hertfordshire Partnership NHS Trust (mental health)
(d) Mind West Essex
(e) Open Road, Essex (drug and alcohol service)
(f) CRI, Hertfordshire (drug and alcohol service)
(g) South Essex Partnership University NHS Foundation Trust[1]

1.7.5 Chronologies and IMRs were requested from:

Agency	IMR and Chronology Received
ADAS (Alcohol and Drug Advisory Service)	Yes
East Hertfordshire Council, Housing Services	Yes

[1] It was later established that the Trust did have brief contact with Ryan during his time in prison, but that they were no longer the provider of that service. Information was sought and has been included in the Review.

Essex County Council Connexions Service	Chronology and further information provided
Essex County Council Education	Yes
Essex County Council Youth Offending Service	Yes
Essex Partnership NHS Foundation Trust (formerly North Essex Partnership NHS Foundation Trust)	Yes
Essex Police	Yes
Essex Young People's Drug and Alcohol Service (now provided by The Children's Society)	Chronology and further information provided
Genesis Housing	Information provided
Her Majesty's Prison and Probation Service	Yes
Hertfordshire Constabulary	Yes
National Centre for Domestic Violence	Yes
National Probation Service	Yes
Northamptonshire Healthcare NHS Foundation Trust (Mental Health In-Reach Services at HMYOI Glen Parva and HMP Bedford)	Yes
Oxleas NHS Foundation Trust (Mental Health In-Reach Service at HMP Rochester)	Yes
Parsonage Surgery – General Practice for Michael	Yes
Princess Alexandra Hospital	Yes
Specialist Treatment and Recovery Service (STaRs, Community Drug and Alcohol Service)	Yes
Stansted Surgery – General Practice for Deborah and Ryan	Yes

Sussex Partnership NHS Foundation Trust (Primary Mental Health Care Service at HMP Ford Open Estate)	See 1.7.10
Uttlesford District Council Environmental Health	Yes *Not included in Review as no relevant contact or learning*
Uttlesford District Council Housing Service	Information provided
Victim Support	Yes

1.7.6 Agency representatives not directly involved with the victim, perpetrator or any family members, undertook the IMRs, which were internally quality assured.

1.7.7 Most IMRs received were comprehensive and enabled the Review Panel to analyse the contact with Deborah, Michael and Ryan and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received.

1.7.8 During the DHR process most agencies demonstrated commitment to identifying the learning from this case. Ten IMRs made recommendations of their own and promptly acted on this learning, and later in the review provided updates on IMR recommendations when requested.

1.7.9 Ryan was held in six different prisons from June 2012 to April 2015, and accessed Mental Health In-Reach Services from NHS Trusts while in prison. One prison (HMP Blundeston) had since closed. One prison (HMP Lewes) he was in for only twelve days. As a result, records with regard to his engagement with Mental Health In-Reach Services were sought from the remaining four. Trusts delivering services in three of the prisons responded with chronologies and IMRs.

1.7.10 One (Sussex Partnership NHS Foundation Trust) responded that they had no records for Ryan. Following the completion of the Independent Mental Health Investigation, it was discovered that the Trust did have contact, but within their primary health care service, not in reach mental health provision (which they do not deliver). Hence the review's initial request was incorrect. The Trust were then contacted and contributed information and comments on the Overview Report.

1.7.11 The Essex County Council Connexions service is no longer provided. The electronic records of Ryan's engagement with the service were provided to the DHR, and the chair discussed the case with the Council's Head of Commissioning Education & Lifelong Learning, who is responsible for a small team of Targeted Youth Advisors that delivers a service similar to Connexions.

1.7.12 Essex Police provided the information from the MARAC. When further questions were raised about the process in this case, the independent chair contacted the MARAC team directly, with the support of the Essex Police Review Panel representative, and responses were received and incorporated into the Report.

1.7.13 The Review Panel members and DHR Chair (Report Author) were:

(a) Althea Cribb, DHR Chair and Report Author (Associate, Standing Together Against Domestic Violence)
(b) Allison Gardner, Safer Places
(c) Carol Rooney, Niche Health and Social Care Consulting (Mental Health Investigation Lead)
(d) Carolyn Smith, Essex Partnership NHS Foundation Trust (formerly North Essex Partnership NHS Foundation Trust)
(e) Claire Bennett, East Hertfordshire Council Housing Services
(f) David Padgett, Victim Support
(g) Fiona Gardiner, Uttlesford District Council Community Safety
(h) Frances Mason, National Probation Service (Essex)
(i) Gareth Clement, ADAS (Alcohol and Drug Advisory Service)
(j) Ian Cummings, Essex Police
(k) Jo Barclay, Essex County Council Education
(l) Kate Harvey, National Probation Service (Hertfordshire)
(m) Lee-Ann Williams, Chelmsford Prison, Her Majesty's Prison and Probation Service
(n) Lidia Woods, Essex Specialist Treatment and Recovery Service (STaRs, Community Drug and Alcohol Service)
(o) Mette Vognsen, NHS England
(p) Mohammed Shofiuzzaman, West Essex Clinical Commissioning Group
(q) Tina Snooks, Essex County Council Youth Offending Service
(r) Tracy Pemberton, Hertfordshire Constabulary

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

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

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

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

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

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

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

(f) Timothy Samwell, HMP Rochester

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

1.7.17 Consistent engagement and contributions from some agencies was a challenge, particularly with regard to requests for information to be submitted, meeting attendance, and comments being made on drafts of the Overview Report and other information to be provided to the DHR. Individual contact was made by the independent chair to follow up on these and make progress.

1.7.18 Through the DHR process it became clear that many of the responsibilities for the response to domestic abuse were held at the county level through the Southend, Essex and Thurrock Domestic Abuse Strategic Board. The Uttlesford District Council Housing and Communities Manager is part of this countywide partnership at a strategic level, and a Community Development Officer engages at an operational level. With the former, this is limited to partnership Housing responses to domestic abuse, and involvement with other work streams is not currently in place.

1.7.19 As a result, some of the recommendations from this DHR have been made for the county level group rather than the Uttlesford CSP, although the latter, as the owner of the DHR, will retain responsibility for keeping track of their progress.

1.7.20 In addition, this DHR recognises that the two-tier structure in Essex has led to complications in relation to the DHR process itself, with the potential for recommendations being agreed at a local level that need to be implemented at a county level, at which point they may have be inappropriate, or have been superseded, by ongoing activities.

1.7.21 Changes made to the DHR process in Essex since this Review has been carried out should address this: coordination of DHRs are now centralised to the Southend Essex and Thurrock (SET) Domestic Abuse team at Essex County Council. They work alongside district level Community Safety Partnerships in the delivery of DHRs, who are also represented at the county level DHR Thematic Group.

1.7.22 Part of the new centralised system is a pool of appointed independent chairs to ensure consistency. The chairs will hold DHR panels at a local level and feed recommendations and action plans back to the central SET Domestic Abuse team, which in turn will share these with the county level DHR Thematic Group which is answerable to the SET Domestic Abuse Board.

1.7.23 A Thematic Review has been completed of DHRs conducted in Essex, with an action plan in place to address shared learning from these. The independent chair met with the county-level leads for domestic abuse and ensured that relevant learning and ongoing actions were incorporated into the DHR.

1.8 Parallel Reviews

1.8.1 *Independent Mental Health Investigation*: Due to Ryan's extensive involvement with mental health agencies, NHS England commissioned an Independent Mental Health Investigation. The NHS England lead for these was part of the Review Panel from the start, so that the two processes could run in parallel as much as possible. In particular, to avoid any duplication in relation to family contact, to reduce causing any additional distress.

1.8.2 Once the Mental Health Investigation had been commissioned (September 2016), the lead investigator was invited to be part of the Review Panel, and the independent chair maintained contact with them throughout the process. The DHR Terms of Reference (Appendix 1) were amended to reflect the ways in which the two processes would work together.

1.8.3 The Mental Health Investigation report was finalised in October 2017 and the findings added to the DHR (see 3.18.16). The recommendations from that report will be monitored by the Clinical Commissioning Group.

1.8.4 *Criminal trial*: The criminal trial concluded in May 2016. Ryan was sentenced to life imprisonment with a minimum term of 32 years. The chair and Review Panel ensured, through contact with and updates from Essex Police,that the two processes could run in parallel.

1.8.5 In light of the criminal court outcome, the Coroner decided no inquest would be held.

1.8.6 *National Probation Service (NPS) Serious Further Offence (SFO) Review*: These Reviews must take place when an offender, who is subject to supervision by a probation provider, is charged with a serious offence including murder. The review process requires a rigorous and open review of practice, in order to identify leaning for the future. An SFO review was submitted to the SFO Unit (National Offender Management Service) in October 2015. The Review was quality rated as good and an action plan has been implemented by NPS Head of Hertfordshire. The electronic records, current and archived files were reviewed, and staff were interviewed for the SFO review. These also informed the content of the NPS IMR.

1.9 Involvement of family, friends, work colleagues, neighbours and wider community

1.9.1 At the first Review Panel meeting, information was shared by Essex Police of the family and friends of Deborah and Michael who were known to them.

1.9.2 The independent chair wrote to:

(a) Deborah's father, son and ex-partner (Ryan's brother and father)

(b) Michael's daughter

1.9.3 Letters outlined the process and purpose of the DHR, included the Terms of Reference, and were sent with the Home Office leaflet and information about support services.

1.9.4 The Victim Support Homicide Service was already supporting them and therefore it was agreed for the letters to be given by hand by the Support Worker. This ensured that someone they were already in a trusting and supportive relationship with introduced the DHR and they had the opportunity to discuss it with them prior to speaking with the independent chair. Victim Support

were also in contact with a friend of Deborah's but was then unable to be reached to ascertain their involvement.

1.9.5 All letters made clear that the family's participation in the review was voluntary, and that they could contribute in different ways: for example, through a face-to-face meeting with the Chair of the Review, making a statement, or through a telephone conversation (not an exhaustive list). The letter emphasised that their contributions could take place at a time and place of their choosing, and that their involvement in the review would not be rushed.

1.9.6 The independent chair met with Deborah's son and ex-partner in April 2016. They reviewed the Terms of Reference, and gave feedback in relation to Deborah and Ryan. They were sent a copy of the draft Overview Report, and met with the chair to discuss it, in November 2016. They asked a number of questions, which the chair took to the relevant Review Panel members. All feedback has been added to this Overview Report.

1.9.7 At the completion of the Overview Report and Executive Summary, the chair contacted both and asked how they would like to progress. Both asked for a summary of what had been changed in the Overview Report, instead of reading the report again. A summary was sent, and further contact made to answer any questions and receive feedback and comments. The pseudonyms for the report were also checked.

1.9.8 The independent chair contacted the family a final time to inform them that the review was completed, and had been handed to the CSP. The contact details for the CSP lead were provided, and an outline of what would happen next. The CSP lead was given the contact details for the family, who was tasked to contact the family prior to the review being published.

1.9.9 The independent chair conducted a telephone interview with Michael's daughter, and her feedback was incorporated into the DHR. She was invited to read and feedback on the draft Overview Report, and no response was received.

1.9.10 The independent chair also wrote to Ryan in the prison in which he is detained. This was done on two occasions: shortly after the completion of the trial, and again four months later, as no response had been received. During the completion of the review, the independent chair was informed that Ryan had died in prison.

1.10 Equality and diversity

1.10.1 The independent chair and the Review Panel did bear in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the DHR process. No local area protected characteristics were identified as relevant.

1.10.2 Gender was felt to be a relevant factor as Deborah was a female victim of domestic abuse. It is well established that domestic abuse is a gendered crime and recent analysis of domestic homicides in the UK has illustrated that women are primarily the victims of domestic violence homicides and men are primarily the perpetrators[2]. It is of note in this case that Ryan also abused his father. The Review Panel discussed this during analysis of IMRs and is addressed specifically in section 3.31.

1.11 Chair of the DHR and author of the Overview Report

1.11.1 The independent chair and report author was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received DHR Chair's training from STADV. Althea has ten years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has chaired and authored eleven DHRs.

1.11.2 STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. STADV has been involved in the DHR process from its inception, chairing over 50 reviews.

[2] Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office and Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

1.11.3 *Independence:* Althea Cribb has no connection with the Uttlesford CSP or any of the agencies involved in this case. Authors of IMRs were independent of line management of the practitioners working with the individuals in the case.

1.12 Completion of the Review

1.12.1 The Overview Report and Executive Summary were handed over to the Uttlesford Community Safety Partnership in October 2017 for the action plan to be completed and the Review to be submitted to the Home Office for quality assurance, followed by publication.

1.12.2 The action plan was not progressed by the CSP until March 2019. The action plan was not progressed by the CSP until March 2019. Changes within the staff responsible for the Community Safety Partnership and changes within the structure of the Community Safety team further added to the delay. A misinterpretation of an email that led the CSP lead to believe that the process could not be progressed, as the mental health report had not been received, the lack of agency updates and not having a dedicated resource in place led to the action plan remaining incomplete.

1.12.3 Once recognised, the situation was resolved as quickly as possible, and the families were informed. The action plan was updated to reflect action taken and changes made to services since the completion of the Review. The Review was submitted to the Home Office Quality Assurance Panel. The Panel approved publication of the Review, subject to some changes:

(a) A proof read of the reports: completed prior to publication

(b) The Panel felt that the report was very lengthy which they found difficult to read so suggested annexing some of the content around the perpetrator to provide a more balanced report: this action was completed, with summaries of Ryan's contact in the main report, and the detail moved to an appendix. It was important to retain the detailed information in the Review, as this had been welcomed by the family in trying to understand what had happened, and was the basis for many learning points.

(c) The action plan needs updating to show dates and deadlines: completed.

(d) The panel noted that whilst economic abuse was recognised in the report, it would be beneficial to label it as such: completed.

(e) The report would benefit from further consideration of how standard risk cases are managed and whether this could be enhanced: an update was

provided from the Southend Essex and Thurrock Domestic Abuse Team, as follows:

- A commissioning process took place in 2019 resulting in a new Domestic Abuse Helpline. COMPASS went live on 1st April 2019 and is the new 24-hour point of access for victims of domestic abuse across Southend, Essex and Thurrock providing information, advice and guidance and, where appropriate, assessment and access to specialist services. Its function is to increase accessibility to ensure victims of domestic abuse (women, men and young people aged over 16) get the right support at the right time. It is funded by Essex County Council in partnership with the Office of the Police, Fire and Crime Commissioner for Essex.
- Callers speak with a trained member of staff and there is also an online form for both public and professionals wishing to make a referral via the website. COMPASS is delivered by Southend on Sea Domestic Abuse Projects. The telephone number is 0330 333 7 444. The website is www.essexcompass.org.uk. Community services and specialist accommodation are delivered by SOS Domestic Abuse Projects, Changing Pathways and Next Chapter. These community-based services are local hubs incorporating specialist accommodation such as refuges, Independent Domestic Violence Advisors and outreach work.

(f) At the Quality Assurance Panel, further information was provided from NOMS in relation to recommendation 3. This is included in Appendix 5.

1.12.4 Following the completion of the above actions the Review was published as quickly as possible, and the families were notified.

Additional changes and updates since October 2017:

1.12.5 Since the Review was completed there have been significant changes in the way domestic abuse and DHRs are managed and responded to in Essex. These are outlined below.

1.12.6 In discussions towards the completion of this Review, we looked at learning from the delay that occurred: specifically, there were a large number of agencies on the Review Panel, and only two of these had requested updates from the CSP about the progress of the Review towards publication. This raises questions about Essex agencies that are involved in Reviews, and their internal processes for ensuring that they receive updates on quality assurance and publication. The

SET Domestic Abuse Team will take an action forward in relation to this, to ensure that all organisations recognise their joint responsibility for the completion of Reviews and the need for internal processes to track their completion and sharing the learning with staff.

1.12.7 Domestic Homicide Review process: In 2018, the way in which Domestic Homicide Reviews are commissioned and delivered has changed in Essex. A DHR Core Group is in place as a decision-making group to consider notifications of reviews and recommend if they meet the criteria. This includes the relevant Community Safety Partnerships which continue to have statutory responsibility. At the same time Essex introduced different levels of DHRs depending on the type of case, and this level is decided by the Core Group. The Southend Essex and Thurrock Domestic Abuse Team (SET DA Team) oversees the process and coordinates the DHR alongside the independent chair and the CSP. All DHRs are now published centrally on the SETDAB website. The learning is shared across the partnership through Domestic Abuse Reference group and events, and DHR Thematic reviews are undertaken. The CSPs are responsible for overseeing and chasing Action Plans with some oversight and support from the SET DA Team. This new process ensures that a similar situation to this DHR will not occur again.

1.12.8 Regarding MARAC the process is now static with representatives from Police, Children's Social Care, IDVA Services and a Chair always present. In addition referring agencies are asked to attend the meeting in person and any agencies who have had involvement with the individuals in the case are required to provide a written update and can also attend in person if they wish. Each case is allocated 30 minutes and an action plan is completed as a panel to address any outstanding risk that has not been managed by the agencies around the table. This action plan is then given time scales for the tasks to be completed by. There is also now a permanent perpetrator worker within MARAC from Project Columbus (The Change Project) who will look at each perpetrator to see if they can do any behavioural change work with them to address their offending behaviour. The Police will also look to see if they can implement any distraction tactics to interrupt their behaviour. Essex MARAC hear approximately 12 cases a day Tuesday- Friday and each area has allocated days. Southend MARAC takes place weekly on a Thursday as they have fewer cases.

2. The Facts

The principle people referred to in this Report					
Referred to in Report as	**Relationship to Deborah**	**Age at time of Deborah & Michael deaths**	**Ethnic Origin**	**Faith**	**Disability**
Deborah	Victim	54	White British	Not known	None known
Michael	Victim (friend of Deborah)	60	White British	Not known	None known
Ryan	Perpetrator of homicides Son of Deborah	23	White British	Not known	None known

2.1 The deaths of Deborah and Michael

2.1.1 *Homicide:* Deborah lived in Uttlesford with Ryan. Michael lived separately in Uttlesford. The murders took place at Deborah's home.

2.1.2 At 11pm on the date of the homicide, Essex Police received a 999 call from a man who stated that there had been a murder, and gave Deborah's address. The man kept hanging up, and refused to answer the operator's questions.

2.1.3 Police attended and found Ryan in an alley close to the stated address with blood on his hands and carrying a carrier bag. When asked where the blood was from, he indicated the address.

2.1.4 Officers entered the address and discovered Deborah, who was pronounced deceased immediately, and Michael, who was pronounced deceased at the scene following unsuccessful attempts by the attending paramedics to resuscitate him.

2.1.5 An officer observed Ryan laughing, and given the circumstances, arrested him. On transfer to the police station, a mobile phone was found on Ryan that was identified as the one that had made the original telephone call.

2.1.6 *Post Mortem:* Deborah had been stabbed at least 41 times in the head, neck and torso and died of these multiple stab wounds. Michael had suffered 56 wounds to his head, face and neck and died of severe head injuries.

2.1.7 *Criminal trial outcome:* Ryan pleaded not guilty and was convicted after trial of both homicides in May 2016. He was sentenced to life imprisonment with a

minimum term of 32 years. Although Ryan's mental health was a prevalent feature in this DHR, it did not feature in Ryan's defence.

2.1.8 The Judge said it was a "*brutal and sustained attack. One image that will stay in the mind of anyone involved in this case is that of the reconstruction of your mother's face showing the stamp injury attributed to your shoe on her left cheek. You are a man who attacked the people who loved you the most. Look at what you have done to them. By your actions you have ruined your family's life and you have ruined your life."*

2.2 Outline of relationship between Deborah, Michael and Ryan and family makeup

2.2.1 *Summary of relationships:* Deborah was Ryan's mother, and he lived with her at the time of the homicide. Michael was a friend of Deborah's who was visiting at the time. Some information received by the DHR suggested Michael may have been Deborah's intimate partner but this cannot be confirmed.

2.2.2 *Members of the family and the household*: Deborah had another child, an adult who did not live with her. Deborah's ex-partner, Ryan's father, lived nearby. Michael did not have any family with whom he was in contact at the time of the homicide (see 2.7).

2.3 Information relating to Deborah

2.3.1 Deborah was aged 54 at the time of her death. She was not employed, but had worked for most of her life, latterly as a school dinner lady. She had two (adult) children, Ryan being the younger. She and Ryan's father had separated approximately nine years previously. Information about Deborah from her family is presented below (see 2.6).

2.3.2 Deborah sought help from her General Practice and specialist agencies for issues relating to her mental health, and excessive alcohol use; she also called police a number of times with regard to Ryan's abusive and violent behaviour.

2.4 Information relating to Michael

2.4.1 Michael was aged 60 at the time of his death. Following the homicide, police established that Michael had multiple health problems, and had recently been treated for cancer.

2.4.2 Information from police, Michael's family and Deborah's family was not conclusive as to whether Michael and Deborah were in an intimate relationship or were friends.

2.4.3 Michael's daughter, who contributed to the DHR (see 2.7), had been estranged from him for many years.

2.4.4 It is clear from the information gathered for this DHR that Deborah and Michael spent a great deal of time together, liked to drink alcohol together, and Deborah had recently been Michael's carer following his cancer treatment.

2.5 Information relating to Ryan

2.5.1 Ryan was aged 23 at the time of the homicides, which took place three months after he was released from a lengthy custodial sentence for grievous bodily harm against his father. He was living with Deborah at the time.

2.5.2 Since leaving education after GCSEs he had been employed sporadically up to that conviction.

2.5.3 Ryan told the mental health trust that he had begun using illegal substances (starting with cannabis) when he was aged 11. His drug use, subsequent mental health issues, abuse and violence were significant factors in the course of his life and as a result the lives of his mother Deborah, his father and other friends and family.

2.5.4 Prior to the custodial sentence for grievous bodily harm, Ryan had lived between his father's and Deborah's, and his whereabouts were not always known.

2.6 Information from Deborah's family

2.6.1 The independent chair met with Deborah's son and ex-partner (Ryan's brother and father). They contributed the following about Deborah and her relationship with Ryan. Information specifically about Ryan is below (see 2.9).

2.6.2 They described Deborah as "*bubbly, very friendly … an extrovert*", that she was "*creative*" and loved cooking, and that she loved company.

2.6.3 When the children were young Deborah had looked after them and with their father had tried to make sure they "*had everything*" they needed.

2.6.4 Deborah had always worked, including as a school dinner lady for a long time, but that she had had to leave when her drinking "*took over*".

2.6.5 Deborah had always enjoyed drinking; it had always been a part of her life, but over time it had become "*worse and worse*". Her son felt that Ryan's behaviour (including breaking into Deborah's house, and causing disturbances) had an impact on Deborah's drinking; that she had always "*been a drinker*" but that dealing with Ryan's behaviour made it worse.

2.6.6 They talked about Deborah's help seeking for her alcohol use. Their impression was that after Deborah had gone through the detox process, she had stopped drinking for a few months, but that she should have had follow up to ensure that this continued. They didn't know why she hadn't got this – perhaps she hadn't felt she needed it at the time, or others had judged that she hadn't needed it, but it would have been helpful. The family felt that drinking was such a significant part of Deborah's life that reducing, rather than just stopping, her drinking would have been more realistic.

2.6.7 It was their view that Deborah and Michael were not in a relationship. They were friends, and Deborah had helped Michael after his operation(s) for cancer. Michael "*was a drinker as well*" and Deborah "*enjoyed having the company*" but that was "*as far as it went*".

2.6.8 Deborah's ex-partner felt that he and Deborah were not offered support or help in managing Ryan. Professionals would visit them or they would attend appointments, but because of confidentiality they would not share anything about Ryan or his treatment; and then Ryan stopped engaging with those services.

2.6.9 He said: "*I said [to Ryan] I'll take you to there and there and do this and do that, we're not poor people so it's not really a big problem that carer thing, it's not a thing that would bother us much. The only thing was that something had to be done with him, and nothing was.*" Deborah's son said: "*we didn't know what to do, that was the problem … [we needed] advice on what to do with him*".

2.6.10 The family were aware that Ryan posed some risk to them, and were concerned and fearful of what he could do. At one point Deborah's ex-partner told Deborah to "*put all the knives away*" but she wouldn't do that. They both stated that Ryan had never been violent towards Deborah:

Deborah's son: "*he'd never touched her, he had a soft spot for her. Same thing with the cats. He'd be angry all the time but then he'd cuddle up to the cats – what's so special about the cat? He'd never hurt mum had he?*"

Deborah's ex-partner: "*No, and I've seen your mum, when he's been taking drugs, and she's gone up to him and bashed on him in a rage, and I've thought, in a minute he's going to flip, but he never did, he didn't touch her, no.*"

2.6.11 For both, this meant that the incident of the homicide was "*out of the blue*" – because Ryan had been "*behaving himself*" since coming out of prison, but also because he had never been violent towards Deborah before. Similarly, the incident in which Ryan attacked his father (for which he was convicted of grievous bodily harm) came after a period of months in which Ryan had been working and not behaving in any ways that caused concern.

2.7 Information from Michael's family

2.7.1 The independent chair interviewed Michael's daughter on the telephone, and she contributed the following.

2.7.2 She explained that Michael and her mother had divorced when she was aged three years; and that she had last seen him when she was aged eight: Michael had dropped her and her mother at the airport for them to go on holiday with family, and when they returned she had no contact with him at all. She made many efforts to find Michael but was unsuccessful.

2.7.3 In October 2014, Michael's landlord visited her mother (Michael's ex-wife) to tell her that Michael was in hospital with cancer, which was severe. Her mother told her, and she went to see Michael in hospital. She wrote him a letter expressing how she felt about all that had happened.

2.7.4 When she visited the hospital, she spoke with doctors who informed her that Michael's cancer was not as bad as she had thought; that he had had all his surgery, and was not dying. She went in to see Michael and gave him the letter; she "*said what she wanted to say*" and left. Due to his surgery and cancer he was unable to speak at the time but he was awake and she felt he acknowledged what she was saying. She asked Michael to pass any response he had to her letter and visit through his landlord and her mother. She received no response.

2.7.5 Michael's daughter stated that she knew from her mother that Michael had always been a drinker. Everything else that she knows about Michael she found out after his death: that he was homeless a few years ago, had found a property, and seemed to be trying to get back on track.

2.7.6 She reported that Michael's landlord didn't think that Deborah and Michael were in a relationship, but the information she saw when going through Michael's effects suggested to her that they were: Deborah was recorded as Michael's carer when he was discharged from hospital, and also as his emergency contact while he was an inpatient. Hospital letters to Michael were addressed to Deborah's address. It was clear to her that Deborah was caring for Michael.

2.8 Information from Ryan

2.8.1 No information was received from Ryan (see 1.9.10 for details of the attempts that were made).

2.9 Information about Ryan from his and Deborah's family

2.9.1 Ryan's father stated that Ryan was "*borderline dyslexic*" and had gone to a "*dyslexic school, but they never invited him in to the dyslexic classes*"[3]; in Ryan's father's view, this was because of Ryan's behaviour. Ryan did have an educational 'statement' but it did not state that he was dyslexic (because he was 'borderline').

2.9.2 Ryan's father and Deborah had tried to manage Ryan together; once it became impossible for Ryan to live with Deborah, he went to live with Ryan's father.

2.9.3 Ryan's brother stated that he felt part of the problem for Ryan was that "*drugs are too readily available*" and for Ryan it had started at a young age and that this should be tackled.

2.9.4 Ryan's father and brother talked about the fact that Ryan would not engage with services, largely because from his perspective he was right and everyone else was wrong, and so he couldn't see why he needed the services.

2.9.5 For the family, it was never clear how his drug use and mental health issues interacted: did the drug use cause the mental health issues, or was he "*self-medicating*" to deal with feeling the way he did?

2.9.6 Ryan's father said: "*we went to the early intervention in psychosis team and they used to send someone round, they're supposed to be highly trained these people … and you think to yourself well you'll go along with it because this is all*

[3] The records available to this Review showed that Ryan had attended mainstream schools.

there is, so you go and see them and there were a couple of them came round, but then he's [Ryan's] not really taking any notice of them, now should they be able to identify that as him being a danger, at that stage, or not? Should there be someone who can identify that problem at that stage? It's not easy is it?"

2.9.7 Commenting on the police attending incidents at Deborah's house, Ryan's brother referred to a "*catch-22 [in which the police] can't leave until he's [Ryan's] gone, [but] he's not going as he's got nowhere to go.*"

2.9.8 Ryan's brother said: "*What went well for Ryan? Nothing stands out, not for me anyway. Not a lot was any use .... Not in terms of the help. Nothing seemed to make a huge difference.*"

2.9.9 Ryan's father felt that the only way Ryan could have been managed was for him to be detained, or forced through a criminal order, to engage with mental health services. The fact that Ryan did not have a diagnosis for his ongoing mental health issues was also a problem, and Ryan's father did not understand why Ryan didn't have a diagnosis.

2.9.10 Ryan's father expressed frustration at the fact that he had a significant role in managing and supporting Ryan, but that agencies couldn't tell him anything.

2.9.11 He said, "*you always hope that things will get better, that things will change, why doesn't he just get a job, why doesn't he just do this, do that, but he must have been taking drugs because he's acting like that – well that might not be the case.*"

Ryan's conviction for Grievous Bodily Harm, time in prison and post-release

2.9.12 Ryan's father and brother felt very strongly that, rather than being sent to prison in 2013, Ryan should have been assessed and given an order in relation to his mental health. Ryan's father was concerned that, if Ryan is again sent to ordinary prison for the homicides, "*in 20 years, in 30 years whenever it is that they let him out, he's still going to be the same isn't he?*"

2.9.13 After his release from prison (for assaulting Ryan's father) when Ryan went to live with Deborah, Ryan's father would check up on him and Deborah would report that he was "*absolutely fine*". Ryan was doing some strange things, such as cleaning the skirting boards, but nothing concerning. Both Ryan's father and brother felt that once Ryan was living with Deborah, they both improved:

Deborah was "*sorting herself out a bit*" and drinking less, and Ryan was "*behaving himself*".

2.9.14 Ryan's father said that probation had organised for Ryan to have somewhere to stay but it wasn't appropriate and Ryan couldn't stay there. Ryan's father said, "*when [Ryan] was released, I was assured that he would be totally assessed, and everything would be done – all the i's would be dotted and the t's would be crossed – rubbish.*"

2.9.15 Deborah felt under pressure to take Ryan in after his release from prison. Ryan's brother said: "*she actually said she wouldn't have him back. Her friends were saying, you can't have him back, that's it. There just wasn't a choice in the end.*"

2.9.16 Ryan's father did not understand why Ryan's licence, on his release, did not stop him from living with Deborah. He recounted a meeting with a probation officer in which she stated that it would not be appropriate for Ryan to live with Deborah, but this did not appear on Ryan's licencing conditions.

2.10 Comments from Deborah's family about the Overview Report

2.10.1 Deborah's son and ex-partner (Ryan's brother and father) were provided with a copy of the draft Overview Report in November 2016. They were given time to read the report, followed by a meeting with the independent chair to ask questions and give their feedback. The chair took their questions back to the relevant agencies for further exploration and incorporated this into the Overview Report.

2.10.2 Deborah's son's and ex-partner's feedback was that it felt that "*no-one talked to each other*" and that the impression they had from reading the agency contact with both Deborah and Ryan was one in which practitioners did "*their bit*", documented it and then "*moved on*" as if their job were done.

2.10.3 They recognised that probation had taken on board that the response following Ryan's release in April 2015 was not adequate, and were pleased to see all of the actions that had been taken. They also expressed concern that it was not clear that something like that situation would not happen again, in particular the lack of license conditions for Ryan on his release, and the lack of supervision of Ryan when he came to live with Deborah. This query was put to probation who provided the following response:

2.10.4 "*The issues around pre-release arrangements were in the context of the officer's workload at the time. All staff now have their workloads regularly monitored and the particular staffing issues that were acute at the time have now been resolved. [With regard to] the rationale for reducing Ryan's reporting to monthly, [it] was based on the combined factors of what appeared to be an increase in stability in accommodation and an improving outlook. Having said that, we now know this was not the case. Additionally, any reduction of reporting can only now be implemented with manager approval/scrutiny.*"

2.11 Overview and Chronology of each agency involvement

2.11.1 During the Terms of Reference timeframe for this DHR, Deborah had contact with eight agencies. Michael had contact with three and Ryan had contact with 17.

2.11.2 Deborah's and Ryan's contact is separated into two chronologies below. They are separated to show as clearly as possible their pathways through agencies and their experiences of contact with professionals. Additionally, Ryan's contact with agencies was significantly more extensive that Deborah's; to include her history alongside Ryan's could risk losing the focus on her. Due to the extensive contact, some of the chronology concerning Ryan is summarised, with the detail attached in Appendix 1.

2.11.3 Michael's contact with agencies is presented below (see 2.11.11). Summaries of Deborah's and Ryan's contacts are presented below (see 2.11.4 and 2.11.6), followed by the detail in sections 2.12 (Deborah) and 2.13 (Ryan).

Summary of Deborah's contact with agencies

2.11.4 Deborah's contact with her General Practice and STaRS (and ADAS) was centred on her request for help to deal with problematic alcohol use as well as mental and physical health issues (as a result of which she also attended Princess Alexandra Hospital).

2.11.5 Her contact with Essex Police, the Multi-Agency Risk Assessment Conference (MARAC) and Victim Support was in response to her calls about Ryan's abusive and violent behaviour.

Summary of Ryan's contact with agencies

2.11.6 Ryan's contact with agencies during the Terms of Reference timescale was extensive. The Terms of Reference started in 2003, when Ryan started secondary school aged 11. From this time he was in contact with the school and other education services until he finished his GCSEs and left education in 2008. He was open to the Connexions service (an advice, guidance and support service for young people) from 2007 to 2011.

2.11.7 He was also coming in to contact with Essex Police at this time (starting in 2005) for drug, theft and violence offences (including abuse and violence against his mother Deborah and his father). These resulted in convictions and criminal justice orders involving the Youth Offending Service (2008 and 2009-10) and the Essex Young People's Drug and Alcohol Service (EYPDAS) (2010), and subsequently probation (2011-12).

2.11.8 This overlapped, as he turned 18, with contact with his General Practice and the Early Intervention in Psychosis (EIP) Team at Essex Partnership University NHS Foundation Trust (EPUT[4]) with regard to his mental health, from 2010 to 2012. In November 2010 he was hospitalised under the Mental Health Act Section 2. He was discharged from the inpatient service in December 2010, and was re-admitted in January 2011, and discharged again in February 2011. He remained an open case to the Early Intervention in Psychosis (EIP) Team until he was imprisoned in August 2012.

2.11.9 Alongside ongoing reports from Deborah and his father to Essex Police through 2010, 2011 and 2012, Ryan was also coming to the attention of Hertfordshire Constabulary (from 2011) for offences of abuse and violence against his father. These resulted in a conviction and period of imprisonment (starting August 2012). Ryan was held in six prisons and moved eleven times, during which he had contact with four mental health trusts. He was on probation licence after his release in April 2015.

2.11.10 In 2011 Ryan applied for housing in Essex; and in 2012 he applied in East Hertfordshire.

Michael's contact with agencies

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

2.11.11 Michael had minimal contact with agencies. The only contact relevant to this DHR was with his General Practice and Princess Alexandra Hospital. Practitioners at both attempted to engage with Michael about his problematic alcohol use, or had opportunities to do so.

2.11.12 Michael attended the Emergency Department of Princess Alexandra Hospital in March 2014 following a fall down the stairs. He was noted as smelling of alcohol, and recorded as having said he had been drinking prior to the fall. He was treated for the injury and discharged.

2.11.13 The General Practice had contact with Michael about his drinking in February 2015 when he attended an appointment smelling of alcohol. The doctor attempted to engage with Michael about his use of alcohol, and recorded that Michael "*became quite hostile at any attempts to discuss*" and said he would continue to drink.

2.12 Chronology of Deborah's involvement with agencies

2010

2.12.1 In April 2010 Ryan's father called Essex Police, as Ryan was being aggressive. No offences had been committed; Ryan's father was identified as at standard risk[5] through the DV1[6].

2.12.2 In November 2010 Deborah called Essex Police and reported Ryan was making threats against her and trying to break down the back door. Ryan was arrested for a breach of the peace; subsequently no further police action was taken against Ryan (he was assessed at the police station and detained under the *Mental Health Act 1983* following this; see 2.13.65). Deborah completed a DV1 and was identified as at standard risk.

2011

2.12.3 In February 2011 Deborah called Essex Police stating that she wanted Ryan removed from her home as he had been taking drugs. Ryan later pleaded guilty to drug offences. Essex Police did not record it as a domestic incident.

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[5] Definition: current evidence does not indicate likelihood of causing serious harm

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

2.12.4 A week after that incident Deborah attended her General Practice seeking help due to "*stress*". The doctor recorded that Deborah stated: "*son has a history of mental health issues and been in hospital. … [Deborah] feeling stressed and anxious and unable to work*". A medical certificate was provided for Deborah to be off work and she was given the number for Mind (mental health support organisation)[7] for her to contact them for support. Deborah did not discuss this again with the General Practice until almost a year later (January 2012, see 2.12.11) although she did have appointments about physical health issues during this time.

2.12.5 Ryan called Essex Police twice in September 2011 alleging that he had been assaulted, first by Deborah and then four days later by his father. No police action was taken and Ryan refused to complete the domestic abuse form on both occasions. On the first occasion the alleged assault took place while Deborah was trying to get Ryan to leave her home. On the second occasion Ryan was noted to have "*mental health issues*" and Deborah was recorded as telling officers Ryan "*was becoming increasingly difficult to deal with and she no longer wanted him living at home*".

2.12.6 Deborah called Essex Police in October 2011 and reported that Ryan was "*smashing … up*" her home and that although "*he had not been violent before she was concerned he would be now*". A DV1 was completed with Deborah and she was identified as medium risk. Ryan pleaded guilty to charges of criminal damage and received a six month community order with probation (see 2.13.94).

2.12.7 In November 2011 Deborah called Essex Police as Ryan had broken into her home. When officers attended, Ryan had left. A DV1 was completed with Deborah and she was identified as standard risk. Deborah was given advice about security arrangements for her home and getting a restraining order against Ryan.

2.12.8 Ryan's father called Essex Police on 28 December 2011 and reported Ryan had been aggressive towards Deborah; that Ryan had mental health issues and "*everyone was scared of him*". Ryan was asked to leave the house by officers, which he did. A DV1 was completed with Deborah in which the risk was identified

[7] Mind West Essex were contacted as part of this review and had no record of contact with Deborah.

as high[8]. The Essex Police supervising officer recorded that although there had been no offences, the incident would remain open to the Domestic Abuse Safeguarding Team[9] as the high risk identification needed to be confirmed by that team. When the incident was recorded on the appropriate database it had apparently been downgraded to medium risk[10] with no rationale recorded, neither did the record state who had made the decision.

2.12.9 Two days later on 30 December 2011 Deborah called Essex Police and reported that Ryan was outside her house and about to "*kick off*" as he was under the influence of drugs. Officers removed Ryan to prevent a breach of the peace. Deborah did not complete the DV1; through completion of a 'skeleton' DV1[11], officers identified her as at medium risk.

2012

2.12.10 Ryan's father called Essex Police on 13 January 2012 and reported that Ryan was threatening suicide; no offences were recorded and Ryan was not detainable under the Mental Health Act. This contact was not recorded as domestic abuse.

2.12.11 Shortly after this, Deborah had two appointments with her General Practitioner in January 2012, two days apart. In both she reported "*stress with a family member*" that was an "*on-going issue*" and that the police had been involved, and that the family member had been assessed for a "*section*" but not met the threshold. In one appointment, she was recorded as "*not coping with work*" and was signed off. She was given the contact details for Mind. A review appointment was set for a week later, there was no record of this taking place; her next contact was almost a year later, in December 2012 (see 2.12.31).

2.12.12 Deborah called Essex Police three times in eight days at the end of January 2012. She reported that Ryan was abusing her and this was a "*regular occurrence*". On the first occasion Ryan was removed from the premises; no

[8] Definition: identifiable indicators of risk of serious harm; the potential event could happen at any time and the impact would be serious

[9] At this time there were three teams covering the three Local Policing Areas of Essex who were responsible for responding to victims of domestic abuse who had reported to police; they have since been replaced by one Central Referral Unit.

[10] There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, e.g. failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol misuse.

[11] On occasions when the victim declines to complete the DV1, the officer completes it with the information they have available, and makes an assessment of risk based on this information

further action was taken. Deborah did not complete the DV1; an officer completed a 'skeleton' DV1 and Deborah was identified as medium risk.

2.12.13 On the second occasion Deborah reported (in the middle of the night) that Ryan had broken into her home (after she had "*kicked [him] out*") and "*threatened to rape her*". Deborah was recorded as reporting she felt that no one was helping her and that Ryan would have to harm her before agencies did anything. She stated he had threatened to kill friends and family members in the past. Ryan had left when officers attended, and no further action was taken. Deborah completed the DV1 and was identified as medium risk. She was given advice about security in her home and obtaining a restraining order.

2.12.14 Later that same day Deborah contacted the National Centre for Domestic Violence (NCDV), a national organisation supporting victims of domestic violence with applications for non-molestation orders. Deborah stated she had been advised to call by a police officer (unnamed). NCDV drafted an order and posted it Deborah the same day. No further contact was made to the service by Deborah.

2.12.15 On the third occasion, Deborah reported Ryan had tried to break into her home and had shouted "*I am going to f***ing kill you*". Deborah believed he may follow through with the threat. Ryan was arrested for criminal damage, threats to kill and using violence to secure entry to the house. He pleaded guilty to criminal damage and was sentenced to a compensation order of £200. The Crown Prosecution Service (CPS) stated that Ryan should not be charged with threats to kill. The charging advice from the CPS requested that the Court prosecutor make an application for a restraining order when Ryan appeared for the criminal damage charge; there is no record as to whether this was progressed.

2.12.16 Deborah completed the DV1 and was identified as high risk. As a result of this, Deborah was contacted by a Domestic Abuse Liaison Officer (DALO)[12] who offered support and advice. Deborah was also referred to the MARAC.

2.12.17 The DALO contacted Deborah the day after the incident. The following was recorded from the conversation:

[12] Officers whose role it is to support domestic abuse victims following their report to the police; since renamed Domestic Abuse Safeguarding Officers.

Ryan's behaviour was becoming erratic and was a major cause for concern. This incident was the worst he had been, and Deborah felt that if he had been able to gain entry to the house that he would have caused her harm. Deborah talked about Ryan's mental health issues although these had "*never been confirmed*" and his heavy drug use, which she felt had an impact on his aggressive behaviour. The DALO described Deborah as having "*reached the end of her tether. She has been worn down by Ryan's behaviour. She does not sleep properly and is always looking over her shoulder.*" The DALO agreed to arrange a Crime Reduction Officer to visit Deborah to carry out a security assessment of her home (this took place on 22 March 2012). The DALO noted that Deborah had been seeing a counsellor but she wasn't happy with them, and advised her to see her General Practitioner to gain a referral to a different service. The DALO recorded that Deborah needed some support and assistance, and discussed the support available from Parentline Plus[13], who Deborah said she would contact. Deborah was noted as having contacted the NCDV (see above) to explore obtaining a non-molestation order, however she was not entitled to legal aid. Deborah was recorded as not feeling positive about this as an option, as she believed that if Ryan breached it he could be sent to prison and be surrounded by drugs, which would not solve the problem. Following Ryan's sentence of a compensation order for the criminal damage, Deborah was recorded as having told the DALO that she was very disappointed with the outcome and felt "*it's not worth calling the police*". The DALO recorded giving advice to Deborah to call the police on every occasion

2.12.18 Following this same incident, Victim Support received a notification via an automated system from Essex Police. The notification was flagged as domestic abuse. The Victim Contact Unit attempted telephone contact on the same day. Deborah's phone went straight to voicemail; no message was left as per the policy not to leave messages in domestic abuse cases.

2.12.19 As a result of Deborah's identification as high risk, she was referred by the DALO to the Victim Support Independent Domestic Violence Adviser[14] service

[13] Now Family Lives (www.familylives.org.uk) a national family support charity providing help and support in all aspects of family life.

[14] Nationally recognised specialist domestic abuse support role engaging with high risk clients. See

(now delivered by Safer Places). Contact was attempted four times: twice on the same day as the referral (mobile switched off; phone to voicemail); once the next day (1 February 2012, phone to voicemail) and once the day after that (2 February 2012, phone switched off). The record showed that the IDVA emailed the DALO to inform them that contact was not established. The case was closed.

2.12.20 Deborah was next in contact with Essex Police in March 2012, when she called to report that Ryan had thrown a brick through the front window of her home. Officers established that Deborah had not seen Ryan do this: she believed it was him as she "*has on-going problems with him*" although she had not heard from him since the previous incident at the end of January 2012. No further action was taken. A DV1 was completed with Deborah; she was identified as high risk. Deborah was then downgraded to medium risk (no rationale for this was recorded).

2.12.21 The day after the incident, Victim Support received a notification via an automated system from Essex Police. The notification was not flagged as domestic abuse and as per policy, a letter was sent to Deborah offering support. The case was closed after no response was received.

2.12.22 Two days after the incident a member of the Police MARAC[15] team contacted Deborah (as per procedure for all victims to be discussed at MARAC) and recorded that she "*is ok and does not feel that there is anything further she needs from MARAC*".

2.12.23 The MARAC meeting was held shortly after this on 13 March 2012. MARACs are nationally recognised as multi-agency meetings, usually held on a monthly basis, to share information and safety plan for high-risk domestic abuse victims.

2.12.24 Essex Police shared information about the incident that led to the referral (from the end of January 2012, see 2.12.14), the incident from March 2012, and information from the DALO's contact with Deborah (see 2.12.16). Information was also shared by:

(a) Probation: Ryan was on a six month community order; he was residing with his father but this was also problematic as Ryan had assaulted him; housing was a significant issue for Ryan and he had not been accepted for housing

[15] A regular local multi-agency meeting to share information about, and make action plans for, high risk victims of domestic abuse. For more information see: http://www.safelives.org.uk/practice-support/resources-marac-meetings.

in supported accommodation in Uttlesford as his needs were assessed to be too high; Probation were liaising with the North Essex Partnership University NHS Foundation Trust (NEP) and the EIP Team about Ryan's care and housing.

(b) NEP Criminal Justice Mental Health Team: Ryan was open to the Early Intervention in Psychosis Team and had previously been admitted twice to the inpatient unit "*due to heavy drug use*".

(c) IDVA: MARAC record stated "*case closed*" (see 2.12.19).

(d) Uttlesford District Council: Ryan was seen in November and a referral completed for supported housing (see 2.13.95 & 96).

2.12.25 The following actions were recorded:

(a) Safer Places (voluntary sector specialist domestic abuse provider covering west Essex): Send Deborah information offering support.

(b) Probation: Update MARAC on Ryan's housing.

(c) Essex Police: Check the Crime Reduction Officer visit was offered and make a welfare call to Deborah regarding an update on the non-molestation order.

(d) MARAC Team: Forward the case notes to Hertfordshire MARAC as Ryan was living with his father.

(e) NEP Criminal Justice Mental Health Team: Provide an update to MARAC on Ryan's progress

2.12.26 In an update to the minutes, all actions were recorded as completed with the exception of the Essex Police actions. The police records show that the actions were completed (including on 23 March 2012 that the information about Ryan and the risks he posed to Deborah and his father was shared with Hertfordshire Constabulary).

2.12.27 Three days after the MARAC meeting, a superior officer reviewed the downgrading of Deborah that took place following the incident earlier in March (see 2.12.20). They concluded that Deborah should remain at high risk and that a further referral should be made to the MARAC to "*offer them [the family] all the help and support we can in an effort to prevent any more domestic [incidents] occurring in this household.*" This was recorded as completed on 25 March 2012; there were no further records in relation to this and the MARAC team received no referral.

2.12.28 At the same time, the visit of the Crime Reduction Officer (arranged by the DALO following the incident at the end of January 2012) took place. A number of recommendations were made, which, as she owned the property, she would need to action.

2.12.29 The DALO made a follow up call to Deborah in April 2012. Deborah reported that she felt the Crime Reduction Officer visit was "*not much help*". She was recorded as saying that Ryan was not causing her problems at the time. This was the last contact between Deborah and Essex Police.

2.12.30 In August 2012 Ryan was arrested for grievous bodily harm against his father and remained in custody from them until April 2015 (see 2.13.126).

2.12.31 In December 2012 Deborah saw her General Practitioner; the appointment was recorded as due to "*stress related problem*" relating to her parent being unwell and because her "*son has serious issues*". Deborah was signed off work. She returned and saw the same General Practitioner two weeks later, and it was recorded that her "*son in prison for five months (beat up his father). Very low and wants advice/counselling.*" Deborah was prescribed anti-depressant medication. The record stated that Deborah would self-refer to Mind and to Open Road[16]. The notes after Open Road stated "*as had drink problem in recent past*".

2013

2.12.32 A review appointment took place at the end of January 2013. Referrals to Open Road and Mind were again discussed. Deborah was recorded as "*depressed and drinking a lot*". Deborah was provided with questionnaires to complete, the purpose of both was to allow the General Practitioner to assess the severity of a patient's anxiety and/or depression. At an appointment two weeks later (February 2013) Deborah had not completed these nor had she contacted Mind or Open Road.

2.12.33 At the next review appointment, two weeks later (end of February 2013) the General Practitioner made a referral for Deborah to the Community Mental Health Team (NEP).

2.12.34 This referral was received in early March 2013 by NEP: the referral stated it was for "*severe depression and anxiety*" and also that Deborah was "*an alcoholic*"

[16] Open Road were contacted as part of this review and had no recorded contact with Deborah.

and "*son [is] in prison for the past 7 months and her marriage*[17] *broke down some time ago*". The referral was passed to the Community Drug and Alcohol Team (CDAT, now STaRS), and a joint assessment with the Community Mental Health Team (CMHT) was arranged for 8 April 2013 (the appointment letter was copied to the General Practice).

2.12.35 Deborah saw her General Practitioner again twice in March 2013 and was prescribed anti-depressant medication; she then did not attend until September 2013. A referral for Deborah to ADAS was recorded at the end of March 2013.

2.12.36 Following this referral ADAS wrote to Deborah twice offering her appointments, in April and May 2013 (letters copied to Deborah's General Practice). She did not respond to these letters and her case was closed.

2.12.37 Deborah attended a rearranged appointment with CDAT and CMHT at the end of April 2013. The following history was taken for Deborah:

(a) She was 52 years old and was in an 8-month relationship with a male[18] who was also consuming excess amount of alcohol.

(b) Deborah reported that her son Ryan had a history of using illicit substances and was in prison for assaulting his father (her ex-partner) and this was listed as one of her main concerns.

(c) Deborah had stopped working seven weeks earlier and was finding it difficult to function with everyday tasks, and struggling with money as she was not on benefits.

(d) Deborah reported drinking alcohol daily approximately 40 units on a typical day[19] and no history of using illicit substances; she reported the current episode was of three years at this level; she would start drinking one hour after waking.

(e) Deborah reported experiencing alcohol withdrawal symptoms: tremor, sweats, nausea, agitation and anxiety, and black outs. She complained of pain in her liver and kidney area.

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[17] NB: this was as recorded by the agency; Deborah and Ryan's father had never married.

[18] Not believed to be Michael.

[19] According to Alcohol Concern's online unit calculator, this is the equivalent of approximately 20 pints of lager or 17 standard-size glasses of wine; the recommended weekly limit is 14 units.

(f) Deborah had been prescribed antidepressants by her General Practitioner but had ceased taking them in the last couple of months.

(g) Deborah was recorded as being "*low in mood and anxiety over family problems*".

2.12.38 The interim care plan was for the CMHT not to offer a service, and for Deborah to be supported by CDAT through the following actions:

(a) Arrange a medical examination for Deborah.

(b) Offer Deborah to attend the Preparation for Change Group at CDAT (the aim of the group is to reduce alcohol intake and to prepare for treatment if that has been indicated).

(c) For Deborah to keep a drinks diary and to explore applying for benefits.

(d) Deborah was advised not to drive.

(e) Deborah was given advice and information regarding the sudden cessation of alcohol intake.

(f) It was noted that Deborah had also been referred to ADAS [by her General Practitioner].

2.12.39 CDAT wrote to Deborah's General Practice and to ADAS with this outcome.

2.12.40 Deborah was given three appointments for medical examinations in May 2013, which she did not attend. The CDAT Duty Worker spoke with Deborah who reported drinking 27 units of alcohol a day, and had also been looking after her parent who was unwell. She reported that her son was in prison, and that she had lost her job the week before. Deborah told the worker that she found it difficult to get to CDAT; the worker explained that Deborah would have to wait a lot longer for an appointment nearer to her, and Deborah agreed to attend CDAT. Deborah was offered an appointment at the end of June, which she did not attend.

2.12.41 CDAT next contacted Deborah in August 2013, requesting that she contact the service or they would close her case. Deborah contacted them, and attended a medical examination appointment on 9 September 2013.

2.12.42 Two days after that appointment Deborah attended her General Practice and was prescribed anti-depressant medication and a medical certificate was issued (in relation to Deborah accessing benefits). No further prescriptions of the anti-depressant were recorded.

2.12.43 Deborah met with the CDAT Worker twice in October 2013. Deborah was recorded as drinking 5 units per day. She was recorded as having been attending the Preparation for Change Group[20] and requested a "*community medically assisted withdrawal from alcohol treatment*". (STaRS have informed the DHR that records were not kept in relation to these groups.)

2.12.44 Deborah stated that her (adult) child would be at home with her during the treatment and that friends would also be present to help. It was noted that ADAS had closed her file, as she had not responded. The record stated that a risk assessment had been updated, and a care plan completed.

2.12.45 The risk assessment and recovery plan identified the following:

(a) History of consuming alcohol at harmful levels, currently alcohol dependant.

(b) Deborah reported fleeting impulsive thoughts of suicide when intoxicated, with recent overdose attempt with a friend's prescribed medication seven months prior.

(c) Deborah also reported feeling distress over her son's imprisonment and her parent's ill health.

2.12.46 The agreed plan was to cease alcohol use and aim for abstinence. Deborah would be assessed for treatment either as an inpatient or community detox with a follow up consultant appointment to discuss and assess for supportive medication post detox. Deborah was given a Trust-line crisis card and explained to her contact numbers and who to contact in emergency.

2.12.47 Through November 2013 the CDAT Worker engaged with Deborah, and Deborah's friends and family, to arrange detox treatment at home for January 2014. This felt too long to wait for Deborah, and so inpatient treatment was explored and Deborah entered this in early December 2013. This was accompanied by a plan for Deborah to be re-referred to ADAS (by CDAT) and for her to see her General Practice following detox for medical intervention to support abstinence.

2.12.48 Deborah attended her General Practice in mid-December following her successful completion of detox treatment. The General Practice also received a

[20] The Preparation for Change Group was a weekly rolling group for clients to attend to prepare for treatment, facilitated by a support worker. A qualified nurse would attend a session every 4 weeks to talk about the detox process i.e. medication, what to expect during treatment.

letter from the inpatient doctor requesting Deborah be prescribed medication to support relapse-prevention, and that this prescription should continue for a year.

2.12.49 ADAS contacted Deborah following her detox to offer an appointment. Deborah did not respond and no further contact was made. Shortly after this, at the end of December 2013, CDAT closed Deborah's case and she was discharged to the care of her General Practice, who was also written to.

2014

2.12.50 In January 2014 Deborah attended her General Practice and was prescribed one month of the abstinence-supporting medication. It was added to Deborah's list of prescribed medications, for her to request a repeat, which she did not.

2.12.51 In April 2014 Deborah attended the Emergency Department of Princess Alexandra Hospital with an injury to her foot, after having fallen; she could not remember the nature of the fall. She was treated, and also received treatment from the Orthopaedic Consultant in June 2014.

2015

2.12.52 Deborah had no contact with any agencies until January 2015, when she attended her General Practice three times. At the first appointment (with a nurse, with regard to a physical health issue) recorded that Deborah "*came with carer*"; no records were made as to who this was. At the next two appointments (one with the same nurse and then with a General Practitioner) Deborah requested help to stop drinking and referred to medication she had had in the past in relation to this. Deborah was given the details of Open Road to self-refer. There were no further recorded discussions of Deborah's alcohol use.

2.12.53 During early 2015 Deborah was in contact with Princess Alexandra Hospital and her General Practice with regard to a physical health issue. At a medical procedure pre-assessment Deborah was noted to be drinking more than 21 units per week. The record also stated that Deborah was "*reluctant*" to give the information. Her last appointment (with the same General Practitioner that she saw in January) was 14 May 2015, in relation to a physical health issue.

2.13 Chronology of Ryan's involvement with agencies

2.13.1 The detailed chronology covering 2003-2011 is in the appendix. A summary of 2003-2009 is above (see 2.11.6). A summary of 2010-11 is below, followed by a detailed chronology for 2012-2015.

2010

2.13.2 In 2010 Ryan had regular contact with the Youth Offending Service (YOS) following receipt of a referral order for common assault. This was temporarily suspended due to Ryan's mental health.

2.13.3 He attended his General Practice, at times accompanied by his father, with regard to his mental health. This led to a referral to the Community Mental Health Team (Essex Partnership University Trust, EPUT) for suspected psychosis based on his symptoms: he thought the radio was talking about him; that everyone was talking about him and looking at him; and could hear voices talking about him. Ryan had threatened to kill his best friend and all of his friend's family, saying he thought the friend was controlling his brain. It was also noted that Ryan's father referred to Ryan's cannabis use. He was assessed, and his parents were spoken with.

2.13.4 From February onwards Ryan had with NEP. He was prescribed medication and assessed as mild to moderate risk of self-harm, low to moderate risk of violence to others in which it was noted that he had been verbally and physically aggressive to Deborah and others. In February and March, he received intensive contact with the Crisis Resolution and Home Treatment Team, during which records reflected fluctuations in his symptoms, awareness, and attitude to his drug use.

2.13.5 He was then referred on to the Early Intervention Psychosis (EIP) Team and remained under their care until his arrest for assaulting his father in August 2012. He had stabilised sufficiently for his YOS referral order to be restated. He was referred to the Essex Young People's Drug and Alcohol Service (EYDAS).

2.13.6 For the remainder of 2011 Ryan was in contact with the EIP Team, YOS and EYPDAS. At times the EIP Team could not reach Ryan, and spoke with his father or mother instead. Ryan's father made contact to seek help about Ryan's symptoms. His mother and father both reported concerns over Ryan's aggressive behaviour towards them. No action was taken in relation to this at first; later family therapy was recommended, which Ryan declined.

2.13.7 YOS referred Ryan to the Connexions Service for support in seeking work. Shortly after this the YOR order closed on schedule. Ryan's contact with the EIP Team became sporadic and then stopped; the service continued contact with Ryan's mother and father. At the end of the year Ryan was found by Essex

Police and taken to hospital as he was thought to have overdosed. He went missing from hospital and Deborah called police reporting Ryan was outside her house and was threatening her (see 2.12.2). Ryan was arrested and later detained under the *Mental Health Act 1983 Section 2* due to his symptoms. He improved and was discharged a month later. His father continued to contact NEP with concerns over Ryan's symptoms and behaviour.

2011

2.13.8 At the start of 2011 Ryan's father contacted NEP due to his concerns over Ryan's symptoms. Ryan was assessed and detained under the Mental Health Act; during this he became aggressive and threatening, and police were called. Six officers restrained Ryan. Ryan remained on the inpatient ward until February when he was discharged. He continued to be under the care of the EIP Team; it was recorded that he did not believe he was unwell, but that the illicit drugs caused the symptoms. Shortly after discharge Deborah called police (see 2.12.3) due to Ryan's drug use, and he was convicted of drug offences and received a 12-month conditional discharge at court. Deborah also contacted the EIP Team for help in managing Ryan's behaviour.

2.13.9 The EIP Team recorded that Ryan was reluctant to engage with the service, displayed verbal and physical aggression, had no insight into his illness and continued to use cannabis. Throughout 2011 Ryan's contact with the service was limited. Ryan called Essex Police twice in mid-September 2011 alleging that he had been assaulted, first by Deborah and then four days later by his father (see 2.12.5). Shortly after this Ryan's father started to contact the EIP Team with concerns over Ryan's mental state and behaviour. The following month Deborah called police (see 2.12.6) as a result of which Ryan was convicted of criminal damage and within two days had received a six-month community order with probation.

2.13.10 Ryan met regularly with probation. The risk management plan outlined the following actions for the probation officer: to liaise with the police to assist in the monitoring of Ryan's relationships with family; to liaise with housing providers in order to assist Ryan to obtain independent accommodation; to contact mental health services and drug agencies. The objectives set for Ryan's period of supervision were to address: victim awareness; housing; agency involvement in respect of drugs and mental health (Ryan's lack of engagement and motivation

were noted with regard to this last objective). From then until April 2012 Ryan attended weekly supervision appointments with the probation officer.

2.13.11 In December 2011 Ryan's father called Hertfordshire Police and reported that earlier that day Ryan, who had mental health issues and had been "*smoking dope*" had "*grabbed him by the throat … and threatened to kill*" him. Ryan had left the scene 15 minutes prior to the call. Officers attended and established that Ryan's father had no injuries and was not willing to provide a statement.

2.13.12 There were two further calls to police from Ryan's parents concerning his behaviour.

2012

2.13.13 In January 2012 probation worked with Ryan on his accommodation, including a meeting with the Housing Liaison Officer employed by the Probation Trust. The officer discussed Ryan's drug use with him, and asked him to complete a drug diary on two occasions. Ryan was recorded in January and March 2012 as not using cannabis. He reported an argument with his mother because she thought he was selling it. On that occasion, as he left the appointment, Ryan was recorded as saying he did not want to see his father again and that he "*wants to beat him up*". The officer also noted their impression that Ryan expected others to "*do everything for him*", particularly in relation to accommodation and applying for benefits.

2.13.14 Also in mid-January 2012 Ryan's father called Essex Police as Ryan was outside Deborah's home threatening suicide. Officers attended and considered Ryan was suffering from a mental illness to the extent that they detained him under *Mental Health Act Section 136* and took him to a police station for his own safety. An Approved Mental Health Professional assessed Ryan and concluded that there was insufficient evidence to section him, and he also refused an informal referral. A note was made that it would be "*helpful to have family therapy sessions*". Ryan was released. Ryan's father called the EIP team to inform them Ryan had been "*sleeping in car on mother's driveway after being 'thrown out' for being challenging, violent, aggressive and threatening to both parents*". He had "*threatened to kill self and family*". The outcome recorded was that "*as Ryan refuses to engage with EIP not a good idea for [them] to attend*" and Ryan's father was persuaded to call police. He called again three days later: Ryan continued to be "*verbally aggressive to mother and himself*". A change of Care

Coordinator was offered but declined by Ryan's father "*as Ryan will refuse to engage*".

2.13.15 Immediately after this a CPA review was carried out; it was not recorded whether Ryan had been seen. Appointments would continue to be offered to Ryan and the team would "*cold call*" him every two months. Ryan's father would continue to update the team. The next review was scheduled for July 2012 (six months later). At the end of this month (January 2012) Ryan did not attend an appointment at the EIP Team office.

2.13.16 Deborah called Essex Police ten days later (end of January 2012) to report that Ryan was in her house smoking drugs and abusing her (see 2.12.12). Ryan was removed to prevent a breach of the peace.

2.13.17 Four days later Deborah called Essex Police to report that Ryan had broken into her home and threatened to rape her (see 2.12.13). No action was taken as officers established no offences had been committed.

2.13.18 Two days after this Deborah called Essex Police again to report that Ryan had tried to break into her home and threatened to kill her (see 2.12.14). While in police custody Ryan was assessed by the mental health social worker; there was "*insufficient evidence to section him*"; reengagement with the EIP Team was discussed and Ryan agreed to meet at his father's house. A risk plan entry was made in relation to Ryan's violence and aggression. Ryan's father also called the EIP Team to inform them of the incident. The Care Coordinator spoke with Ryan who stated "*left fathers' as did not want a physical fight with him. Went to sleep in mum's shed, his clothes were wet and he was cold so smashed window to get some clothes as he knew he had the money to pay*". Ryan agreed to meet "*providing illicit drug use was not discussed*".

2.13.19 Ryan was not charged with threats to kill. He pleaded guilty to criminal damage and was sentenced to a Compensation Order of £200. There was no separate penalty for breaching the Conditional Discharge (imposed for 12 months on 9 March 2011, see 2.13.76) or the fact that it took place during the Community Order imposed on 31 October 2011. There is no record on the probation system to show that they had prepared a report for this sentencing. The probation officer discussed the offence with Ryan and noted that he blamed his mother entirely for the incident. After this the officer updated the assessment to include information about both incidents; the risk assessment remained at medium.

2.13.20 In early February 2012 the EIP Team conducted two home visits with Ryan in which illicit drug taking was not discussed. At the first, help was provided with Ryan applying for benefits. Ryan was recorded as feeling "*justified*" in his actions (criminal damage) at Deborah's home because it was his "*family's fault he behaves like this as they will not tell him if they are planning to leave him any money when they die and will not give him money now.*"

2.13.21 Probation made contact with the EIP Team at this time (communication had been ongoing) about help with Ryan's housing. Ryan attended General Practice for an 'Annual Mental Health Review', recorded as living with his father but waiting for Social Services to rehouse him.

2.13.22 At the next home visit, housing options were discussed, and Ryan's father informed the EIP Team of the incident outlined in the next paragraph.

2.13.23 On 14 February 2012 Ryan's father called Hertfordshire Constabulary and reported that Ryan had just thrown two glasses at him. He stated that Ryan had mental health problems and had left five minutes ago. A Police National Computer check showed Essex Police had listed Ryan for arrest for an offence of possession with intent to supply a controlled drug (there are no Essex Police records relating to this). Officers attended the scene and conducted a search of the area for Ryan. They documented a small cut to Ryan's father's arm, who informed officers that Ryan had made numerous comments in the past that he was going to kill himself by jumping in front of a train, although he had never self-harmed or attempted suicide, and hadn't made such threats on this occasion. Ryan's father stated that in his opinion Ryan would not carry out those threats. Procedures in relation to domestic abuse victims were followed with Ryan's father. Later that night officers made arrest enquiries at Deborah's address, which were recorded as "*negative*".

2.13.24 Ryan called Hertfordshire Constabulary shortly after midnight at the end of that day (early hours of 15 February 2012), and reported he had left his house, as his father had been violent. Ryan would not give his location; he was recorded as being "*strange*" in manner. The call was linked to the call from Ryan's father. The following morning he was arrested (at his father's home) for common assault against his father. Ryan stated he was not receiving treatment for any illness, disability of mental health problems, and was not taking any medication. In interview Ryan admitted throwing a glass at his father, intending to hit him,

although with not much force. The reason Ryan gave for this was that he believed his father should give him £10,000-20,000 to keep him happy, and his father had refused. Ryan was given a caution for the assault.

2.13.25 Ryan informed probation of the caution he had received. He stated that the incident came about because he had argued with his father because Ryan felt that his father should buy him a house because he had lots of money. The officer carried out some targeted work around victims with Ryan.

2.13.26 In early March 2012 Deborah called Essex Police reporting that Ryan had thrown a brick through her window (see 2.12.19); she didn't see him but believed it was Ryan as she "*has on-going problems with him*". No action was taken. Shortly after this the MARAC meeting was held to discuss Deborah's case. The EIP Team and probation recorded the meeting on their systems.

2.13.27 In March 2012 Ryan did not attend two appointments at the EIP Team office.

2.13.28 In April 2012 Ryan approached East Hertfordshire Council Housing Service seeking accommodation. He was recorded as saying he lived with his father, and that he had been evicted by his parents (who were separated) on a number of occasions; he also advised "*he was arrested for assaulting father but claims it was his father who assaulted him*". Ryan was given information about the YMCA, and advised to complete the online housing register form, which he did. In the application Ryan recorded he was under the care of the "*Community Mental Health Team following a psychotic episode caused by taking street drugs. Not on drugs now and no lasting mental illness.*" Ryan completed a medical form in support of his application for the Housing Register, in which he stated his medical problem was that he was "*recovering from psychosis*" and was on no medication. He stated he had a lack of confidence and some anger at living with his father, who he didn't get on with. The medical form was referred to an independent medical advisor who stated that it was "*difficult to assess [the] severity*" of Ryan's psychosis and recovery and that he was "*clearly living in stressful conditions currently. May need to review with more information about his mental health*".

2.13.29 Later that same month Ryan called Hertfordshire Constabulary and reported his father had attacked him. He stated he had been beaten up and strangled but refused an ambulance. Two minutes later Ryan's father also called 999 and reported that Ryan, who had mental health issues, had attacked him. At the

scene, officers recorded that Ryan was in an agitated condition. He was recorded as stating: "*I had an argument with my dad, I said I was going to stab him in the head. He then grabbed me around the throat*". Ryan was warned by officers to calm down. Ryan was recorded as saying: "*I hate him and I hate living there, I'm so angry I feel like I just wanna punch you in the face right now. I don't wanna live with him, if I wanna smoke cannabis then I will do so and he can't stop me. Sometimes I feel like going out and smashing someone's head in with a shovel just so I go to prison and not live with him*". Ryan was arrested for actual bodily harm (the exact nature of the assault and any injuries were not recorded). The detention record outlined that Ryan was in good health, not receiving treatment for mental health issues, and was not taking any medication. The arresting officer recorded in the Prisoner Handover package that Ryan's father had stated Ryan had mental health issues, but that there was nothing on record to indicate this and Ryan was recorded as not requiring an Appropriate Adult. In interview Ryan was recorded as having become aggressive and uncooperative and the officer was so concerned about his behaviour that they terminated it early. Due to Ryan's father's statements about Ryan's mental health, including reference to Ryan having previously been detained under the *Mental Health Act 1983*, a decision was made to refer the matter to the Mental Disorder (MDO) Panel[21]. Ryan was given unconditional bail and he was known to have returned to his father's home. The case officer contacted Ryan's father for a welfare check following the incident, and recorded the information he provided on the crime report: that Ryan had been "*sectioned*" in November 2010 and was under the care of the Early Intervention Team, Essex.

2.13.30 Later in April 2012 Ryan's Community Order was terminated by probation, as the end of the six months had been reached. The officer recorded that Ryan was "*more stable*" and was receiving benefits, living with his father and contributing financially. Ryan informed the officer that he was on bail for the incident of assault against his father; no further information was sought.

2.13.31 In May 2012 the MDO Panel concluded Ryan was appropriate for prosecution, as they could find no evidence of treatment (in Hertfordshire). Ryan was charged

[21] A multi-agency panel to ensure that the best course of action is taken for all concerned in relation to an offender, i.e. whether they should be diverted towards treatment. The Panel makes recommendations to the CPS and Court on this.

with common assault; he pleaded guilty at court and was sentenced to a £200 fine.

2.13.32 After this, in mid-May 2012, Ryan's father called the EIP Team and reported that Ryan had been "*drug free for three months, but worried as Ryan still having psychotic symptoms, e.g. will like people one day and extremely hate them the next, would act paranoid and isolate himself … could not be clear if Ryan was hallucinating.*" An action was recorded to pass the information to the Care Coordinator.

2.13.33 The next record was a risk plan review in early July 2012. It was not recorded whether Ryan was seen, spoken to, or where the information from the update came from. The risks identified were: "*non-compliance with medication; increased aggressive behaviour; non-engagement with services; history of misuse of substances; history of suicidal ideation; no insight*". It was noted that Ryan's father had reported Ryan was "*settled in mood*".

2.13.34 Two weeks later (mid-July 2012) the scheduled six-monthly CPA review took place. Ryan was not seen; Ryan's father attended. It was noted that Ryan had been "*seen on three occasions over review period as does not want to engage*" as he did "*not feel he has a mental illness and if he works with a team [he] will be sent back to hospital*". Ryan's father reported that Ryan was stable and working, which had improved his self-esteem and mood, and he had stopped using illicit substances. The plan recorded was for Ryan's father to inform the team of any changes and for "*Ryan to remain on caseload but until willing to engage he will not be seen*".

2.13.35 On 10 August 2012 Hertfordshire Constabulary received a call from the ambulance service stating they were attending an assault at Ryan's father's address. At the same time, a 999 call requesting police and ambulance was received (it is not clear from whom). Officers attended; ambulance staff were attending to Ryan's father who had a head injury, he reported he couldn't remember how it had happened. A neighbour who was present had not witnessed the incident but had seen Ryan leave. Ryan was found nearby and arrested, and later charged with grievous bodily harm. The detention record stated that Ryan was in good health and was not receiving treatment for any illness or mental health problem. Bail was refused on the basis that Ryan was likely to commit further offences; he remained in custody until trial in June 2013.

2.13.36 Ryan's father contacted the EIP Team to inform them of this incident and that Ryan was in custody.

2.13.37 In September 2012 Hertfordshire Constabulary records show an entry to the domestic abuse documentation in which the Domestic Violence Officer (DVO) outlined they had spoken to the (Hertfordshire) Community Mental Health Team, who had no record of Ryan[22]. The DVO contacted that Team's Single Point of Contact to make a referral and recorded being informed that they did not have a form they were prepared to forward via email. A further entry stated, "*it has been confirmed that male is not known to Mental Health Team. Nothing further for DVO. Case finalised.*"

2.13.38 Ryan was in custody from his arrest on 13 August 2012 for grievous bodily harm against his father, through to his sentencing on 26 June 2013. During this time Ryan moved between HMP (Her Majesty's Prison) Bedford (which was the prison closest to the court) and HMYOI (Her Majesty's Young Offenders Institution) Glen Parva four times. He had sporadic contact with the Mental Health In-Reach Teams both prisons[23].

2.13.39 The mental health in reach service to HMP Bedford at that time was delivered by South Essex Partnership University NHS Foundation Trust (SEPT) but has since been taken over by Northamptonshire Healthcare NHS Foundation Trust (NHFT), in April 2016.

2.13.40 Information provided by NHFT with regard to Ryan's contact in HMP Bedford could not go back to September 2012 and before, as the records were held by the organisation that was delivering the service at the time, SEPT. Information was requested directly from SEPT and was received towards the end of the Review process.

2.13.41 This information showed that on entry to HMP Bedford Ryan told the nurse at reception screening that he had no mental health history. Following contact from the NEP EIP Team, Ryan was assessed by the Mental Health In Reach Team (SEPT) in early September 2012. He stated he had been in the inpatient unit because he had taken "*some dodgy drugs*" and had been discharged because

[22] They were contacted as part of this Review and confirmed no contact with any of the individuals involved.

[23] Mental Health In-Reach Teams in each prison are provided by different mental health trusts, and it appears from the information that has been provided to this DHR that Ryan's electronic notes did not always transfer with him when he moved prisons.

they said "*there is nothing wrong with you*". He denied any symptoms such as hallucinations and said that previously "*people lied*" saying he had experienced this. He denied any history of violence or aggression towards his mother Deborah, and stated he was angry with her because she did not respond to his letters asking for money. Ryan showed no evidence of mental disorder and declined to be under the care of the mental health team, but agreed to further review. This was done again just before his move to HMYOI Glen Parva, and there were no issues or concerns noted. A transfer letter sent to HMYOI Glen Parva stated Ryan had been under the care of mental health in reach, and had previously been under the care of the NEP EIP Team.

2.13.42 The EIP Team recorded receipt of the transfer letter from HMP Bedford Mental Health In-Reach Team to HMYOI Glen Parva Mental Health In-Reach Team (that had been copied to EIP) stating that Ryan had been on the HMP Bedford caseload. HMYOI Glen Parva Mental Health In-Reach Team (provided by NHFT) recorded receipt of the transfer letter for Ryan from the Mental Health In-Reach Team at HMP Bedford, following which he was seen and assessed by a Registered Mental Health Nurse.

2.13.43 The assessment outlined Ryan's history of assault against his father leading to this period of custody; a previous diagnosis of drug induced psychosis in 2010 and two admissions under the *Mental Health Act Section 2*. It also stated that Ryan had "*smashed his mother's back door when she wouldn't let him in due to fear he would assault her*". The initial assessment of risk was: "*Increase in levels of aggression/violence when becoming mentally unwell. At such times believes people can read his mind by looking into his eyes. Currently denying any psychotic symptoms but eye contact poor which may indicate his suspicion that people can read his thoughts. Lack of insight into mental illness.*"

2.13.44 The Registered Mental Health Nurse also recorded that Ryan did "*not appear to have any remorse for his actions and stated that it wasn't a serious assault and he didn't understand why he had been remanded into custody*". When the nurse put to Ryan the seriousness of the injuries he caused to his father, he "*smiled and looked away*". Ryan was angry to be in custody and blamed his father for this, and that he had lost his job as a result.

2.13.45 Ryan denied taking illegal substances for some months. It was noted that Ryan's CPA with the Early Intervention Team had last been reviewed in July 2012. A Care Plan was established.

2.13.46 Ryan was seen in October 2012, following which he was moved briefly to HMP Bedford for a court appearance. He re-entered HMYOI Glen Parva and was seen by the Mental Health In-Reach Team in early November 2012. No concerns were noted in relation to Ryan's mental state; a record noted that Ryan had said the Judge was requesting a psychiatric report before sentencing. A plan to see the In-Reach Team weekly was agreed.

2.13.47 Ryan was seen again in mid-November 2012 following a request from a prison officer who had concerns over Ryan's behaviour ("*says he becomes angry quickly and may assault his pad-mate*")*)*, following which it was recommended that Ryan not share a cell.

2.13.48 Ryan was then seen three times in November and early December 2012. He saw a psychiatrist who recorded the following: "*no thought disorder*"; Ryan does not want medication and "*said there was nothing wrong with him*". The psychiatrist noted: "*Some dyslexia when in school – can just about read and write. Finds calculations and work hard. Struggles to cope with day to day life. Enjoying attending healthcare education. …. May have borderline intellectual functioning or mild learning disability. Can be vulnerable to other prisoners – benefits from being in single cell. ... No aggressive behaviour in prison. 'Beat up father because I got scared as he asked me to leave the kitchen, I thought anything can happen'*."

2.13.49 Ryan was seen three more times by the Mental Health In-Reach Team in December 2012 when it was felt that his mental health had deteriorated. Ryan was recorded as having "*agreed reluctantly*" to start anti-psychotic medication. There were six further appointments in January 2013: Ryan was taking his medication, which was then increased and Ryan "*feels better and clearer in his thoughts*". Ryan was later recorded to be taking the medication but not happy about it. He consistently stated his belief that he would be taken to hospital for his sentence. There are no further records in any service relating to the medication Ryan had been taking, or when this stopped.

2013

2.13.50 In January 2013 the EIP Team called Ryan's father for update on trial. The EIP Team also called HMP Glen Parva Mental Health In-Reach Team. They were unable to reach them and subsequently the CPA was completed and Ryan recorded as discharged to the Mental Health In-Reach Team at HMP Bedford (there was no associated correspondence with this).

2.13.51 Ryan was transferred to HMP Bedford for trial in February 2013; the record stated "*notes faxed to CPS [Crown Prosecution Service] at [the] Crown Court*." Ryan was handed over to the Mental Health In-Reach Team at HMP Bedford via an email. They gave Ryan's brief history (see 2.13.134) and stated that while at Glen Parva Ryan had been seen "*regularly*" by a Mental Health Worker and had attended a drug and therapeutic service that provided day time groups that focused on Ryan's socialisation. The email mentions entries on the system about contact with Ryan's solicitor with regard to a psychiatric report but the email author had no knowledge of that.

2.13.52 The Mental Health In-Reach Team at HMP Bedford saw Ryan in March 2013. Ryan maintained he had a "*stable mental state*", had been accepted for work and was sharing a cell with no management or vulnerability issues identified. No psychotic or depressive symptoms were observed and he was noted to continue not to be on mental health treatment. He informed the worker that the court were "*happy with [the] outcomes of [the] court report and to his understanding, there are no suggestion[s] of mental illness.*"

2.13.53 Contact was attempted with the Early Intervention in Psychosis (EIP) Team to provide an update; a message was left. Ryan would remain under review, and if he continued to present with no severe or enduring mental illness he would be discharged, which is what then took place.

2.13.54 There was then no recorded contact between Ryan and a mental health service in prison until November 2013 (see 2.13.151).

2.13.55 Ryan was convicted in June 2013 of grievous bodily harm against his father. The court requested a pre-sentence report to be prepared by probation; this was completed by the then Hertfordshire Probation Trust. The pre-sentence report concluded that Ryan posed a medium risk of harm to a known adult and lacked victim empathy. The psychiatric report did not identify any symptoms of psychosis or mood disorder. Ryan's serious risk of harm to a known adult was

unlikely to reduce unless he addressed his: drug use; intense family conflict; very limited victim awareness; beliefs that supported the use of violence.

2.13.56 The pre-sentence report was supported by an OASys (Offender Assessment System), on which it was incorrectly recorded that Ryan had been assessed as posing a high risk of harm. OASys is a probation assessment tool that provides a consistent framework to offender managers in assessing an individual's risk of serious harm and likelihood of re-offending. Depending on the level of risk of harm and sentence type, this will trigger the completion of a risk management plan and other associated tools, such as probation's Spousal Assault Risk Assessment (SARA).

2.13.57 A community-based proposal was not made to the court, as a custodial sentence was the only option, given the offence. A 63-month sentence was given. Ryan had already served 10 months in custody having been refused bail while awaiting trial. He served a subsequent 22 months, which was 32 months in total: half the actual sentence, as is standard practice.

2.13.58 Following trial and sentence he was held in five different prisons and moved seven times until release in April 2015.

2.13.59 Due to the pre-sentence report assessment that Ryan posed a medium risk of harm, there was no expectation from probation that they would be involved in early sentencing planning; they would have expected the prison to carry this out. The prison believed Ryan had been assessed as high risk (as per the OASys entry), and would have expected action to be taken by probation in relation to sentencing planning. The error was not identified until a much later date and the sentencing-planning meeting took place in August 2014 (14 months after Ryan was convicted and sentenced; see 2.13.153).

2014

2.13.60 Oxleas NHS Foundation Trust provided information on Ryan's time in HMP Rochester from November 2013 to March 2014. (Prior to this Ryan had been held in HMP Bedford from trial until July 2013 and in HMP Blundeston from then until November 2013. *The Independent Mental Health Investigation states that Ryan did not have contact with the mental health team in HMP Blundeston*). On entry to HMP Rochester in November 2013, Ryan disclosed no mental health issues and none were identified. Ryan stated he had never been in a mental

health hospital, and was on no medication. No further concerns with his mental health were noted.

2.13.61 In March 2014 Ryan was moved to HMP Ford Open Estate due to his progression through his sentence and re-categorisation to Category D (eligible for 'open' conditions[24]). *The Independent Mental Health Investigation states: Ryan was referred to the Primary Mental Health Care service (provided by Sussex Partnership NHS Foundation Trust) by the practice nurse over concerns that Ryan may have a learning difficulty. The assessment concluded Ryan showed no psychotic symptoms or concerns about intellectual ability and was discharged in May 2014 from the Primary Mental Health Care service.*

2.13.62 Two months later (May 2014) Ryan was transferred back to closed conditions (HMP Rochester) due to having no completed OASys (due to the mis-recording outlined above, see 2.13.147).

2.13.63 During his one month in HMP Rochester Ryan was again assessed by Oxleas NHS Foundation Trust: no changes were recorded from the initial screening outlined in the above (see 2.13.151). Ryan was transferred back to HMP Ford in June 2014 once the OASys was in progress; and was there until December 2014, and records show he did not access mental health services in that time.

2.13.64 The sentence planning meeting took place in August 2014 (delay explained above, see 2.13.149) with Ryan's prison offender supervisor and a probation officer. Ryan's living arrangements were discussed. Probation decided that Ryan would be managed as a medium risk offender.

2.13.65 A prison case note following the meeting indicated that there was insufficient time while Ryan was in prison for him to complete Offender Behaviour Programmes prior to his release and so they could be added as a licence condition.

2.13.66 The probation officer completed a formal risk review (OASys) in early December 2014, four months prior to Ryan's release. The review included:

(a) Mention that Ryan thought there might be a possibility of him returning to live with his mother.

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

(b) That Ryan was considered to be coping well in custody.

(c) That Mandatory Drug Testing had been negative, which was perceived as suggesting Ryan had some control over his drug use. NB: on 26 November 2013 a record was made of suspicions that Ryan was using 'legal highs' in prison. No further information is available. Mandatory Drug Testing cannot detect the use of legal highs due to the complexity of the chemical compounds.

(d) A SARA (Spousal Assault Risk Assessment) was completed, which identified Ryan's father and other family members to be at medium risk of physical violence from Ryan. In relation to when risk was likely to be greatest, the assessment stated, "*when Ryan is unable to get his own way*". It highlighted the need to liaise with the police about Ryan and his contact with his father.

(e) That a condition would be required for Ryan not to attend his father's address, and for Ryan to complete the Thinking Skills Programme.

2.13.67 The following conditions were added to Ryan's licence: for Ryan to comply with any requirements specified by his supervising officer for the purpose of ensuring that Ryan addressed his substance misuse with CRI Spectrum and not to enter his father's address without the prior approval of his supervising officer.

2.13.68 Ryan's third and final time in HMP Rochester began in December 2014, and ended in April 2015 when he was released. His initial health screening, as the previous two, identified no physical or mental health issues.

<u>2015</u>

2.13.69 Ryan was referred to the Mental Health In-Reach Team at HMP Rochester in January 2015 by the Prison Psychology Service. This referral noted no immediate mental health concerns but the review was considered as part of Ryan's Release on Temporary License (ROTL), as it is good practice to share information regarding previous mental health history. An appointment was scheduled which Ryan did not attend. A record was made to reschedule the appointment. This was not done.

2.13.70 In February 2015 Ryan's father contacted the service and requested Ryan be seen as he had concerns over Ryan's mental state following a recent visit. Ryan's father gave some of Ryan's history in relation to previous admission to mental health hospital.

2.13.71 Ryan was assessed in February 2015. A personal history was taken where Ryan reported that he had been bullied at school and was diagnosed as borderline dyslexic. He stated he had some GCSE qualifications. He stated his parents had separated when he was 12 years old and that he lived with his mother until he was 19. He denied any violence or aggression against his mother. He reported that he had no contact with either parent, apart from receiving some letters from his father and blamed his father for many of his problems. He stated his father had removed him from the house, resulting in him being homeless and sleeping rough. He had only worked for one month and stated that he had received money from his grandfather and so did not need to work until this money was exhausted; at that point he had to use benefits. Ryan reported that he believed that his parents/grandparents would give him further financial assistance so he would not have to seek work. He planned to live with his mother upon release, although believed that his father would accommodate him, although Ryan acknowledged that his father considered him unwell.

2.13.72 The notes refer to information received from the Mental Health In-Reach Team from HMYOI Glen Parva regarding Ryan's mental health history, but these are not recorded in the Oxleas system. Ryan was recorded as saying, in response to this history, that the psychiatrist had discharged him as "*there is nothing wrong with you*" and that his medication was stopped (it was not recorded when that took place). Ryan denied any current drug usage.

2.13.73 Ryan's case was discussed at the Multi-Disciplinary Team meeting in February 2015 at which it was felt that there were no current mental health issues, and that Ryan would be seen once more and then discharged.

2.13.74 The next record was when Ryan was seen in April 2015 (shortly before his release) for his exit / pre-release interview. No concerns were noted; Ryan was recorded as declaring no physical issues and declined consent for the release of medical information to his General Practice or others.

2.13.75 HMP Rochester had Deborah's home as the release address for Ryan. The PD1 is the form used to establish the address a prisoner will be 'released' to: prisoners must have an address prior to release. HMP Rochester sent the PD1 to Hertfordshire Probation Trust for completion: it is probation's responsibility to ensure the offender has a release address. The returned form stated that Deborah had informed the probation officer she could not provide Ryan with

accommodation; applications for hostels had been made. The probation officer added: "*Should Ryan have alternate accommodation that he would like to put forward I am more than happy to assess that address for his release.*" No further action was taken by probation or the prison.

2.13.76 Ryan was released from prison in April 2015. Essex Police received a notification: there was limited information regarding the offence and no release address was given. As a standard notification of release, no action was expected. As Ryan's last known address was Deborah's, the information was sent on to the Inspector for the local Neighbourhood Policing Team. There were no further records.

2.13.77 Ryan re-registered with his General Practice on release. He attended in April and May 2015 seeking help with insomnia (for which he was prescribed medication) and for a medical statement to assist with benefits. He told the General Practitioner that he had been seeing a psychiatrist while in prison, and a referral was made for him to the NEP Community Mental Health Team. The Access and Assessment Team contacted Ryan and spoke with him on 4 May 2015. Ryan was recorded as stating he was "*not paranoid, suicidal or hearing voices. Was having sleeping problems and would discuss with [General Practitioner]*". His main concern was accessing benefits. He did not "*want or need*" engagement with NEP. The record noted Ryan to be "*well-spoken and coherent*", and denied being a risk to others. Ryan was discharged back to his General Practitioner, who was also written to.

2.13.78 Ryan had probation supervision appointments every week from his release until 30 June 2015 (ten appointments). Until he moved in with Deborah, the main focus was his accommodation. Ryan reported good relationships with both his parents. The officer recorded that Ryan was "*putting obstacles in the way of realistic housing options*", noting he would not consider shared housing facilities due to his mental health issues; yet he did not engage with the Mental Health Team following a referral from his General Practitioner.

2.13.79 The officer updated the assessment of Ryan on 26 April 2015. A SARA was completed and Ryan was assessed to pose a medium risk of harm to others. The sentence plan objectives remained the same: Reduction of incidents of aggression and intimidation through participation in Thinking Skills Programme; improved management of personal relationships through victim empathy work;

reduced incidents of aggression through participation in Anger Reduction Programme. The records show the focus of Ryan's supervision was accommodation; when he was arrested for the homicides, he had not been referred to any of the above programmes or other services (i.e. CRI).

2.13.80 It quickly became difficult for Ryan's parents to continue to fund the hotel, and Ryan asked if he could live with his mother. The probation officer agreed this on 6 May 2015 as a temporary measure while other housing options were pursued. The risk assessment was not reviewed. There was no record of the probation officer speaking with Deborah. Housing options continued to be noted as limited as Ryan would only accept a single room.

2.13.81 Following the move to Deborah's, Ryan was recorded at supervision appointments to be getting on well with her. He was noted as not "*overly concerned*" about his housing situation.

2.13.82 At the beginning of June 2015 the probation officer recorded a decision to reduce Ryan's reporting from weekly to monthly. The officer also noted on that day that Ryan had taken some responsibility for his own actions, in accepting that his drug use was a factor in his aggressive behaviour towards his father. At the end of that month Ryan had his last supervision appointment before he killed his mother and her friend. He reported no issues living with his mother; it was noted that his father had brought him to the appointment.

2.13.83 Also at the end of June, Ryan attended his General Practice for further help with insomnia. Ryan declined to complete the standard questionnaires used by health professionals to establish an individual's mental health state (specifically anxiety and depression). The Nurse recorded that Ryan was "*very concerned re me suggesting more M[ental] H[ealth] assessment, says he has been discharged from Mental Health Team.*" Ryan was recorded as reporting no suicidal ideation; that he was living with his mother; not working; drinking alcohol but not to excess; and denied using any recreational drugs. The record stated he was well kempt, made good eye contact and was not tearful. A review was set for a week's time, during which Ryan agreed to complete the questionnaires at home. No further appointments were recorded.

3. Analysis

3.1 Domestic Abuse / Violence and Deborah and Michael

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

3.1.2 Deborah reported what was happening to Essex Police and to NEP. Ryan was also a perpetrator of domestic abuse against his father, in the form of physical violence, as reported to Hertfordshire Constabulary and NEP.

3.1.3 No evidence was provided to the DHR relating to Michael's relationship with Ryan, or any indications of prior abuse of violence from Ryan to Michael.

3.2 Organisations in contact with Deborah

3.3 Deborah's General Practice

3.3.1 The IMR from the General Practice did not address the Terms of Reference for the DHR. It stated that the General Practice had engaged with other agencies appropriately with regard to Deborah's alcohol use; and that there was no documentation of any violence or threats against her following Ryan's release from prison in April 2015. As a result, the independent chair sent questions to the General Practice; these questions and the answers provided are below:

(a) *From independent chair*: The record states that Deborah "*came with carer*" in January 2015: was any enquiry done as to who this was? If so was it recorded? If not why not, and would you have expected enquiry to have been done?

Answer: The General Practice has a Carer's Policy, and they would expect all Practitioners to record information about carers, including adding the appropriate 'code' to the system. They are unable to state why this was not done at the time, except for the fact that Deborah saw a locum General Practitioner.

(b) *From independent chair*: When Deborah disclosed difficulties at home / with the family / with Ryan: was there consideration for enquiry around domestic abuse? If not why not, and would you expect this to have taken place? What pathway would the General Practice have followed if Deborah had disclosed experiencing abuse or violence from Ryan? Does the Surgery have in place policies and procedures (and access training to support these) on adult safeguarding and domestic abuse/violence?

Answer: The General Practice does not have a specific domestic abuse policy, but this is contained within policies and training on safeguarding children and adults, and these pathways would be followed if domestic abuse were identified. All clinicians have an awareness of domestic abuse; however the General Practice recognise that this is more robust in relation to safeguarding children. The General Practice has recognised that thorough knowledge of domestic abuse could be improved, and will take action on this through seeking a briefing from the Adult Safeguarding Nurse at West Essex Clinical Commissioning Group. An update provided by the General Practice in March 2017 outlined that the adult safeguarding nurse for West Essex CCG is delivering a training session to surgery staff in May 2017, including domestic abuse. In addition, four clinical members of staff have attended J9 training[25] relating to domestic abuse and this will be fed back to all staff members.

Independent chair comment on answer: This outcome is welcome, to ensure that all staff at the General Practice have a deeper understanding of the nature of domestic abuse, including familial abuse, and in particular where responses and pathways do not fit with child or adult safeguarding processes. The Review Panel heard that the Essex MARAC process now ensures that a victim's General Practice can be identified and the MARAT (Multi-Agency Risk Assessment Team, see below) how alerts them to the referral for their patient. A recommendation (1) is made to ensure that the Clinical Commissioning Group supports General Practices to identify high risk victims and refer them to the MARAC.

[25] Established in a number of areas in Essex and elsewhere in the UK: Where the J9 logo is displayed, it alerts victims that they can obtain information which will help them to access a safe place where there can seek information and the use of a telephone.

(c) *From independent chair*: After completing detox in December 2013, the General Practice was written to by the CDAT consultant asking for Deborah to be prescribed Acamprosate for one year to support Deborah's abstinence from alcohol. The chronology lists one occurrence of this prescription and no more, please can you explain?
Answer: The medication was added to Deborah's medical records as a monthly prescription. It was for Deborah to request this as a repeat prescription, and she did not do this. The General Practice is unable to follow up with patient repeat prescriptions, and, as they believed that Deborah was receiving support from ADAS, would have seen that as a safety net for Deborah accessing the help needed.
Independent chair comment on answer: This DHR notes that this is understandable on behalf of the General Practice, but unfortunate in light of the fact that Deborah was not accessing support from ADAS, which the General Practice had no way of knowing. The General Practice have fed back to the DHR that they would have been better able to support Deborah had there been a joint approach between CDAT, ADAS and the General Practice: this could have helped to understand the factors in Deborah's life at that time that influenced her engagement with services, and led to action to address these with her and better support her long-term abstinence from alcohol. A recommendation (2) has been made.

(d) *From independent chair*: Was there consideration, when Deborah came to the General Practice to seek help with her drinking (January 2015), of re-referring her to CDAT, as she had been engaged with them before?
Answer: The General Practice provided Deborah with the details of Open Road, a self-referral service, who could then have referred Deborah on to CDAT if the need were indicated.

3.3.2 It is the view of the independent chair that a more proactive response from the General Practitioner at this point could have resulted in Deborah receiving support for her drinking. In the past she had not self-referred to Open Road and other services; she had engaged with CDAT, and not with ADAS. Deborah clearly felt comfortable seeking help from her General Practitioner, and had in the past received a direct referral for support, rather than signposting. This practice could have been repeated here.

3.4 Princess Alexandra Hospital

3.4.1 The hospital had two contacts with Deborah in which there were opportunities to explore her home life and any issues she may have been living with; we cannot know how she would have responded at that time, but she could have been given the opportunity.

3.4.2 The first was when she attended the Emergency Department with an injury following a fall, and it was noted that Deborah could not remember exactly how it had happened. While it may have been an accident, when someone attends with an injury and cannot remember how it was caused, this should be cause for alarm.

3.4.3 The Hospital now have in place routine enquiry in the Emergency Department, in which all patients are asked if they feel safe, and their responses are recorded. Domestic abuse disclosures are flagged on that person's record, and they are referred to the on-site Independent Domestic Violence Advocacy service, called the Daisy Project, delivered by Safer Places. They also deliver face to face training to staff, and this covers issues of familial domestic abuse.

3.4.4 This enquiry was not in place when Deborah attended in 2014, but if anyone were to attend now and present with the same issue, they would be asked about their safety and domestic abuse.

3.4.5 The second occasion was during the pre-assessment for the procedure, in which a routine question around alcohol was asked, and Deborah stated that she drank more than 21 units of alcohol a week, but was recorded as "*reluctant*" to give the information. It would have been appropriate for the staff member to enquire further with Deborah about her alcohol use, in order to make relevant referrals if Deborah accepted them.

3.4.6 The hospital IMR outlined that staff have access to a drug and alcohol service provider on site (ADAS), and can seek advice and make referrals. There is no specific training on drug or alcohol issues (or on mental health) for staff but it is included in mandatory safeguarding training and some ad hoc training is undertaken by the ADAS staff on site.

3.4.7 On one occasion Deborah was listed as Michael's carer during his contact with the Hospital. At the time a referral for a carer's assessment would have been done on the request of the individual; now it would be more proactively offered.

3.5 Essex Specialist Treatment and Recovery Service (STaRS)

3.5.1 Deborah was engaged with this service from 23 April 2014 to 31 December 2014. Following an initial joint assessment with the Community Mental Health Team, Deborah was allocated to CDAT, now STaRS as the conclusion of the assessment was that Deborah's "*primary problem*" was alcohol use. There was no record made as to whether this was a course of action Deborah felt happy or comfortable with, although she did agree.

3.5.2 Further information provided by STaRS to the DHR outlined how the staff assessed the issues of mental health and alcohol use for Deborah: that until Deborah had abstained from alcohol for some time it was not possible to make an assessment of her mental health, and that the need for a referral to mental health services would be kept under review by CDAT.

3.5.3 A history was taken for Deborah in which she disclosed her difficulties with alcohol, that she was struggling to cope and struggling for money, and she was concerned for her son Ryan who was in prison for assaulting his father (Deborah's ex-partner). There was no record of enquiry with Deborah regarding when Ryan would be released from prison, and whether she felt she would be at risk from him following that release. While Deborah certainly had a significant issue with alcohol at that time, she was obviously struggling with a number of different issues that were affecting her drinking and her mental health, and no actions (e.g. referrals or signposting) were taken that could have supported the whole of her situation and experience (e.g. worries about money and about Ryan). It is of note that the first time she sought help around her mental health, alcohol and other difficulties was while Ryan was in prison: staff did not show professional curiosity in relation to Deborah's disclosures.

3.5.4 Following the initial assessment Deborah missed four appointments for a health check; each time a further appointment was offered, but there was no record of a conversation with Deborah to understand why she was missing the appointments (in particular as, during this time, she was attending the Preparation for Change Group; although it may be that the worker was not aware of this until Deborah responded to their final letter). Deborah attended a health check following a final phone call four months after the initial assessment. The

focus from this point on was on detox treatment for Deborah; initially planned to take place at home, and subsequently carried out as inpatient treatment.

3.5.5 Appropriate procedures were followed for this route of care for Deborah; yet following completion of her detox treatment she was discharged from the service without proper checks that she had engaged with ADAS (which she hadn't, see 2.12.48). As a result, Deborah received no ongoing support following the detox; and there was no service engaged with her that could have ensured that she continued to request the prescription for the abstinence-supporting medication from her General Practitioner. A recommendation (2) has been made.

3.5.6 The lack of enquiry around Deborah's relationship with Ryan is identified and addressed in the STaRS IMR, with the following recommendations made:

(a) Genograms to be completed as part of on-going assessment. An update provided in March 2017 demonstrated that these are now being completed.

(b) Explore family relationships and dynamics considering risk vulnerability and safeguarding. An update in March 2017 stated "*Essex STaRS will explore family relationships and if a client is at risk Essex STaRS will arrange to see the client in another area/building where it is safer and no risk to the client's vulnerability. If there are any safeguarding risks the Essex STaRS worker will refer to the Trust safeguarding team. They will also discuss the situation with the Essex STaRS Family Practitioner. At present they are liaising with the Victim Support Worker from Social Services.*"

3.5.7 During Review Panel discussions, the service outlined that a risk assessment is in now in place that asks clients about domestic abuse, and that this risk assessment is reviewed every three months with clients. A pathway exists for practitioners to refer to the Adult Safeguarding Team within NEP with links to Safer Places as the specialist domestic abuse support service.

3.5.8 The Review Panel heard that the service delivery design has changed significantly since the time that Deborah was engaged with CDAT: "*Essex STaRs (Specialist Treatment and Recovery Service) provides specialist prescribing for clients/patients with opiate/alcohol problems. It is a statutory drug/alcohol service provided by North Essex Partnership University Foundation NHS Trust. The service works in partnership with our non-statutory providers. One of the providers we work closely with is called Open Road. They provide open access for anyone who would like advice, information, support, assessment and access*

to formal treatment with drug/alcohol problems. They provide the psychosocial intervention."

3.5.9 In addition to the IMR recommendations and other changes that have taken place in the service, this DHR makes a recommendation (9) in relation to dual diagnosis policy and practice (see 4.2.2).

3.6 Alcohol and Drugs Advisory Service (ADAS)

3.6.1 The service recognised in Review Panel discussions that an enhanced approach should have been taken in attempting to engage Deborah in the service following her detox and the referral from CDAT (December 2013). As outlined above (see 3.5.8) the service design and delivery has changed to ensure that this would no longer occur.

3.7 Essex Police

3.7.1 Essex Police attended Deborah's address on 14 occasions between 16 April 2010 and 7 March 2012. These were responses to 999 and non-emergency calls from Deborah, Ryan and Ryan's father. Ryan was: removed from the premises or arrested in order to prevent breaches of the peace; arrested for drugs offences or criminal damage; on two occasions he was detained under the *Mental Health Act*; or no offences were recorded as a result of which no action was taken. On two occasions Ryan called police and on their attending no offences were disclosed; Ryan declined to complete the DV1 and 'skeleton' forms were completed with the outcome of 'standard' risk (a 'skeleton' form is one in which the officer uses the information available to them to assess risk).

3.7.2 All of the incidents were flagged and responded to as domestic abuse with the exception of one incident in which Ryan was arrested for possession of illicit substances (6 February 2011). Given the history evident by this time, this incident should have been recorded as domestic abuse and appropriate procedure followed. Consideration should also have been given to Deborah as a potential victim of domestic abuse, and the risk she may have faced, on the two occasions when Ryan made the initial call.

3.7.3 A DV1 was completed with Deborah on nine occasions; she declined on two further occasions, and in one incident the completion or otherwise of a DV1 was not recorded (13 January 2012). On the two occasions that Deborah declined to complete the DV1, a 'skeleton' DV1 was completed.

3.7.4 Deborah was assessed as standard risk on three occasions (including one 'skeleton') and medium risk on three occasions (including one 'skeleton'). On one occasion she was identified as high risk and this was later downgraded to medium; she was identified as high risk on two occasions. There was opportunity to review Deborah's risk in light of all the reported incidents together, rather than focusing on each individual incident and risk identification process separately, through the MARAC; however, police only shared information about the most recent two incidents at that meeting.

3.7.5 Following two incidents (November 2011 and January 2012) the officers recorded advising Deborah to seek a "restraining order" against Ryan; this is incorrect, and Deborah should have been advised – as she later was by the DALO – to seek a 'non-molestation order'[26]. It would be helpful for Essex Police to ensure that frontline officers, as well as specialist domestic abuse officers, are aware of the correct advice to give to victims seeking civil orders.

3.7.6 The Essex Police IMR outlines the Essex Police response to domestic abuse incidents as follows:

(a) Frontline officers handle cases identified through the completion of the DV1 as standard or medium risk. The Central Referral Unit (CRU), a dedicated unit for responding to domestic abuse and safeguarding issues, manages high-risk cases.

(b) Following the initial completion of a DV1, this must be delivered as quickly as possible to the CRU; it is then input onto the Police system Athena (previously PROtect) by CRU staff and a further risk identification process is carried out. The information is transferred automatically overnight, and entered in a reduced form onto Essex Police intelligence systems.

(c) If the victim is identified to be at medium risk, a Domestic Abuse Safeguarding Officer (DASO) makes referrals to partner agencies as appropriate, and sends a letter to the victim that offers advice and support. A

[26] S.12 of the DVCV Act 2004: Restraining orders may be made by the Court against an offender following conviction or acquittal for any criminal offence. Non-molestation orders are civil injunctions that prevent the perpetrator from using or threatening violence against the victim (and if applicable their child/children) or intimidating, harassing or pestering them. Both orders are intended to be preventative and protective on behalf of the victim.

phone call might also be made to the victim. (No action is taken on standard risk cases. See the update on responses to standard risk above, 1.12.)

(d) In cases where the victim is identified to be at high risk, the case is referred to and handled by the Domestic Abuse and Safeguarding Team for that geographical area. A DASO will contact the victim that day by phone; if no contact is made after several attempts, officers are dispatched to the address to check the victim's welfare. A safety plan is discussed with the victim and a marker is placed on the police response system.

(e) Since Essex Police's contact with Deborah, a new system is in place for MARAC (see 3.8).

(f) In relation to the investigation, high risk cases must be updated every 24 hours and be subject to review by a supervisor every 48 hours; medium risk cases to be updated every four days and reviewed by a supervisor every seven days; standard risk cases updated every six days and reviewed every 14 days.

(g) At the time that Deborah was involved with Essex Police, referrals were made to the Independent Domestic Violence Advisor service, provided by Victim Support (see 3.9), only in cases where the offender had been charged.

(h) The CRU now makes referrals to the IDVA service (Safer Places) for all high-risk victims.

3.7.7 The Essex Police IMR outlines that proper process and procedure was followed for the incidents identified as domestic abuse on all but two occasions. The first was the 28 December 2011 when the DV1 indicated that Deborah was high risk, and this was downgraded to medium with no rationale recorded. A recommendation is made in the IMR to ensure this does not occur:
"*Where a DA risk assessment is re-graded, it is recommended that all staff are reminded of the importance of recording the rationale behind the decision which should be accurately recorded within the Athena record and attributed to the officer making the decision.*"

3.7.8 The second was following the incident of 7 March 2012, in which a record was made for a MARAC referral to be made, and this was not followed up on. A MARAC discussion was held on 13 March 2012 following the referral for the incident on 28 January 2012; the IMR author considers that a further MARAC

discussion could have been useful and that the second referral should have been followed up on. While the referral was not recorded as received by the MARAC team, the second incident (7 March 2012) was referred to at the MARAC meeting.

3.7.9 The IMR also highlights that more positive action could have been taken following this incident on 7 March 2012, in which officers took no action when Deborah reported that Ryan had thrown a brick through her window. While there was no evidence at the scene that Ryan had committed the offence, the IMR outlines that given the history of domestic abuse that was evident on the police system (including that Deborah was a high risk victim and Ryan a high risk perpetrator of domestic abuse), and the warning markers for Deborah's address, consideration could have been given to arresting Ryan. A recommendation is given in the IMR for "*the officers and supervisors who dealt with this incident are given management feedback regarding their performance and the need to take positive action at domestic abuse incidents, particularly where they are dealing with a high risk victim and perpetrator*".

3.7.10 A lack of positive action is further noted in relation to the incident of 26 January 2012, in which Ryan threatened to rape Deborah. The IMR author considered that officers saw this as "*an idle threat*" and therefore "*not pursued by the officers*". While the supervising officer was noted to have "*queried*" this, and a record was made of Ryan's strange behaviour, the officer's endorsement was that Ryan had "*mentioned*" he was going to rape his mother, indicating that the supervising officer, as well as the officers who responded to the incident, did not take the threat seriously.

3.7.11 Essex Police make two recommendations in their IMR to address the identified learning:

(a) Where a DA risk assessment is re-graded, it is recommended that all staff are reminded of the importance of recording the rationale behind the decision which should be accurately recorded within the Athena record and attributed to the officer making the decision. *Update*: An Essex Police procedure is in place setting out the responsibilities of attending officers and supervisors in relation to assessment and recording of domestic abuse incidents and risk assessments. All operational officers attend three-day Public Protection awareness training, which includes content in relation to

risk assessment. In addition, monthly 'Inform' bulletins and the 'Officer's Guide to Vulnerability booklets (issued to every officer) outline the responsibilities. A new Investigative Advisory Team is responsible for checking the quality of investigations and safeguarding for cases of vulnerability, including domestic abuse

(b) It is recommended that the officers and supervisors who dealt with this incident are given management feedback regarding their performance and the need to take positive action at domestic abuse incidents, particularly where they are dealing with a high-risk victim and perpetrator. *Update*: This has been progressed through the appropriate internal process.

(c) That Essex Police officers are reminded of the content of the action plan produced following the Her Majesty's Inspectorate of Constabulary (HMIC) in 2014 (*Everyone's Business: Improving the Police Response to Domestic Abuse*[27]). Specifically, to highlight the following: "*The existence of information sharing hubs across Southend, Thurrock and the wider Essex area, which support victims and manages offenders*" and "*When signing off domestic abuse incidents supervisors are to bear in mind the training they have received which focused specifically on safeguarding and referrals to partner agencies, as well as perpetrator and vulnerable case referrals.*" Update: since the IMR was written, the Action Plan has been updated and a 2016/17 Plan is currently in place. Monthly 'Inform' bulletins make officers aware of this, and an article, which included information about MARAC and was published on the internal Essex Police website in April 2017. The above information is also included in the mandatory training for officers.

3.7.12 The Essex Police IMR demonstrates an effective analysis of the incidents involving Deborah and Ryan. Nevertheless, Deborah clearly felt that she was not getting the support she felt she needed. During her conversations with the DALO following the incident of 28 January 2012 Deborah expressed frustration with the visit of the Crime Reduction Officer, and also with the sentence Ryan received for that offence (compensation order). Safety options were discussed with Deborah (non-molestation order and security) and the support possible through

[27] https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/03/essex-approach-to-tackling-domestic-abuse.pdf

Parentline Plus. Deborah may have benefited from engagement with an IDVA service designed specifically to support her, and it is unfortunate that they were unable to reach her (see 3.9).

3.7.13 Deborah told the officer who called her prior to the MARAC discussion (9 March 2012) that she did not need any further support; other conversations suggest that this was not the case, and it may be that Deborah, like many victims of domestic abuse, was unaware of the support available and what she could ask for. Officers making pre-MARAC calls need to be aware of this, and ensure that they give information to victims of the possible support that is available. In addition it is important to ask open ended questions about the needs of the victim so that they are encouraged to ask for any and all support/help they would like, without being restricted to just what is available, in case other opportunities may be presented through the MARAC meeting. This is addressed through the learning in relation to MARAC (see 3.8).

3.7.14 When Essex Police received the notification regarding Ryan's release from prison in April 2015, there was no indication given on the notification that would have highlighted to officers the need to take positive action in relation to Deborah.

3.8 Multi-Agency Risk Assessment Conference (MARAC)

3.8.1 A MARAC is an opportunity to view a victim of domestic abuse – and the perpetrator, in a holistic way, taking into account their history, environment and overall situation. Deborah was discussed at the MARAC on one occasion (in March 2012) following an incident reported to Essex Police in January 2012. This apparent delay was caused by the fact that MARAC meetings took place on a monthly basis, with deadlines in place for referrals to enable time for agendas (with case information) to be circulated to all attendees, and information to be gathered by them in preparation for the meeting.

3.8.2 It was a positive finding for this DHR to note that the key agencies involved with Deborah and Ryan attended the MARAC and shared the information they had.

3.8.3 Looking at the actions that were recorded (and completed) it is difficult to see what they would have achieved in relation to Deborah's safety and the risk posed by Ryan. Deborah was offered support through the MARAC process (a standard 'pre-MARAC' phone call was made to her prior to the meeting) and her involvement with the police DALO. But her case was listed as "*closed*" by the

IDVA service. The MARAC meeting was an ideal opportunity for the IDVA service to find a way of contacting Deborah again, for example by working with an agency she was already involved with.

3.8.4 At the end of the information sharing and action planning, were the MARAC Chair and attending agencies satisfied that, as a result of the discussion and actions, Deborah's risk could be reduced from high? If not, what further action could have been taken?

3.8.5 The DHR learned that a new process is now in place to manage and respond to all high-risk victims. The following outline has been provided:
A MARAT has been created, forming the core membership of MARAC meetings: Essex Police; Adult's and Children's Social Care; Health; Probation; Community Rehabilitation Company; Housing; Substance Misuse; IDVA service. 'Allied partners' will contribute on a case by case basis. The MARAT is co-located, with an operational manager. Police incidents assessed as high risk will be received by the team every day. Non-police referral to the MARAT is the same as for MARAC: a DASH risk checklist outcome of high risk, or a professional judgement of high risk. The MARAT discusses a case and generates a multi-agency action plan (covering the victim, perpetrator and any children) within ten working days of the referral being received. MARAC meetings take place twice a day, Monday to Friday, and cases are allotted a thirty-minute discussion time.

3.8.6 Referrals are made to the IDVA service immediately, and there is emphasis in the discussions on the voice of the victim. The Quality Assurance Framework for the new process sets out high expectations, that will be monitored and evaluated, including a feedback form to be completed by victims. In addition, guidance has been developed for agencies responsible for feeding back to the victim following a MARAC meeting.

3.8.7 In light of the learning from this DHR that Deborah was not seen holistically by agencies, this emphasis is welcome and addresses the issues that the independent chair and Panel had with the MARAC process in Deborah's case.

3.8.8 The Essex MARAC/MARAT has protocols in place for MARAC to MARAC transfers, when a victim moves area; in this case information was passed from the Essex MARAC to the Hertfordshire MARAC due to the risk Ryan posed to his father as well as to Deborah.

3.8.9 The independent chair contacted Hertfordshire MARAC to enquire about this transfer of information. While the records from 2012 could not be accessed (as the provider for MARAC Coordination had since changed), the MARAC team confirmed that, should this information be received now, then a safeguarding review would take place with the potential victim (in this case it was Ryan's father).

3.9 Victim Support

3.9.1 Deborah could have benefited a great deal from talking through her situation from an independent advocate who understood her situation and whose role was specifically to support her practically and emotionally until such time as her risk was reduced. Deborah was unable to make a choice about accessing this service because she could not be reached on the phone. Given that the service is dedicated to supporting victims who are at high risk of serious harm or homicide, when a victim cannot be reached the concerns should be heightened and appropriate action taken to establish the safety or otherwise of that victim. Victim Support clarified that the contact that was attempted, and the subsequent email to the referrer (police) followed their procedure at the time.

3.9.2 The IDVA service is now delivered by Safer Places, who provided the following information about making contact with newly referred victims: "*We will attempt contact within the first 24 hours of receiving a referral and make attempts over the next few days at various times including weekends as our operating hours are Monday to Sunday 08:00 to 22:00. If we don't have any success within five days we will contact the referring agency to try and arrange a joint meeting if they are also working with them.*" This improved process is welcome. In addition this DHR suggests that Safer Places consider alternative ways of contacting victims, as in some cases letters, text messages and emails can be a safe means of contact, provided adequate research has been done to establish this.

3.9.3 A question was raised during Review Panel discussion on what number appears on a victim's phone when they are called by the IDVA service: if the number appears as 'unknown' or 'no caller ID' then it is possible that a victim will be unwilling to answer the call. Safer Places informed the DHR that numbers are not visible to those being called to support the victim's safety in case the perpetrator is monitoring their phone or answers the call. This unfortunately means that many potential clients of the IDVA service may not respond to calls,

but in light of the proactive response outlined by Safer Places in the previous paragraph, other means of making contact should be pursued.

3.10 Organisations in contact with Michael

3.11 East Hertfordshire Council Housing Service

3.11.1 This service followed procedure and policy during their contact with Michael, and there was nothing in their contact that suggested concern.

3.12 Parsonage Surgery – Michael's General Practice

3.12.1 Michael's General Practitioner attempted to engage Michael in discussion about his alcohol use, and showed good practice in pursuing this and offering referrals. Given Michael's response to this conversation the General Practitioner offered all the support available in the circumstances.

3.13 Princess Alexandra Hospital

3.13.1 Emergency Department staff had an opportunity to engage with Michael about his alcohol use on the occasion that he attended having fallen down the stairs. As outlined above (see 3.4.6) staff receive some training on drug and alcohol issues as part of safeguarding training, and would therefore have engaged with Michael if they felt he required a safeguarding response in relation to his alcohol use.

3.14 Organisations in contact with Ryan

3.15 Essex County Council Education

3.15.1 The information available to the IMR author was in the form of Ryan's secondary school file.

3.15.2 The IMR author notes that the school records were limited, with no records in relation to his time at primary school. The paperwork that was available was often not dated, duplicate records were contained in the file and there was no proper order to it. The file did not contain evidence of assessment or analysis of Ryan's behaviour, or his response to interventions. There was no record of involvement of partner agencies in working with Ryan – or consideration of this.

3.15.3 Recommendations are made in the IMR for:

(a) Schools to be reminded of the need to ensure previous school files are obtained when a child / young person is admitted.

(b) Schools to be reminded of the need for accurate, clear, dated records with the name of the author written. Further work with schools about quality of recording, including reflective / evaluative information should be undertaken.

3.15.4 There was no formal record on file to indicate the school was aware of Ryan's drug use, which we know was an issue for him at that time from his later disclosures to NEP.

3.15.5 The Review Panel representative for Education provided the following information:

While schools are not required to teach PSHE (Personal, Social, Health and Economic) education, the Education Act 2002 requires all schools to teach a curriculum that is "*broadly based, balanced and meets the needs of pupils*". Schools must "*promote the spiritual, moral, cultural, mental and physical development of pupils at the school and of society, and prepare pupils at the school for the opportunities, responsibilities and experiences of later life*" while having a duty to keep pupils safe. This is strongly supported by 'Keeping Children Safe in Education' (DfE 2016) and the Ofsted Inspection Framework.

3.15.6 The Review Panel representative indicated that, while there was no standard format for delivery of PSHE, all schools include this in the curriculum in one way or another. The representative would expect all secondary schools in Essex to carry out awareness raising with students around drug and alcohol use, but this is for individual school to decide if, when and how to do this.

3.15.7 The Education Service IMR makes a recommendation for schools to be reminded of the need to deliver drug and alcohol advice to pupils and for the Risk Avert Programme to be promoted with secondary schools in Essex. An update provided in March 2017 stated that the former has been covered in safeguarding forums, and a template has been established, with guidance, for schools when a pupil transfers. With regard to the second point, this has also been covered at safeguarding forums, and is constantly revisited. Templates have been established and sent to all schools for reporting and recording concerns. These are promoted in briefings and other communications and meetings.

3.15.8 The Community Safety lead for Uttlesford District Council also informed the DHR that they run 'Crucial Crew' each year with young people at schools across the district, with information about safety, mental wellbeing, internet safety, domestic

abuse, drugs and alcohol. Partner agencies are involved in the delivery of this, including Essex Police and Safer Places.

3.16 Essex County Council Connexions Service

3.16.1 The Connexions service is no longer delivered in Essex. Essex County Council delivered the functions prior to them ceasing in 2012 and a number of Targeted Youth Advisors are still employed by the Council. They deliver a similar function to the Connexions Intensive Personal Advisors (IPA), in that their role is to work with young people to remove barriers to them accessing universal services such as education, training, employment or social activity.

3.16.2 The former service was aware of difficulties Ryan was having with his parents, but this information was either given to them by other agencies (NEP and YOS) or disclosed by Ryan in the presence of those agencies. The IPA would not have had the skills, or remit, to engage with Ryan in relation to those issues and would have expected those agencies to be addressing these issues with him. The records show that the IPA did support Ryan with his engagement with NEP.

3.16.3 The Targeted Youth Adviser service confirmed to the DHR that all staff in the youth service complete an online domestic abuse training, in addition to standard safeguarding training.

3.17 Ryan's General Practice

3.17.1 The focus of the IMR from the General Practice is on the time period following Ryan's release from prison (from April 2015).

3.17.2 The IMR outlines that there was no sharing of information from the Prison with regard to Ryan's receipt of services for mental health while in prison. (We now know that Ryan had declined consent to the last healthcare service he was engaged with in prison for this information to be shared.) Following his release, the General Practice did not know what he had been convicted of, or what services he had accessed while in prison. The General Practitioner identified no mental health issues when Ryan re-registered with them following his release. It was therefore good practice that, seeing that he had previously been under the care of NEP, they re-referred Ryan at that time.

3.17.3 The independent chair sent questions to the General Practice; the answers provided are below.

(a) *From independent chair*: Once Ryan was engaged with NEP from February 2010, he attended the Surgery in June 2010 and March 2011 for physical

health issues: was there exploration of his mental health needs at that time? Would you have expected this discussion to take place?
Answer: The General Practice would not have expected there to be discussion of Ryan's mental health situation at these appointments, as he was under the care of NEP at the time, and nothing in his presentation at those times suggested a change.

(b) *From independent chair*: Please can you expand on the issue of communication between prisons and the General Practice?
Answer: "*When a patient is released from prison, there is no feed-back from the Prison Service. We feel that a medical discharge summary, detailing medication, investigations, any identifiable risks, counselling, anger management etc, would be beneficial. This needs to be highlighted in the review as a wider issue for regional and national agencies to address.*"

3.17.4 The new General Practice Contract for 2017/18 includes the following which is relevant to this point and is hoped to address this learning: prisoners will now be able to register with a General Practice prior to leaving prison, enabling the "*timely transfer of clinical information*" and better care following release[28].

3.18 North Essex Partnership University NHS Foundation Trust (NEP)

3.18.1 The NEP IMR concludes that "*the treatment and support options offered to Ryan and his family were appropriate to the situation presented to practitioners in this case… the only resolution … would have been for Ryan to cease using drugs"* which he indicated he would not do. The lack of recognition of Ryan as domestic abuse perpetrator is highlighted in the IMR, and addressed below.

3.18.2 There were documented occasions of NEP practitioners engaging with Ryan's drug use. There was one record in which NEP staff engaged with the YOS about Ryan's contact with EYPDAS (July 2010); there is no evidence of joint working, or consideration of a pathway of dual diagnosis.

3.18.3 The first part of Ryan's contact with NEP in 2010 was an intensive period of care from the CRHT Team, while he was treated for symptoms of psychosis and monitored closely. He was deemed detainable under the *Mental Health Act* but, as per procedure (and because Ryan was willing), the least restrictive option of

[28] https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/ [accessed 29 March 2017]

home treatment was followed. Once Ryan's condition was seen to have stabilised, his care was transferred to the EIP team. It is at this point that the family appeared to start to feel let down by the level of service, with Ryan's father contacting the team regularly to ask when Ryan would be seen. The NEP IMR outlines that the EIP team's purpose and way of working was explained to the family. It is not clear that the family fully understood why there was, what appeared to them, a sudden drop in the amount of contact. The practitioners clearly felt that the 'crisis' was over for Ryan and the family; the family, whose day-to-day experience of Ryan was of his behaviour and mental state fluctuating, felt differently.

3.18.4 It is evident that NEP staff completed and reviewed care plans and risk assessments throughout the time Ryan was involved with the service. These care plans, reviews and risk assessments did not always name the violence, threats and aggression he displayed towards his parents and others. Where this was named, there is no evidence in the care plans of specific actions to address this, beyond the suggestion of family therapy. The Review Panel discussed, and NEP agreed, that this suggestion was inappropriate, and potentially dangerous, for the family to engage in given that Ryan was perpetrating domestic abuse against Deborah and his father. NEP confirmed that family therapy would now not be recommended in situations such as this.

3.18.5 In some instances information from Ryan's father and Deborah about Ryan was given a great deal of weight, leading to Ryan not being seen because they had indicated that he would refuse. At other times, when they reported his violence and aggression, and that his mental state was fluctuating / changing / getting worse, it did not lead to action. There were occasions when there was no evidence that practitioners carried out (or attempted to carry out) their own assessment of Ryan as a result of information they received.

3.18.6 In February 2011 a plan was made for the Care Coordinator to make weekly home visits to Ryan, and at the first of these in March 2011 Ryan stated that he was "*happy for visits to continue*". There are a number of records indicating Ryan 'did not attend' appointments but it is not clear what attempts the Care Coordinator made. There was no record of a home visit until the CPN suggested it at the end of September 2011; and no further visits took place after that until February 2012. At that last home visit, Ryan again indicated that he would

continue to meet with NEP at home; but no further home visits were conducted. There is no evidence of decision making around not making home visits, and no evidence, with the exception of the conversation with the CPN, of practitioners challenging Ryan's family's view that he 'wouldn't engage'. The family may have believed that he wouldn't: staff were in a position to use their professional judgement to make decisions and actions in response to the care plan, and attempted direct observation of Ryan, not relying solely on the views of Ryan's parents.

3.18.7 At other times, Ryan's family's views did not receive due attention. For example their regular reports of Ryan's violence and aggression did not lead to any referrals or signposting for the family to gain support for themselves. A Carer's Assessment was offered, via letter, to Ryan's father. NEP recorded that he had passed it to Deborah, and she had declined. This offer came early in NEP's involvement with Ryan (June 2010) and was not offered again. It may be that neither Deborah nor Ryan's father saw themselves as 'carers' and therefore saw no need for the assessment. An open conversation with them could have established their support needs and led to advice, referrals and/or signposting.

3.18.8 Liaison with other agencies, specifically the police, could have supported more holistic risk assessment in relation to Ryan: there were eight police call outs in the time that NEP was engaged with him. Following the Mental Health Act assessment in early January 2011 that concluded Ryan needed to be detained in hospital, his aggressive behaviour was such that police were called and six officers were required to restrain him. Despite this, the NEP record stated "*no recorded danger to others*".

3.18.9 In December 2010 Ryan's father contacted the service to report that Ryan's mental state had significantly deteriorated, and they were very concerned: they were advised to contact again if it developed into a 'crisis'. It is not clear what more needed to be reported for it to become a 'crisis', and their response comes across as dismissive of Ryan's father's concerns.

3.18.10 The records during Ryan's engagement with the EIP team suggested that there were times when he disengaged, and other times when he stated that he was happy to engage with the service, but the course of action taken by staff was not always clear. Documentation on who attended appointments, which team or

practitioner had contact with Ryan or a member of the family, was likewise not always clear.

3.18.11 The IMR outlines the following learning:

(a) That NEP staff did not identify or name Ryan's behaviour towards his parents as domestic abuse; and no domestic abuse specific risk assessment was carried out.

(b) NEP is recognised to not be adequately involved in the MARAC process, largely due to a lack of resources. An IMR recommendation is made to address this including the allocation of resources. (NEP was involved in the MARAC in this case through the criminal justice team only.)

(c) A further IMR recommendation is made to review the provision of specialist domestic violence oversight and effective recording processes for cases being managed or referred by practitioners.

3.18.12 In addition to the learning outlined in the NEP IMR, this DHR found the following:

(a) That recording of practitioners' contact with Ryan was often unclear and incomplete, and that this may have had an impact on the effective progress of his care plan.

(b) That at times there was overemphasis on the views of Ryan's parents in relation to Ryan's willingness to engage.

(c) In contrast, there were occasions when practitioners did not appear to respond directly to the concerns and issues raised by Deborah and Ryan's father. At times, it seemed that Ryan's parents were seen as a source of information about Ryan, but not as having both a direct role in his day to day care, nor as being at risk from him when his mental health fluctuated.

3.18.13 An update provided by NEP in March 2017 outlined the following to address the learning outlined above: "*Safeguarding policies (children, adult and domestic abuse), clinical risk management, carers strategy, mental capacity act already refer to the use of professional judgement, the importance of clients having the opportunity to have safe, independent assessment and, where appropriate, consultation with relatives/carers, involvement of family and identification of needs, concerns and risks. The revised Domestic Abuse and Violence Policy will include additional guidance around the involvement of families/carers, especially with regard to service users who are perpetrators. Level 3 training is based on Think Family. It includes responsibility to engage with families/carers and as well*

as identifying risks, assessments and sources of support for service users who are victims of abuse. It also focusses on when the service user is the perpetrator, thus includes when to breach confidentiality, DASH risk assessment and for perpetrators The Change Project."

3.18.14 With regard to the learning outlined above in relation to recording (see 3.18.12.a):

In March 2017, NEP is in the process of merging with South Essex NHS Foundation Trust to become Essex Partnership University Trust. As a result, the record auditing process is likely to change. At present, audits show areas of good practice (up to date care planning and risk assessments, evidence of consent and capacity, listening to service user) and concern. The areas of concern include lack of genograms; lack of recording of all contacts regarding a service user and contact with family/carers. Areas of concern are being addressed through training as well as supervision.

3.18.15 The DHR welcomes this audit process and the way it is being used to improve recording and the subsequent impact these improvements will have on practice.

3.18.16 The Independent Mental Health Investigation concluded that "*it would not have been possible for mental health services to predict or prevent Ryan's actions on the day of the homicides*" but that the Investigation has nevertheless "found a number of areas where best practice and policy were not adhered to." The investigation report outlines that the "*Trust (NEP) no longer exists in its previous form, and service provision has been redesigned. Where we have had evidence of improvement we have not made recommendations, in the areas of domestic violence and risk assessment training, management of waiting times in the psychosis service, and the oversight of quality of IMRs.*"

3.18.17 The following recommendations have been made:

(a) The Trust should evidence the embeddedness of their revised domestic abuse and safeguarding training, by reporting on and monitoring training and safeguarding supervision figures against targets.

(b) The Trust should ensure that appropriate communication links are maintained and monitored with Multi Agency Risk Assessment Teams (MARAT).

(c) The Trust should implement structures to monitor adherence to policy guidance with regard to transfers of care, transition from services and inclusion of the service user and carers in the process.

(d) Trust CPA and discharge policies should provide clear guidance on how liaison with prison services mental health teams will occur at entry and exit, to maintain continuity of care.

(e) Commissioners of prison health services in the East, North Midlands and the South must ensure that robust procedures are in place to maintain continuity of mental healthcare in prison, on reception and on inter-prison transfer when a prisoner has received secondary mental health care in the community.

3.19 Essex Young People's Drug and Alcohol Service (The Children's Society)

3.19.1 Ryan was referred to this service in May 2009 as part of a Court Order through which he was under the supervision of the YOS.

3.19.2 The records of Ryan's time with the service are not clear, and the worker allocated to Ryan has since left. The electronic records contain no information except for the opening of Ryan's file and its closure some months later.

3.19.3 The paper records contain more detailed information of an assessment with Ryan, following which the caseworker changed. Ryan's statement that he would not engage was not apparently challenged: no further attempts were made to contact him and engage him in the service, and the final contact was just prior to case closure and the end of the Court Order.

3.19.4 There is a discrepancy between the EYPDAS records and those of NEP and YOS. The latter both record discussion with the EYPDAS worker on 7 July 2010 (see 2.13.50) in which they recorded the worker had seen Ryan "*a few times*" and it was felt that he had reduced his drug abuse considerably such that he was no longer being seen however would remain open to them. This discrepancy cannot be resolved due to the provider changing and the members of staff leaving, but suggests that the worker had more contact with Ryan than was recorded in the paper or electronic file.

3.19.5 The current Service Manager provided the following context to the service provided to Ryan:

"*The majority of young people with whom we work, do so on a voluntary basis and the young people consent to be seen as this supports engagement. Where young people are expected to engage with us as a condition of their order with the YOS [as was the case with Ryan], we find they can be more difficult to engage and it is not unusual for some young people to not want to comply and be reluctant to engage. We work together with the YOS and other partners to try to engage and our approach is to at least attempt three contacts with young people. This usually involves both phone and written approaches before we take the decision to close a case; this is always with the open invite for young people to engage at a later stage.*"

3.20 Essex Police

3.20.1 In addition to the analysis provided above (see 3.7), the IMR author highlights that referrals to partner agencies could have been made in response to the noted history of Ryan's mental health issues. For example, in responding to the incident in which Ryan was reported missing by the hospital, and was found on 7 November 2010, the responding officer noted that Ryan "*could be violent towards police*". The officer, as well as adding this to the police system, should have shared this with mental health and ambulance colleagues. It was recorded that Ryan was "*taken home*", it is not clear whether this was to Deborah's or to his father's, and there was no record of inquiry with them over their safety.

3.20.2 Appropriate action was taken on those occasions when Ryan was arrested and brought into the police station, specifically assessment by a health professional and detention and removal to a mental health ward when deemed to be required. Ryan was routinely offered referral to a drug support service while in the police station on each occasion.

3.20.3 The IMR author considers that both Deborah and Ryan could have been considered vulnerable adults at points, and received the appropriate referrals for this.

3.20.4 It is further stated that since 2015 officers and staff have completed several compulsory e-learning packages on mental health and learning disability awareness and could therefore now be considered to provide an enhanced response to cases such as these.

3.20.5 Essex Police's IMR recommendations and actions are outlined in the section above relating to Deborah (see 3.7.12).

3.21 Essex County Council Youth Offending Service

3.21.1 The IMR author outlines that all of the contact with Ryan was in line with relevant process and procedure at the time. There was ongoing and effective engagement with EYPDAS and the Mental Health Link Worker. The decision to suspend the National Standards, and subsequently apply for an extension for Ryan to complete his order were correctly made and acted upon.

3.21.2 The IMR author does state that the additional group work programme should not have been added to Ryan's contract at the point the order was extended, due to Ryan's mental health and vulnerability. Nevertheless Ryan completed the order satisfactorily.

3.21.3 Ryan's parents attended the assessment meeting, referral order panel meetings and were present during the home visits made. The IMR author highlights that the YOS Case Manager could have shown more professional curiosity and follow up with the family following information gathered at the initial meetings. Further, while Ryan's needs were identified and relevant referrals were made, it was not apparent that a relationship had been built up between the Case Manager and Ryan, or his parents. Supervision of the Case Manager focused on the practical progress of the order, and did not include the reflective practice that would always be included in supervision today.

3.21.4 The Review Panel also noted that the Case Manager appeared judgemental of Ryan's parents, recording finding them to be "*colluding*" with Ryan not taking responsibility for his previous actions or the order. What could have been more productive would have been to work collaboratively with Ryan and his parents, as outlined in the above paragraph.

3.21.5 Since Ryan's engagement with YOS working practices have changed and as a result the IMR makes no recommendations. The IMR author provides the following information:

"*There is now a more transparent, holistic approach to working with young people and their families. Process, policy and procedure have changed over recent years to include more inclusive work with families. The focus of assessments has moved away from purely criminogenic factors to consider all aspects of the young person's life, young people and their families are fully involved in creating and reviewing plans for their work with the YOS and*

Management oversight is more prevalent and more reflective. Caseloads have also reduced since that time."

3.21.6 These developments are welcome.

3.22 Hertfordshire Constabulary

3.22.1 The IMR author outlines the significant finding that each of the four incidents involving Ryan between December 2011 and August 2012 were dealt with separately. Each new incident did not take account of previous ones.

3.22.2 As a result, the IMR author states, officers did not take account of Ryan's underlying problems (drug use and mental health issues) and his relationship with the victim (father). Information about Ryan's mental health was recorded for the incident on 11 April 2012, but it is not clear whether this information was shared with the Crown Prosecution Service when Ryan came before the court.

3.22.3 The IMR notes that a MARAC referral should have been made, on the basis that there had been clear escalation (four or more incidents within twelve months). Since Hertfordshire Constabulary's contact with Ryan and his father, a new system is now in place in which the Domestic Abuse Investigation and Safeguarding Unit is centrally based and examines all reported domestic abuse incidents in the County. This has led to a more standardised approach and a MARAC referral would now always be made in these circumstances.

3.22.4 Ryan's father informed officers of Ryan's mental health history; this was not acted upon as it should have been. Ryan should have been assessed with regard to his fitness to be detained / interviewed, and whether an Appropriate Adult was required. On the one incident where Ryan's mental health was recognised, and his case referred to the MDO Panel, information was not passed on (that had previously been provided by Ryan's father) that Ryan had accessed mental health services in Essex. This led to MDO Panel concluding that Ryan was appropriate for prosecution as no evidence of mental health treatment could be found (as only Hertfordshire agencies were involved).

3.22.5 The IMR outlines that since this incident, all custody staff have been briefed in writing about the need to complete pre-release risk assessments in all cases where the detainee's vulnerability is evident, such as mental health. These risk assessments will be reviewed as part of the routine Custody Audit process.

3.22.6 The IMR highlights the actions of the Domestic Violence Officer following the incident of 10 August 2012 with regard to contact with the (Hertfordshire)

Community Mental Health Team and that proper recording did not take place in terms of the rationale for the actions taken.

3.22.7 The IMR notes that recording on the 'Family Front Sheet' and the main police system was not always clear, consistent or making clear links between the two. A recommendation is made in the IMR to address this that: "*All officers and staff should be reminded to include their rationale on the Family Front Sheet for any actions or decisions they have taken.*" An update provided in March 2017 stated that this action had been completed: "*All DAISU [Domestic Abuse Investigation and Safeguarding Unit] staff received an input into this on their scheduled training days (covered in a five-week cycle) in 5th October 2016. This training will be repeated as necessary due to a turnover of staff and indeed is being repeated in the next round of training days starting in March 2017."*

3.23 Her Majesty's Prison and Probation Service (HMPPS)

3.23.1 The chronology and IMR from HMPPS is a factual record of Ryan's movement between prisons, and the date of his sentence-planning meeting. It notes that the prison understood Ryan was categorised as a 'high' risk offender, as per the (now shown to be) incorrect entry on OASys. HMPPS would have therefore expected Ryan to be seen by probation much earlier than the sentence planning meeting in fact took place; this is explained further in the NPS section (see 3.27).

3.23.2 The PD1 form, sent to probation by the prison to establish Ryan's release address, was returned stating that Ryan could not live with Deborah. Nevertheless, her address was given on his release, because the prison had no further information from probation on an alternative address. Deborah's family fed back to the DHR that they did not understand how this could have happened: if Deborah's address was not appropriate, then it should not have been put on his release documents.

3.23.3 HMP Rochester clarified the process as follows: "*If a prisoner's proposed release address was not considered/assessed as suitable by probation we would expect that the prisoner would be required to report to probation on release and they would find an alternative address that they deemed suitable, which could be an approved premises or other accommodation they deem suitable.*" This is addressed further in the probation section below.

3.23.4 Ryan moved eleven times during his time of imprisonment; in addition to the delay in the sentence planning meeting, this may also have impacted on the ability of staff to carry out rehabilitation / programme work with Ryan.

3.23.5 Ryan accessed mental health services while in the prisons (see 3.25-27).

3.23.6 This DHR notes that the relationship between prisons and probation services has, since that time, changed significantly with the creation of the NPS and Community Rehabilitation Companies (CRCs). Each individual prison will liaise with these services according to their own systems. Robust systems have been confirmed to be in place in HMP Rochester for the identification of prisoners' risk levels and appropriate action being taken in relation to sentence planning.

3.23.7 One outstanding concern relates to the fact that Ryan's sentence plan requirements (which were unable to be met during his time in prison) were not added to his licence requirements. As this practice appears to vary between individual prisons, a national recommendation (3) is made for HMPPS to ensure that instructions are provided to ensure all prisons have adequate structures in place to communicate with the NPS prior to an offender being released to ensure that the licence conditions reflect the sentence conditions.

3.24 Northamptonshire Healthcare NHS Foundation Trust: Mental Health In-Reach Service, HMP Bedford and HMYOI Glen Parva

3.24.1 Northamptonshire Trust provided information in relation to Ryan's care: they delivered the service to him in HMYOI Glen Parva, but at that time the service in HMP Bedford was delivered by South Essex Partnership NHS Foundation Trust.

3.24.2 The Mental Health In-Reach Teams' involvement in both prisons with Ryan was brief due to his short stays between moves while awaiting trial for the assault against his father. Ryan had a number of appointments and was assessed on an ongoing basis, culminating in his starting anti-psychotic medication in December 2012. The notes suggest that this medication had a positive effect on Ryan's mental state, but that he was not able to see this or see any problem with his mental health or behaviour.

3.24.3 The NHFT IMR identifies the learning that in the Team at the time there were too many professionals involved, with a lack of clarity on who was responsible for what actions. A recommendation is made to ensure a lead is identified for coordinating and sharing information.

3.24.4 Information was sought from the NEP EIP Team but there is no record of dialogue being achieved or the transfer of any records/information. The IMR identifies this learning, and makes a recommendation to ensure that relevant history from community based mental health services is gathered.

3.24.5 Action has been taken on these. A system is in place where there is liaison between an individual's key worker and the identified duty nurse for that day to keep the key worker informed of progression of information gathering.

3.24.6 Ryan's care was transferred between the prisons appropriately through conversations between the services in HMP Bedford and HMYOI Glen Parva; they had access to the same electronic records to view Ryan's history within each service.

3.24.7 During his second time in HMP Bedford (prior to trial in June 2013) Ryan's mental state was assessed as improved, and he was no longer on medication (although there are no records relating to the detail of this). His case was subsequently closed. There was therefore no transfer of his case to the next provider of mental health services (Oxleas, see below) when Ryan moved there in July 2013. This is particularly unfortunate, as when he arrived into their care, he did not disclose any mental health history or issues and denied having been in a mental health hospital. Later notes from Oxleas refer to information received from HMYOI Glen Parva Mental Health In-Reach Team, but these were not recorded on the system and so it is not clear how they were shared or what information had been provided.

3.24.8 The issue of transfers between prisons is addressed in section 4 (see 4.2.4).

3.25 Sussex Partnership NHS Foundation Trust: Primary Care Mental Health Service, HMP Ford Open Estate

3.25.1 The Trust's contact with Ryan was brief, and involved an assessment based on concerns that he may have a learning difficulty, which the assessment showed he did not have. A second assessment a month later showed he did not need mental health intervention and was discharged from the primary mental health service.

3.25.2 Sussex Trust are on SystmOne and therefore would have had access to Ryan's history of engagement with mental health in reach teams. Local procedures are in place:

(a) "*To identify any previous mental health history at the point when a prisoner arrives from a court.*

(b) *When clients are transferred in or out of the prison the electronic patient information system SystmOne is used by all prisons which means that the individual's records are immediately available.*

(c) *If an offender is released from prison a discharge letter is sent to the GP as standard practice.*

(d) *Where the individual is subject to Care Programme Approach, a handover will take place with the relevant team.*"

3.25.3 Ryan's journey through mental health services in prison is addressed in section 4 below (see 4.2.4).

3.26 Oxleas NHS Foundation Trust: Mental Health In-Reach Service, HMP Rochester

3.26.1 Oxleas Trust did not have a record of any information shared from the previous Mental Health In-Reach Teams (in HMP Bedford and HMYOI Glen Parva). Some information received from the Glen Parva Team was referred to in a practitioner's notes, it is not clear what information was shared or how. In light of this, when Ryan did not disclose any mental health issues or history on his entry to the prison, and was not showing any signs of any issues, there was no action they could take.

3.26.2 Once Ryan was referred into the Mental Health In-Reach Team, there was a lack of positive activity to follow up with him in relation to his needs, for example he did not attend an appointment and this was not re-booked.

3.26.3 The IMR from Oxleas Trust sets out the following of practice issues in relation to Ryan's care:

(a) If an offender fails to attend an appointment, then In-Reach services must ensure this appointment is re-booked within 10 working days.

(b) The Multi-Disciplinary team meeting must ensure that all triages are fully discussed with a clear action plan for the offender included; and that this is followed up in subsequent meetings.

(c) All information received on clinical aspects of an individual's care must be uploaded onto electronic record systems.

3.26.4 The following recommendations are made in the IMR which address this learning; the updates provided (March 2017) are added to the list below:

(a) All appointments planned for the day are discussed in the daily team meeting. Any offenders who have failed to attend the previous day should be added to the work plan for the following day. *Update*: Daily (minuted) team meetings discuss referrals; when someone does not attend an appointment, they are added to the 'pending' list to be offered another one.

(b) All triage assessments with associated plans to be discussed in the weekly team meeting and the minutes of this uploaded. *Update*: Triages are a standing item on the agenda, are minuted and added to the system.

(c) If information is received from another source, i.e. father, then greater detail should be recorded of the conversation and where requested, a return call/letter should be sent and documented. *Update*: training has been reviewed, and refresher training has taken place on communication with family/significant others, and on documentation on the electronic system.

(d) All clinical information must be scanned onto the current clinical record. Minutes of meetings include a follow up to ensure that work is completed and not lost between meetings. *Update*: Action points remain red on minutes until completed, and staff are emailed action points directly.

3.26.5 Ryan was discharged from the mental health service prior to his release; therefore there was no case to transfer to a community provider. The issue of transfers between and in/out of prisons is addressed in section 4 (see 4.2.4).

3.27 National Probation Service (NPS)

3.27.1 Ryan's contact with Probation began prior to the creation of the NPS and CRCs.

3.27.2 Ryan's period of supervision by (the former) Essex Probation Trust showed some good practice and some lessons to be learned. The probation officer is noted to have worked in partnership with the housing support officer and the NEP EIP team in efforts to achieve a housing solution for Ryan and engage him in appropriate services. The officer participated in, and shared information at, the MARAC meeting to discuss Deborah in March 2012.

3.27.3 The IMR outlines that the officer should have been more proactive in seeking information from police about the previous domestic abuse callouts by Ryan's parents, and that had this information been obtained, it could have assisted in the completion of a specific domestic abuse analysis (called SARA: Spousal Abuse Risk Assessment). Probation staff are noted to now receive timely

information from the Police Multi-Agency Risk Assessment Team (for more information on that team see MARAC, 3.8).

3.27.4 It is acknowledged that the officer's training on working with domestic abuse perpetrators would have focussed on interventions for offenders perpetrating intimate partner abuse/violence, not family violence. As a result, the IMR author concludes that a focus on victim empathy issues with Ryan was appropriate.

3.27.5 Ryan's period under licence with (the former) Hertfordshire Probation Trust, now NPS, was subject to a Serious Further Offence (SFO) review and the findings of this were provided in the IMR.

3.27.6 Ryan's involvement with Probation occurred during the time of Transforming Rehabilitation, brought about through the Offender Rehabilitation Act 2014.

3.27.7 Transforming Rehabilitation is the name given to the government's restructure of offender management in England and Wales. A single NPS replaced 35 individual Probation Trusts, and became responsible for the management of high-risk offenders in June 2014. 21 CRCs were established with responsibility for the management of low to medium risk offenders in 21 areas; new service providers were invited to tender and began operation in February 2015.

3.27.8 In this case, the restructure led to a gap in relation to NPS's access to a housing liaison officer: after the split this post was employed by the Community Rehabilitation Company. This contributed to issues relating to Ryan's lack of accommodation that led to him eventually living with Deborah. It also contributed to a significant amount of the contact between the probation officer and Ryan to be focused on his accommodation situation, with other issues not addressed.

3.27.9 This DHR notes that accommodation for offenders continues to be both a significant challenge and a high priority for the NPS. The NPS Review Panel representative informed the DHR that offender accommodation remains one of the main 'significant risks' for the Multi Agency Public Protection Arrangements (MAPPA) Strategic Management Board Risk Register, and the NPS Divisional Risk Register. Action is being taken to engage Housing Departments more fully with the MAPPA process in Hertfordshire, and this is developing.

3.27.10 The probation officer did not speak to Deborah when it was first suggested that Ryan could return to live with her. Probation records suggest that the officer "*did not appreciate the potential risk of agreeing to this move*"; this was despite an initial risk assessment identifying that Ryan posed a medium risk of violence to

others. This was in part because the officer initially recorded the move as temporary: nevertheless, proper checks should have been carried out, and Essex Police should have been notified. The officer knew that Ryan had been imprisoned for a serious, violent, assault against his father (and actions to safeguard him were appropriately taken): it should have been clear that he posed a risk to both parents. Training for officers does cover familial-based domestic abuse, and this issue has additionally been the subject of internal workshops delivered as a result of the SFO review (see the detail below), with the following update provided:

3.27.11 "*The effect of the workshops and training on officer understanding and practice has been evident across the county, with officers seeking advice from managers, checking police 'call-out' information and all other sources of information, prior to approving and then managing a move into accommodation with a family member where there has been previous abuse or violence. We now also work with the family where a move into the accommodation is considered manageable, to have 'trigger plan' for any emerging risks. It would be fair to say that the future risk of any such omissions/assumptions that occurred in this case are now reduced.*"

3.27.12 Ryan was not given licence conditions to engage with mental health services; including this would have meant that Ryan had to engage with them, and not decline the services as he ultimately did. The officer did note that they observed no evidence of Ryan having a mental health issue during their time in contact with Ryan. No conditions were added in relation to Ryan's drug use; the probation officer saw no evidence of Ryan using illicit substances and therefore did not refer Ryan to any community based drug services. The NPS IMR identifies that it would have been helpful for the probation officer to discuss Ryan with their manager at the point when Ryan declined engagement with mental health services. NPS have commented that a drug testing condition should have been added to Ryan's licence, as there had been a history of drug misuse. The issue at the time was, in part, how to respond to the use of 'legal highs' (there was suggestion that Ryan had used these in prison). NPS outline that work is being undertaken locally and nationally, to understand how these drugs impact on behaviour (as there remains no actual test for 'legal highs') and a growing

understanding that those who use 'legal highs' frequently also use Class A and B drugs, both of which can be tested for.

3.27.13 The probation officer's assessment of Ryan as his release approached did not adequately address his previous history, most pertinently the police callouts for domestic abuse against Deborah. Had they obtained this information from Essex Police, the IMR author conjectures, it may have influenced the officer's view of the risk Ryan posed on release. NPS, in the actions outlined below, have addressed this issue.

3.27.14 The MAPPA[29] process was not robust in Hertfordshire at the time: Ryan was a 'MAPPA eligible' offender at Level 1[30] but the probation officer did not discuss the case with their line manager or take the opportunity to discuss the case with partner agencies through the MAPPA process. This could have added positively to the officer's management of Ryan following his declining of further support from NEP after a referral from his General Practitioner (see 2.13.168). A professionals' or MAPPA meeting could have been called to discuss his case. A new system is now in place for managing MAPPA Level 1 case; this has learnt from other processes in nearby areas (see detail below):
"*All cases such as Ryan's are reviewed with a manager in supervision with the purpose of ensuring all information has been gathered and acted upon. … any reduction on reporting also has to be approved by a manager and this would be after a thorough examination of the case.*"

3.27.15 The discussion on MAPPA at the Review Panel led to a question on whether Ryan had been added to ViSOR, the national database supporting MAPPA, containing the details of violent and sexual offenders. Due to the offence for which he had been imprisoned, Ryan should have been added. As a Category 2 Offender[31], this was the responsibility of probation; linked to the errors in relation to MAPPA outlined above, this was also not done. While this might not have solved the problem of the errors in recording between probation and prison, it

[29] Multi-Agency Public Protection Arrangements: for the management of risks posed by sexual and violent offenders.

[30] Where risk management activity is retained by a single agency; this does not mean that other agencies will not be involved, only that it is not considered necessary to refer the offender to a MAPPA meeting.

[31] Offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and remain under Probation supervision.

could have facilitated information sharing, and through that, improved management of the risks Ryan posed.

3.27.16 Ryan's move to Deborah's home coincided with a reduction from weekly to monthly reporting to probation; leading to the officer having reduced opportunities to monitor Ryan's behaviour, drug use, mental health and any other issues. The officer relied on Ryan self-reporting any issues. The NPS IMR states that this decision was flawed.

3.27.17 Ryan's contact with probation was dominated by his accommodation needs. When these were resolved, no action was taken to address his other licence conditions, or to implement the sentence plan, specifically referral to a drug and alcohol agency and referral to offender programmes. There was a lack of recognition of the risk he posed to Deborah in light of his previous offending against his father, and a failure to gather relevant information from Essex Police to inform the assessment of Ryan living with Deborah.

3.27.18 The reports from the family at the time (to probation) and since the homicide (to the DHR) suggest that, as far as they could tell, Ryan and Deborah were getting on well and she didn't report any concerns.

3.27.19 As part of the Probation SFO Review process, the IMR author interviewed the probation officer, and other staff and managers connected to the case. Given the gravity of the incident, NPS (Hertfordshire) undertook a formal investigation of the probation officer's practice. The officer accepted that their assessment and management of Ryan could have been better. Workload was highlighted as being a significant issue at that time. The formal investigation concluded that there were no disciplinary matters to answer but a performance improvement action plan was put in place.

3.27.20 The SFO Review outlined the following learning points and action required (much of which has already been undertaken) to address them:

Learning Point	Action Required or undertaken
New structure for management of Level 1 MAPPA cases is fully embedded in practice.	Confirmation that regular Level 1 meetings are taking place across Hertfordshire Regular management information (MIS) reports are reviewed quarterly to ensure appropriate line management oversight of Level 1 cases.

Learning Point	Action Required or undertaken
This will address the need for the risk posed by offenders such as Ryan being formally addressed within the MAPPA arena	Audit (August 2016) of Level 1 MAPPA cases to confirm: • Evidence of Level 1 process embedded • Evidence of discussion of case management issues • Evidence that actions have been completed.
Completion of the review of MARAC processes. Inclusion of cross border cases.	Victims Manager to conclude review (incorporating the new national guidance). Evidence of deployment of new practice guidance. MARAC audit and associated action plan.
Evidence of the increased use of PI 30/14 regarding drug testing of offender subject to post release supervision.	Discussion of drug testing in relevant Level 1and Level 2 meetings for relevant offenders. Decisions recorded in minutes of MAPPA meetings
Review of the impact of SFO workshops on practice, with particular reference to the assessment of: • interfamilial abuse • cross border working • investigative approach to previous offending and behaviours.	Operational Senior Probation Officers to prepare a short report outlining progress since the workshop. Confirmation that all relevant staff have attended the workshop. Additional workshop to be considered for relevant staff who were unable to attend. Agenda item at NPS Managers meeting to note progress after 6 months.
Implementation of 'Desk Top Instructions' to staff in respect of 'New Case Allocation' to include	Desk Top instructions are devised and deployed to staff. Instructions to include:

Learning Point	Action Required or undertaken
accessing archived records, where applicable	• Archive Retrieval and Storage Guidance 2015. • Reminder to staff to ensure that minutes from external meetings are available in the third party section of the case record (MARAC, Child Protection Conference). Performance information relating to the numbers of requests for archived records would be available from the divisional hub. The divisional Investigations Unit is rolling out some workshops in respect of common learning from SFO reviews. This action will be included in the workshops.

3.27.21 These actions are welcomed by the DHR and by Deborah's family. Their feedback is captured above (see 2.10).

3.27.22 An update on the SFO review learning was provided by NPS in March 2017:

(a) "*The split of probation services in 2014 and the impact for the team staffing resource in 2015 are unlikely to recur. Staffing resource is carefully monitored via the national workload management tool and county wide adjustment made where necessary. An increase in the overall numbers of Probation Officers is underway to ensure vacancy levels are kept to a minimum as far as possible.*

(b) The relevant Offender Manager has completed the performance improvement plan. Spot checks will continue for the next 12 months. Management information is now available to monitor the timeliness of all offender manager assessments (OASYS) and are reviewed regularly as part of performance management.

(c) The learning from the SFO briefings (interfamilial violence) are evidently now embedded in practice. Where an offender is permitted to live with the family (as an alternative to the risks of managing the offender as homeless) a contingency plan agreed with the family has to be in place.

(d) *All staff fully understand the necessity to ensure outside areas are notified of temporary moves into another area, and specifically to ensure contact details e.g. for police and child protection agencies - are clearly recorded and incorporated into the risk management plan and case recording.*

(e) *MAPPA 1 reviews with the MAPPA manager and SPO are now undertaken as business as usual, to ensure a thorough assessment of each case at least once per year.*

(f) *No reduction in reporting frequency can be implemented without the recorded approval of a Senior Probation officer.*

(g) *A new case allocation checklist has been implemented to ensure all offender managers have familiarised themselves with past and present records and where necessary, sought up to date information."*

3.27.23 There are two areas that remain ongoing for NPS:

(a) "*Accommodation for offenders presenting with complex needs and challenging behaviour remains a significant issue both locally and nationally. There are no straightforward answers to this, particularly in an increasingly pressured housing situation in the South East of England. National strategy development remains ongoing. In Hertfordshire negotiations are ongoing for districts to provide a limited number of places for MAPPA 2 or 3 cases. This will assist with a few cases, but is unlikely to have a significant impact on MAPPA 1 cases.*

(b) *New psychoactive substances (previously known as 'legal highs') present immediate and long term offender management issues both within the prison estate and in the community. Staff are gaining increasing knowledge and experience on understanding the signs and symptoms of use and how to challenge and support offenders where use is suspected. However, it remains the case that there is no method to test for NPS usage as there is for prohibited drugs. We await further national guidance on this."*

3.28 Uttlesford District Council Housing Service

3.28.1 The service's contact with Ryan followed proper procedure in relation to his housing situation and the options available to him by referring him into an appropriate supported housing service.

3.29 Genesis Housing

3.29.1 The records relating to Ryan's contact with Genesis Housing were not available due to the length of time that had elapsed, and the fact that he had not had ongoing contact with the organisation but a one-off assessment.

3.29.2 The scheme delivered by Genesis Housing would have been appropriate for someone in Ryan's situation; the Review Panel representative indicated that his support needs may have been too high. His statement of intent to use violence if there was conflict in the house was an understandable reason to decline his application, given the potential vulnerabilities of other residents.

3.30 East Hertfordshire Council Housing Service

3.30.1 The service's contact with Ryan followed proper procedure in relation to his housing situation and the options available to him.

3.30.2 The Review Panel discussed whether the service could have done any more in response to Ryan's disclosure in April 2010 that he had been arrested for assaulting his father. This would have been difficult as they were not in contact with Ryan's father, and only had this small piece of information; in addition Ryan's disclosure mentioned the police, so it may have been reasonable for them to assume that the police would take any necessary safeguarding actions.

3.30.3 The discussion centred on whether housing staff would have recognised Ryan's disclosure as amounting to domestic abuse, as it was against his father and awareness of familial domestic abuse/violence is not always as high as that around intimate relationship-based abuse/violence.

3.30.4 As a result of this discussion, the Review Panel representatives from housing and Hertfordshire Constabulary agreed to discuss awareness raising, and pathways for support. Actions have been taken in relation to both of these, governed by the Hertfordshire domestic abuse partnership: housing attend MARAC, and there is increased awareness of familial domestic violence; pathways for high risk cases are in place and used; pathways for standard and medium risk cases are being established.

3.31 Equality and Diversity

3.31.1 The Review Panel identified the following protected characteristics of Deborah, Michael and Ryan as requiring specific consideration for this case: gender and age.

3.31.2 **How these impacted on agencies responses**

3.31.3 Being female is a risk factor for being targeted by a perpetrator of domestic abuse, making this characteristic relevant for this case, Deborah having been a victim of domestic abuse from Ryan. In particular, women and girls are more at risk of experiencing coercive control, and ongoing abusive behaviours from the perpetrator[32]. This is explicit in the guidance supporting the change to the Government's domestic abuse definition to include coercive control:

3.31.4 "*Without the inclusion of coercive control in the definition of domestic violence and abuse, there may be occasions where domestic violence and abuse could be regarded as an isolated incident. As a result, it may be unclear to victims what counts as domestic violence and abuse – for example, it may be thought to include physical violence only. We know that the first incident reported to the police or other agencies is rarely the first incident to occur; often people have been subject to violence and abuse on multiple occasions before they seek help.*"

3.31.5 This factor should have been recognised by Essex Police through responding to Deborah as the victim of ongoing abuse and violence and possible coercive control from Ryan rather than seeing each incident in isolation. STaRS and NEP should have named Ryan's behaviour as domestic abuse and offered appropriate support to Deborah and Ryan's father. This is addressed further below (see 4.2.1).

3.31.6 Males are statistically less likely to be targeted by a perpetrator of domestic abuse, and in some cases this can lead to them not being identified or responded to adequately. In this case, Hertfordshire Constabulary responded to Ryan's father as a victim of domestic abuse, and appropriate internal processes and referrals were followed with the exception of a referral to MARAC, which should have been made.

3.31.7 The risk to one parent was not translated to an appreciation of risk to the other parent: emphasis was placed on Ryan's risk to his father on release from prison, as he had been convicted of grievous bodily harm against him. This should have

[32] Walby, S. & Allen, J. (2004) 'Domestic violence, sexual assault and stalking: Findings from the British Crime Survey' Home Office Research Study 276, particularly p25: "*Women constituted 89 per cent of all those who suffered four or more incidents.*"

been explicitly recognised as increasing the risk he posed to Deborah. This is addressed further below (see 4.2.1).[33]

[33] Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office and Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

4. Conclusions and Recommendations

4.1 Conclusion

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

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

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

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

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

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

included explicit recognition of, and response to, Ryan as a domestic abuse perpetrator. Ryan's lack of engagement was a risk factor.

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

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

4.1.6 Ultimately, Ryan is responsible for the homicides. A theme throughout his engagement with agencies was a failure to take responsibility for his actions. Neither Deborah, nor agencies, could make him do this or take that responsibility for his behaviour on. But, more could have been done to ensure that Deborah was supported and that agencies fulfilled their duties to recognise and try to manage the risk Ryan posed.

4.2 Lessons to be Learnt

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

(a) STaRS, Essex Police, Hertfordshire Constabulary, Probation (Hertfordshire and Essex) and NEP all had information about domestic abuse perpetrated by Ryan against Deborah and his father. Deborah's General Practitioner did

not know but had a number of opportunities to enquire with Deborah that could have led to a disclosure.

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

(c) Deborah was not seen as a whole person, with many different needs, in relation to a situation, and relationship, that she was managing on a day-to-day basis. The Essex Police DALO offered emotional support but this was short-term; referrals to other services could have followed.

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

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

(f) There was also discussion around the appropriateness of standard responses to domestic abuse being applied to situations of family-based abuse such as this. This was identified by probation (Essex) in that the officer working with Ryan used victim empathy work rather than domestic

abuse specific interventions, as the latter are targeted at male perpetrators of abuse against female intimate partners.

(g) The DASH-2009 risk identification checklist is recognised rightly as a useful tool in identifying the risk a victim faces from a perpetrator. It is an evidence-based tool, developed through a review of domestic homicides and the identification of common factors prior to those homicides. The majority of domestic homicides involve a male killing his female partner/ex-partner[34] and therefore the results of any such review would be skewed towards this situation. Key questions in the DASH-2009 such as those around pregnancy and child contact were not relevant in this case, and those around separation must be viewed differently in a case where the victim is the mother of the perpetrator and potentially feels an additional responsibility, even guilt, for his behaviour and his wellbeing due to societal expectations of parents and particularly mothers[35]. This may have led to an inaccurate identification of risk.

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

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

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

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

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

are multi-agency) and to the wider remit of partners through dissemination seminars to share the learnings and recommendations. Five DHR learning seminars have been delivered across SET in 2017.

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

(a) It is well known that mental health, drug/alcohol use and domestic abuse often co-exist, and the overlapping and interlinking issues can present particular challenges to services and families[36]. The perpetrator may present mental health and/or drug use as the reason, or excuse, for their abusive behaviours, and a focus by agencies on those issues can mask ongoing abusive behaviours and their impact on victims. Victims also at times blame the abuse on the perpetrator's substance misuse, as a way of trying to 'make sense' of their experiences from a loved one[37].

(b) Mental health has been shown to be a feature in a significant number of domestic homicides in which an adult son has killed his parent, often mother[38]. Relevant to this case, the research demonstrated that this is an additional risk factor when combined with substance misuse and previous criminality by the perpetrator.

(c) Deborah misused alcohol, which has been identified as a way in which victims of domestic abuse 'self-medicate' in an attempt to manage their feelings in the face of a distressing situation[39].

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

- STaRS focused exclusively on detox for Deborah, as did her General Practitioner. This effectively left Deborah unsupported in relation to her mental health and her issues with Ryan and his abuse.

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

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

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

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

- The NEP records mention Ryan's drug use sporadically but there was no evidence of direct, sustained engagement with him on this, or records of staff considering how his drug use and mental health issues interacted. The absence of a mental health diagnosis was a part of this. NEP's exclusive focus on Ryan's mental health led to missed opportunities to respond to the domestic abuse he was responsible for.

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

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

(g) The Essex DHR Thematic Review led to the following action, which has been completed: "*Revise working protocols across the substance misuse system (including new risk assessments) to ensure victims and perpetrators are identified and proactively engaged.*" In addition, an action is in progress to ensure domestic abuse is clearly featured within the developed mental health strategy. The SET Domestic Abuse Partnership lead is currently in discussion with the Essex Partnership Trust to take this work forward with an aim to align strategies where possible.

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

(a) The family expressed to the DHR the feeling that, throughout the period of Ryan's engagement with NEP, they were not supported as they would have liked to have been. This could have taken the form of advice and guidance on how to respond to or manage Ryan's behaviour, and a more concerted approach from NEP on engaging Ryan in services. In reviewing the

chronology from NEP, the impression is given that Ryan's 'disengagement' from services was not consistent and there were times when he stated he was "*happy*" for interventions to continue, yet they were not.

(b) Information from Deborah and from Ryan's father was at times given a lot of weight (as outlined in the NEP section, see 3.18.5) and at other times not enough. It was clear to practitioners that they were both heavily involved in Ryan's care and were not in a position to permanently remove themselves from that, even if at times they may have wanted to. Despite the fact that Ryan declined consent for information to be shared with his parents (which NEP adhered to) NEP could have more thoroughly involved them in Ryan's care through the joint meetings with Ryan present, fully taking on board their concerns over Ryan's behaviour and acting on those concerns (in the context of professional assessment of Ryan); and through offering them additional support for themselves.

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

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

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

support from an appropriate agency (e.g. IDVA, or another). Instead the MARAC appeared to achieve little.

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

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

(a) This Review struggled to gain a complete picture of Ryan's engagement with mental health services during his time in prison from August 2012 to April 2015. This period was felt to be important because, prior to his imprisonment he had been under the care of NEP for nearly three years; yet on his release he was under no mental health service.

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

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

(d) Pre-trial Ryan was assessed by two Mental Health In-Reach Teams (in HMP Bedford and HMYOI Glen Parva, see 3.24). Following sentence he was assessed by one (in HMP Rochester, see 3.26). On three occasions (in HMP Blundeston, HMP Rochester and HMP Ford) no concerns were noted. Ryan frequently told medical staff in the prisons that he had no history of mental health issues.

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

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

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

4.2.5 *Housing for offenders*

(a) A recurring discussion for the Review Panel was that of Ryan's accommodation; this reflected the emphasis placed on this issue by Ryan and probation following Ryan's release from prison in April 2015. The actions taken, and what was missed, by the probation officer from April 2015 onwards are outlined in the NPS section (see 3.27).

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

(c) HM Inspectorate of Probation published a review of Transforming Rehabilitation (May 2016) that found "*over two-thirds of offenders released from prison had not received enough help pre-release in relation to accommodation, employment or finances*"[40].

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

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

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

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

(g) The independent chair spoke with the Reducing Reoffending Coordinator for the Essex Police and Crime Commissioner, and the following information was provided on developments in Essex to address this issue:

- Through the Gate resettlement services began nationally in 2015 (shortly after Ryan was released from prison), with the aim of improving the resettlement process for prisoners being released. Community Rehabilitation Companies are responsible for helping prisoners to prepare for release and to resettle in the community. This includes helping prisoners to find accommodation, as well as employment, training or education, and help with managing their finances, benefits and debt.
- Essex Housing Officers' Group (EHOG) meets quarterly and brings all housing authorities and associations together; this links closely with the Crime Reduction Strategy action plan.
- Full Circle is a service working with offenders in Essex who have mental health, substance misuse and accommodation issues,that aims to bring services together around these individuals and link with treatment providers. They work in prison and the community.
- A new pilot called 'Trailblazers' has started in 2017 with funding from the Department for Communities and Local Government: dedicated homelessness prevention 'mentors' have been appointed, each with a

specialism, one of which is offenders. They are available for advice and support to those working to prevent homelessness.

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

4.2.6 *Responsibility of agencies in finalising referrals*

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

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

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

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

(e) These examples suggest that for some agencies, a 'referral' is seen as the end of their involvement. This should not be the case. An agency holds

responsibility for an individual until such time as they are satisfied that the agency referred to has taken on the care of that individual. This did not happen in these cases, leaving Deborah unsupported and, in the case of (b) and (c), unaware that the IDVA service existed and could help her.

(f) A recommendation (12) is made.

4.2.7 *Clients who do not engage with a service*

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

(b) This has been recognised in research looking at alcohol use and domestic abuse in published DHRs[41]:

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

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

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

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

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

(c) Agencies have a duty to do all they can to facilitate and encourage engagement, including identifying possible barriers to that engagement and working to remove them, within the limitations of their service delivery. The Blue Light Project has identified ways in which alcohol agencies can support those people identified as 'change resistant' or 'reluctant to engage': https://www.alcoholconcern.org.uk/blue-light-project.

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

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

(f) A recommendation (13) is made.

4.3 Recommendations

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

4.3.1 **Recommendation 1** (see 3.3.1.b)

West Essex Clinical Commissioning Group to ensure that training is made available to General Practices on identifying domestic abuse and risk to ensure that they are equipped to refer appropriately to the MARAC; to have reference to the materials available through the IRIS project[42] to support this. To report to the Uttlesford Community Safety Partnership on the actions taken.

4.3.2 **Recommendation 2** (see 3.3.1.c & 3.5.5)

West Essex Clinical Commissioning Group to work with EPUT, STaRS, ADAS and other commissioned drug and alcohol and mental health services to

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

establish a procedure for joint working with General Practices to ensure that individuals receive support in a coordinated way. To report to the Uttlesford Community Safety Partnership on the actions taken.

4.3.3 **Recommendation 3** (see 3.23.7)

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

4.3.4 **Recommendation 4** (see 4.2.1.b)

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

4.3.5 **Recommendation 5** (see 4.2.1.i)

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

4.3.6 **Recommendation 6** (see 3.5.9 & 4.2.2.f)

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

4.3.7 **Recommendation 7** (see 4.2.3.d)

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

4.3.8 **Recommendation 8** (see 4.2.3.f)

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

4.3.9 **Recommendation 9** (see 4.2.4.g)

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

4.3.10 **Recommendation 10** (see 4.2.4.g)

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

4.3.11 **Recommendation 11** (see 4.2.5.h)

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

4.3.12 **Recommendation 12** (see 4.2.6.f)

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

4.3.13 **Recommendation 13** (see 4.2.7.f)

STaRS, EPUT, ADAS and Victim Support to review their approach and response to people who 'don't engage' in the service, in light of the learning identified in this DHR, to ensure barriers to people's engagement are identified and acted upon, and that motivational work is done that aims to improve engagement. To take appropriate action where necessary and feed back to the Uttlesford CSP.

For the learning from these agency reviews to be shared through the Essex Southend and Thurrock Domestic Abuse Strategic Board.

Appendix 1: Detailed Chronology for Ryan 2003-2011

2003-2005

1. Ryan attended secondary school from September 2003 (Year 7) to November 2007 (Year 11). No concerns were noted in Year 7 (and no concerns had been communicated from his primary school). From Year 8 (2004) to Year 11 (2007) records about his behaviour and academic performance increased.
2. At the start of Year 8 (September 2004), Ryan was placed on 'School Action Plus'[43] in relation to his "*behaviour*".
3. In August 2005 Ryan first came to the attention of Essex Police, as one of a number of young people who received letters from Uttlesford District Council following nuisance behaviour in the area.
4. In Year 9 (from September 2005) Ryan was recorded as not achieving academic targets, not completing homework, being disruptive and lacking concentration, all of which was felt to contribute to his underachievement. Reference was made in a number of records to Ryan's "*lack of effort and immature behaviour*" and that he appeared to "*need*" attention.
5. In December 2005 Ryan (aged 13) was arrested on suspicion of criminal damage. He was later released without charge; no further details of the incident were available.

2006-2007

6. In March 2006 a resident of the street on which Ryan and Deborah lived reported that Ryan (aged 13) had sworn at her whilst she was driving in her car, and he was cycling on the road. Ryan was spoken with and he denied the office. No further action was taken.
7. Throughout Year 10 (from September 2006) the school recorded many 'incident reports' about Ryan's poor and disruptive behaviour. In the autumn term he was

[43] Under the Special Educational Needs Code of Practice 2001, in order to help pupils with additional needs, schools were required to adopt a graduated response that included a wide range of strategies. Additional support would be provided at School Action and then School Action Plus, after which, if needs were unmet at these levels, a Statement for Educational Need would be considered.

placed on a 'Pastoral Support Plan'[44], and one action within this was for Ryan to be supported on a one to one basis by an Outreach Worker from the Behaviour Support Service. The outcomes of this intervention were not recorded. Some records for Years 9 and 10 outline "*glimmers*" of improvement in Ryan's behaviour; no reasons were identified for these sporadic periods of improvement.

8. In June 2007 Ryan had been referred to the Connexions Service (an advice, guidance and support service for young people[45]). Ryan was initially supported by a Personal Advisor (PA) and through 2007 to 2009 they made regular contact with Ryan with regard to work and training opportunities. Direct contact with Ryan was sporadic and he did not find work or training in that time. At one point he was recorded as working with his father (July 2009).
9. In July 2007 Ryan (aged 15) was recorded as having made threatening and rude gestures to a member of school staff. The Schools Officer gave an Early Intervention Warning.
10. At the start of Year 11 (September 2007) a meeting was held with the school, Police, Deborah and Ryan in attendance. The meeting was to discuss the terms of an 'Acceptable Behaviour Contract'[46] for Ryan (it is possible this is linked to the Early Intervention Warning above). On the advice of a solicitor, Ryan's father informed the school that they would not sign the agreement.
11. Early in November 2007 Ryan (aged 15) was arrested by Essex Police for theft of a moped, and theft of two mobile telephones, and common assault. Ryan was charged with two offences of theft and battery, and received a Final Warning for both of these (for which he came under the supervision of the YOS in March 2008, see below). No further action was taken with regard to the theft of a moped.
12. Later in November 2007 the school informed Ryan's parents that Ryan would be permanently excluded from school, due to: anti-social behaviour; theft of mobile phones from other students; a fight in which a teacher had been injured; offensive sexualised inappropriate language; downloading a sexual image on to a school

[44] A Pastoral Support Plan is an intervention to improve behaviour, which is agreed by a pupil, parent and school.

[45] The aim of the service was to work with young people to remove any barriers preventing them from accessing universal services such as education, employment and training

[46] This was an intervention aimed at addressing anti-social behaviour under the Crime and Disorder Act 1998: a voluntary contract sets out certain conditions that have to be agreed by all parties.

computer; fighting; failing to have correct equipment for lessons; failing to attend detention; failing to complete homework.

13. Ryan was excluded in December 2007 and from then to completion of his GCSEs in summer 2008 he attended the Integrated Support Service.

2008-2009

14. In February 2008 an intelligence report was added to the Essex Police system, that Ryan (aged 15) attended a local Youth Centre on a regular basis and smelt strongly of cannabis; the individual he was believed to obtain the cannabis from was also named.
15. The Final Warning[47] Ryan had received for the offences in November 2007 began with the YOS in March 2008. Ryan met with a Restorative Justice worker for two sessions and completed work on victim empathy, a self-assessment, and a letter of explanation to the victim. Following this YOS involvement with Ryan ended.
16. Essex Police were involved with Ryan (aged 16) twice in January 2009. The first was for theft, when the case was withdrawn from court (no records as to why). The second occasion he was arrested on suspicion of criminal damage; no further action was taken on this but when officers searched Ryan's home they found controlled drugs. Ryan was given an absolute discharge for this at Court in September 2009.
17. In April 2009 a member of the public called 999 and reported that Ryan (aged 16) had assaulted their son. Ryan was arrested and interviewed, and no further action was taken.
18. In November 2009 British Transport Police arrested Ryan for an alleged assault in May 2009. He pleaded guilty to common assault and was sentenced to a four-month Referral Order, under the supervision of the YOS. Shortly after this arrest Ryan was arrested after being searched and found in possession of controlled drugs; there was insufficient evidence to proceed.

2010[48]

19. In January 2010 Ryan and his father attended an Initial Referral Order Panel, where Ryan agreed and signed the contract. Ryan's father was noted as stating, "*the panel had been very fair*". The YOS Officer recorded that Ryan did not initially want to

[47] Final Warnings no longer exist since the Legal Aid, Sentencing and Punishment of Offenders Act 2012. Prior to that Act, the decision to refer for Final Warning was made by Police, with referral to YOS for an assessment for intervention. Police then issued the Final Warning

[48] A significant amount of Ryan's contact with agencies from 2010 onwards related to his mental health. For information about mental health processes, and the terms used in this report, see Appendix 2.

participate in the meeting; and that "*it appears that Ryan feels he shouldn't have to do this as the incident took place in May last year. Ryan's father stated that he felt that Ryan was not emotionally capable of completing this order*". They also recorded their observation that "*there appeared to be a lot of colluding between Ryan and his parents.*" Ryan's father shared (privately) that Ryan had "*become very paranoid, lack of motivation, occasionally aggressive, implying the use of drugs*" and that "*Ryan seemed agitated when explained that some of the sessions could be a group session, [Ryan] stating I can't do groups, won't do groups*".

20. At the same time as this process had begun, Ryan attended his General Practice with "*low mood, poor self-esteem and negative outlook*". The doctor referred Ryan to the EPUT Community Mental Health Team. The team wrote back to the General Practice at the end of January 2010 requesting more information. There was no record of a response to the team.
21. In early February 2010 Ryan had his first appointment with the YOS officer, who noted that Ryan was relaxed and had become more engaging. The officer recorded having "*challenged Ryan and his mother with what appears is that his parents are both colluding*". This was not expanded on in the records.
22. Two weeks after this appointment Ryan attended his General Practitioner again (late February 2010). The notes suggest that his father may have been with him but this was not specifically recorded. Ryan was recorded as reporting he had been referred to the Community Mental Health Team for low self-esteem, and that his father has spoken to a Community Psychiatric Nurse and an appointment had been made for April 2010 (this does not appear in the NEP records). The record stated that Ryan's father had a list of symptoms suggesting psychosis: that Ryan thought the radio was talking about him; that everyone was talking about him and looking at him; and Ryan could hear voices talking about him. Ryan had threatened to kill his best friend and all of his friend's family, saying he thought the friend was controlling his brain. It was also noted that Ryan's father referred to Ryan's cannabis use. The General Practitioner contacted the Consultant Psychiatrist who advised an urgent appointment be made at home with the Crisis Resolution Team, and a prescription be made for an anti-psychotic medication. The General Practitioner recorded a diagnosis of "*psychogenic paranoid psychosis*".
23. Deborah informed YOS of this and Ryan's worker informed the YOS Mental Health Link Worker. Following liaison with the NEP Community Mental Health Team, Ryan's

Referral Order was suspended due to his mental health, which meant that he would not be seen by YOS workers or expected to complete the terms of his order until such time that he was deemed fit to do so.

24. Ryan's General Practitioner visited him at home as planned on 19 February 2010 (the day after his appointment in the practice). The General Practitioner was at this time in contact with the NEP Community Mental Health Team Duty Social Worker with regard to anti-psychotic medication for Ryan. Following the home visit the General Practitioner recorded about Ryan: "*thought disorder in evidence, placid at the moment. Accepts visit from Crisis Team tomorrow. Told the Team should be able to control the voices he hears. Says last cannabis was two weeks ago. Father alludes to [Ryan] taking some last Friday.*"
25. NEP Community Mental Health Team further recorded in relation to Ryan that he was 17 years old, had left school the previous summer and had not worked. In relation to risk, the General Practitioner advised the Community Mental Health Team that Ryan seemed calm and not suspicious of them. There was no recorded history of violence towards professionals, but Ryan was noted to have "*been violent in past to others and his bedroom door had a panel missing where he had recently punched it*".
26. The Community Mental Health Team called Ryan following the General Practitioner's visit. Ryan was unavailable and Deborah was spoken with. She reported that Ryan would not go anywhere; that they were supposed to be going on holiday the next day but won't because he was "*too afraid of going out*". Deborah had taken him shopping and "*he froze convinced everyone was looking at him. Desperate to get back in the car and on way home banged his head on the window repeatedly and crying*". She reported that the day before Ryan had been: verbally aggressive all day; threatening to kill everyone in the shopping area for looking at him; and that he had threatened to kill a friend on another occasion. Deborah was recorded as not feeling threatened. It was noted that Ryan had no previous history of violence or aggression, but had recently punched hole in door.
27. On the same day, the Community Mental Health Team carried out an urgent mental health assessment with Ryan. Ryan's father's views were recorded as:
    a. Ryan had "*got worse*" over the previous six months including thinking radio and people were reading his mind and could get into his mind; that food would go up and not down, that the radio talked to him personally, and he thought his brain was back to front.

b. Ryan understood he had a problem, but believed that others were wrong and he was right, and had "*gone off his friends*".
c. The risks were getting worse and Ryan had turned "*really nasty*"; he had texted a friend and threatened to kill him and his family. Ryan had told his father he would rather be dead.
d. Ryan had been behaving oddly and claimed his brain had been changed and his friends had planted ADHD[49] in his head.

28. Ryan was noted to be under the supervision of YOS.
29. Ryan was willing to take medication. He was assessed as at mild to moderate risk of self-harm, and at low to moderate risk of violence to others, with the following noted: he had been verbally aggressive to Deborah; waved a knife at his brother; punched a hole in a door; sent threatening messages to a friend and told Deborah he would kill that friend if things did not improve.
30. The conclusion was that Ryan was showing signs of a mental disorder and was detainable under the *Mental Health Act 1983*. Home treatment was discussed as the least restrictive option, and was accepted by Ryan. He was prescribed anti-psychotic medication and advised to stop using cannabis. Ryan was referred to the NEP Crisis Resolution and Home Treatment (CRHT) team, and a long-term plan to refer to the EIP Team was noted.
31. Community Psychiatric Nurses (CPN) from the CRHT team carried out a full Care Programme Approach (CPA) Assessment the next day 20 February 2010. In addition to the information captured above, the following was also noted: that Ryan was "*angry and abusive*" having broken a door the night before after accusing Deborah of "*saying things to him*"; and that he would punch the floor when angry and frustrated. Ryan had smoked cannabis since age 11, and had "*poor insight into the effects of drug use*". The record stated "*query drug induced psychosis*". Ryan was accepted for CRHT intervention, and a home visit was planned for the next day.
32. A CPN or a Community Support Worker (or both) from CRHT conducted home visits on nine occasions from 21 February 2010 to 18 March 2010. On seven of these occasions, Deborah and/or Ryan's father were present; on one occasion it was noted that Ryan was seen alone; and on one occasion no record was made. On the days

[49] Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Ryan had no recorded diagnosis for this.

that home visits were not conducted, telephone calls were attempted to Ryan; of 12 calls, five got through to Ryan. Of the remaining seven that were not successful, Deborah was spoken with instead in three. Throughout this time it was noted that Ryan took the prescribed medication.

33. The following contacts by CRHT during this time were of note for this DHR:
    a. 25 February 2010: Ryan was recorded as stating he did not want to continue with cannabis or mephedrone[50] as he recognised it was bad for his mental health. It was recorded that Ryan was provided with advice on finding information about the effects of drug taking.
    b. 27 February 2010: The record stated that Ryan had "*limited insight*" into the effect of using illicit substances on his mental health.
    c. 1 March 2010: The record noted Ryan had "*no insight into the effect of substance misuse, will refuse drug tests*". It also noted that Ryan was "*angry with mother as couldn't find a particular pair of jeans. Accusing parents of many things which were difficult to follow and not quite rational*".
    d. 2 March 2010: Deborah was spoken to as the CPN was unable to get through to Ryan. Deborah was recorded as stating she felt Ryan seemed better, and had a positive attitude to medication. This was repeated on 5 March 2010.
    e. 3 March 2010: Ryan was recorded as being aware that taking drugs was "*not good*" for him and that he was not planning on taking illicit substances. Ryan was noted to be "*happy*" to be referred to the EIP Team.
    f. 10 March 2010: Ryan was recorded as having "*no insight regarding medication*". He denied recent drug use. Deborah disclosed a "*recent incident Ryan called her names and told her to leave house and threatening to kill the kittens. Ryan did not seem to see anything wrong with this behaviour.*"
    g. 11 & 12 March 2010: Telephone calls to Ryan in which it was recorded that he "*sounded fine, no concerns*".
    h. 13 March 2010: During a home visit Ryan was recorded as being in his bedroom saying "*strange things*" and had not had any sleep. Ryan's father was noted as not believing Ryan's behaviour was down to drug use. Deborah was recorded as "*finding it difficult to cope*". The record stated that over the

[50] From www.talktofrank.com [accessed 8 September 2016]: "*Mephedrone is a powerful stimulant and is part of a group of drugs that are closely related to the amphetamines, like speed and ecstasy.*"

previous 18 months "*Ryan [had] become verbally abusive and [had] difficulties around people.*"

i. 15 March 2010: The "*main focus [of home visit] was ongoing conflict and arguments with mother [Deborah] mainly about his behaviour; no job/training so bored at home; Ryan relaxed and engaged*".

34. A joint discharge meeting was held on 18 March 2010 with the CRHT Team CPN, the Youth Offending Service, Ryan, Deborah and Ryan's father. It was noted that Ryan was compliant with the prescribed anti-psychotic medication. The following was also recorded: there were ongoing concerns over Ryan's behaviour relating to lack of motivation, self-consciousness, lack of confidence and anxiety; that Ryan had difficulties sleeping; Ryan was not aware of the impact of his life style on his mental health; Ryan was difficult to motivate or get out of bed due to issues of self-esteem; he found it difficult to accept responsibility for his drug use or offending behaviour.
35. YOS concluded following the meeting that there was no longer any mental health reason that Ryan could not complete his Referral Order. The record of this visit also noted that Ryan "*did not want to see any link between his recent psychosis and drug use*" and "*did not feel his drug use is a problem and was evasive when asked if he was still using drugs*". The Mental Health Link Worker made a referral for Ryan to EYPDAS (see 2.13.41). This referral was recorded as having been accepted by that service. Ryan's Referral Order was recommenced in April 2010 (with an addition to the contract for Ryan to attend the Street Life group work programme). Ryan's father was noted to be unhappy with the decision as there had not been a doctor present at the assessment on 18 March 2010 and he felt that Ryan was not well enough.
36. Following this meeting the NEP CRHT Team discharged Ryan to the NEP EIP Team on the same day. From then until his arrest for grievous bodily harm against his father in August 2012, Ryan was under the care of that team.
37. An EIP Team home visit took place at the end of March 2010 in which it was recorded that the team had delivered Ryan's medication to him, and he was "*doing okay*". Three days later Ryan did not attend an appointment at the EIP Team office; his father attended and reported that Ryan: "*did not want to come*". He stated that Ryan was taking the medication but may also be using cannabis and mephedrone. Ryan was not delusional or hallucinating. Ryan was called mid-April 2010 and a home visit was booked for the end of the month.

38. Shortly after this, Ryan's father called Essex Police to report Ryan was being aggressive. No offences had been committed (see 2.12.1).
39. A week before the EIP Team home visit was due, Ryan's father called the EIP Team to enquire why Ryan had not been seen by the team yet. He was not happy with the response of the team as Ryan was "*getting more aggressive to him and mother [Deborah] and still used illicit drugs*". The role of the EIP Team was explained and Ryan's father was advised to call police if Ryan was aggressive; or call the CRHT Team if Ryan had a "*psychiatric crisis*".
40. At the arranged home visit at the end of April 2010 Ryan was seen with both his parents, and the YOS were also present. Ryan stated he smoked up to seven joints of cannabis a week, was taking his anti-psychotic medication, denied thoughts of self-harm or suicide. It was noted that he spent "*most of [the] session disagreeing with father over him learning to drive, going into Ryan's room*". A home visit was scheduled for two weeks later, which was Ryan's next contact with the service.
41. In early May 2010 YOS referred Ryan to the EYPDAS, and a face-to-face assessment was carried out by the service shortly after. The record showed that Ryan used cannabis daily, and that he had previously used cocaine, ecstasy and mephedrone (which, he was recorded as stating, he would not use again due to the impact on his mental health). The assessment recorded that Ryan had stated he was not prepared to engage in ongoing sessions; in a home visit with YOS and EYPDAS shortly after this, Ryan agreed to further appointments with EYPDAS. A further meeting took place at the end of May, and this was the last recorded contact. EYPDAS communicated this to YOS and the EIP Team.
42. Ryan attended the YOS Street Life group work programme throughout May. Initially Ryan "*came across as very nervous about the group, unconfident, quiet and awkward, struggled to read and write*" and that his father "*came across as quite overpowering and critical*". Following an initial session in which Ryan was "*unresponsive and seemed to find it hard to focus and take on board what was being said*", Ryan subsequently became "*extremely positive and facilitators were very pleased … engaged well with activities from the start*". Throughout this time he also engaged with EYPDAS, completed his reparation hours, completed further work around recognising triggers for himself, and restorative justice.
43. At the EIP Team home visit in early May 2010 (a week after his EYPDAS assessment and starting the group work programme with YOS) Ryan's support from YOS was

noted, along with the note that Ryan "*lacks structure … states he has not used illicit drugs recently*" and was taking the medication. The record also stated that Ryan "*continues to have significant anger issues*". Actions were noted to refer Ryan to the Employability Scheme, which was done and to arrange a further appointment in 6-8 weeks at which point consideration would be given to reducing Ryan's medication.

44. The EIP Team attempted to call Ryan twice later in May 2010 but he did not reply. After the second failed call the team contacted Ryan's father who reported that Ryan had been fine the previous week but may have "*taken something*" at the weekend. The team asked Ryan's father to tell Ryan to contact the team with regard to making appointments.
45. In early June 2010 a CPA review was recorded. It was not recorded if this involved a meeting with Ryan. The "*intervention and actions recorded*" were the referral to Employability and "*regular visits to monitor mental state; attend appointments: monitor efficacy and side effects of medication*". Ryan's early warning signs were recorded as "*thinking other people can read his mind; hearing voices; difficulty sleeping; thinking his thoughts are controlled*". His assessed needs were "*mental state to be monitored; employment activities; history of drug use*".
46. Also in June 2010 Ryan's father was written to with the offer of a Carers Assessment. It was later confirmed that he had passed this letter to Deborah, and it was recorded that she had not requested an assessment.
47. Ryan's father called the EIP Team in late June 2010 reporting "*deterioration in Ryan's mental health*": he was "*isolating himself; told parents [he] hated them and m[ental] h[ealth] services … behaviour indicative that he had [used illicit drugs]*". Ryan's father requested that the next meeting, in early July 2010, be moved to an earlier date and be changed to a home visit. Deborah called two days later to report that Ryan was unwell and would not be able to see the EIP Team that day. She stated: "*over past 4/5 days Ryan's behaviour changed, shouting at parents & when offered work talked about his jeans being 'wonky'*". On the same day a failed home visit was recorded, and a call to Deborah in which she stated Ryan "*should be there [at home]*".
48. A home visit with Ryan (and both parents) was recorded four days later, at the end of June 2010. The team recorded: "*Dispute between Ryan and father over living arrangements. Father had information about Ryan bank account, had been in to Ryan's room and removed 3 knives and found some tablets. Ryan angry that father had done these things; Ryan reports mood fine and eating and drinking well and*

taking medication; no evidence of psychotic symptoms; admitted to taking cannabis, no insight into effect it has on his mental health". No plans or outcomes were recorded.

49. In July 2010 Ryan started work with an Intensive Personal Advisor (IPA) from the Connexions Service. This followed a referral from YOS, although Ryan had been open to Connexions (not the intensive service) since June 2007. From July 2010 the IPA made multiple contacts with Ryan including meetings, telephone calls, sending him information about job opportunities, and supporting him with his CV and with his application for benefits. The IPA engaged with the YOS, NEP, EIP Team to support Ryan, and attended appointments and meetings with him, including joint meetings with EIP and YOS.
50. At the start of July 2010, a Care Plan progress review was carried out at a home visit (YOS and EYPDAS were invited and unable to attend; YOS have no record of this). The EYPDAS worker had informed YOS, who also informed EIP in the same week, that they would no longer be involved with Ryan as he had reduced his substance use and made positive changes. EYPDAS closed Ryan's case after a final home visit in early August 2010. Ryan was advised to contact Open Road in future if he needed support, as he was now 18.
51. The EIP Care Plan review noted Ryan's: "*frequent arguments with family; certain thought disturbances; did not disclose thought interference, withdrawal or broadcasting; reasonable insight into mental health problems; minimise cannabis use and potential effects on mental state*". A recommendation was made for Ryan to "*consider family therapy*" in addition to continuing anti-psychotic medication.
52. At the next home visit, a month later in early August, Ryan was noted to be "*happy to have assessment for family therapy*" and that the service would attend the next meeting, as well as "*appeared relaxed and engaged well with parents; felt fine (confirmed by mother)*". He denied taking cannabis and was noted to be searching for jobs and learning to drive.
53. A home visit one week later recorded that Ryan "*did not express psychotic thoughts or beliefs, but speech confused and sometimes childlike in reasoning. Possibly compounded by poor literacy and disjointed education.*" His employment was discussed and it was recorded that Ryan was "*told if he gets [a] criminal record or points on his [driving] licence, this will make it harder to get a job*".

54. The YOS Case Manager and a Connexions Worker conducted a joint home visit on the same day as the EIP Team (paragraph above) in August 2010, and a plan was recorded for Ryan to have regular contact with Connexions once the YOS order ended. The order was completed and YOS involvement ceased.
55. On 23 August 2010 the 'EIP Referral Pathway'[51] was completed; this did not involve a meeting with Ryan. Ryan's symptoms for psychosis were identified as "*suspiciousness; auditory hallucinations; paranoia*". His medication was noted, as well as his identified cannabis and mephedrone use.
56. Between then and 12 October 2010, Ryan was not seen or spoken with: he cancelled the family therapy appointment at the end of August 2010 and did not attend an appointment at the office in September 2010. Ryan's father was called by the EIP Team once at this time and he indicated Ryan had been working with him, and may have taken illicit substances recently and had been a "*nightmare*" for the rest of the week. A plan was recorded for the EIP to contact Ryan to book an appointment. Two calls were attempted to Ryan which did not get through.
57. In October 2010 Ryan's father called the EIP Team confirming Ryan's two upcoming appointments; he stated he did not think Ryan would attend either, and "*wanted to speak to someone to sort it out*". A home visit took place two days later, in which the following was recorded: "*Most of meeting was between Ryan and father about Ryan's choices in life, drug taking and not taking medication; Ryan seeing flashing lights – more prominent after cannabis use; Ryan states stopped medication as it makes him feel unwell and his father was badgering him to take it; Ryan not happy with father contacting friends and their parents; [Ryan's father] unhappy with services does not know what EIP does; Ryan stated nothing wrong with him, does not work and does not want to do anything*". The EIP service was explained to Ryan's father. Ryan stated he did not want any more meetings.
58. Ryan then did not attend his appointment at the EIP Team office, ten days after the home visit. His father attended and reported that Ryan had not been taking his medication for some weeks; Deborah was reporting "*challenging behaviours and at one point wanted Ryan out*". Ryan's father suspected Ryan was buying and selling

[51] A clinical pathway-referral into the service. The EIP service accepted referral for persons between 14 – 35 years experiencing a first episode of psychosis. A service user would remain with the EIP team for up to 3 years then depending upon individual needs and circumstances would be transferred to another team/agency or discharged.

drugs and "*knows Ryan is angry with him*". Ryan's father was recorded as having "*no faith in EIP as they have not returned his calls*". Ryan's father was offered, and declined, family therapy. He was advised, if Ryan became challenging and aggressive, to call the police. The EIP Team would continue to offer Ryan appointments and try to engage with him "*to monitor his mental state*".

59. The next contact was over a week later in November 2010. Ryan's father called the EIP Team as Ryan had "*taken a turn for the worse … asking to be locked in or he would kill someone. Unclear who Ryan was going to kill. … Father did not want to call police as last time they had done nothing.*" A home visit took place the same day. Ryan had "*Been seeing colours, face changing in the mirror & wants to be admitted to hospital to be given drugs to take away the side effects of drugs he has taken. Stated number of times he needed a pill to take away the colours*". He reported using up to four joints of cannabis a day, and had used speed[52] in the last week. Ryan was asked about his statement that he would "*kill someone*": he stated it was someone he had had an altercation with a year ago "*whilst trying to defend his mother* and that he "*did not know if he would try to carry out the threat*". Ryan was noted to appear angry at his parents at times and family therapy was suggested; the family were "*undecided*". The plan recorded was for the EIP Team to discuss with the doctor Ryan restarting medication; Ryan's family were advised to call the CRHT Team, or taking Ryan to the Emergency Department, if required. The EIP Team would "*continue to monitor and risk assess (liaison with family essential).*"
60. The EIP Team drew up a CPA plan for Ryan, the outcome of which was:
    a. "*Mental state – Liaise with Ryan family to monitor presentation – make telephone calls to Ryan to get Ryan to engage;*
    b. *Engagement with services; attempt to make face to face and telephone contact; arrange meetings in private places; establish good working relationship;*
    c. *Leisure activities; Connexions currently engaged but Ryan does not want to engage;*

[52] From www.talktofrank.com [accessed 8 September 2016]: "*Speed is the street name for the Class B drug amphetamine sulphate. Sometimes speed is used to refer to other types of amphetamines. Speed is a stimulant and people take speed to keep them awake, energised and alert.*"

d. *Drug use; takes cannabis & experiences flashing lights, does not want to stop use; offer psycho-education re effects of drug/mental health; monitor mental state in relation to drug use;*
e. *Relationship with father strained; discuss and offer family therapy; give Ryan choice of who is in appointments;*
f. *Measures to prevent /in case of crisis [staff] available through EIP; early warning signs, hearing voices, difficulty sleeping, thinking other people can read his mind, thinking thoughts are controlled; details of crisis team etc provided."*

61. The next day, the EIP Team attempted to call Ryan twice; they then called Deborah and Ryan's father (separately) to advise of an appointment for Ryan at the EIP team office two days later. Ryan's father stated he did not think Ryan would attend, and requested a home visit instead.
62. On the day of that appointment, Deborah sent a text message to the EIP Team stating Ryan would not attend as he was going to his General Practice. The Team left a message on Ryan's phone for him to call and called the General Practice who informed them that Ryan had not attended his appointment.
63. The next day in November 2010 (following information received) Essex Police attended a location and found Ryan in possession of cannabis and amphetamine; he was arrested. Officers at the station found Ryan to be so intoxicated with drugs that he was thought to have overdosed and was immediately taken to Broomfield Hospital. A search of Ryan's home was conducted and further controlled drugs were recovered.
64. In the early hours of the following morning, Essex Police received a notification from the hospital that Ryan had gone missing, for the second time (the first time he had been returned by security staff). Ryan was found later that morning around six miles from the hospital and was recorded as wandering in and around the traffic in an agitated state. An ambulance attended, but was not used. Ryan was not considered to be detainable under *Mental Health Act Section 136* and was taken home; there were no records relating to why Ryan was taken home rather than back to hospital. One of the officers involved in the incident submitted an intelligence report that stated Ryan had mental health issues that "*made him change mood quickly*" and that he "*could be violent towards police*".
65. On the afternoon of that day Deborah called Essex Police reporting that Ryan was outside her house, had taken drugs and was now threatening her and trying to break

down the back door (see 2.12.2). Officers attended and Ryan was recorded as being violent towards police, and was arrested for a breach of the peace. He was taken to a police station, and was recorded as presenting as a person under the influence of controlled drugs and assessed to be in need of a healthcare professional for a 'fitness to detain' assessment. Ryan refused to be medically examined; the health professional observed him and determined that Ryan was fit to be detained. A later review determined the same. The third assessment was completed later, and Ryan was released on bail by Essex Police and taken by police officers to a NEP mental health inpatient ward where he was detained as a *Mental Health Act 1983 Section 2* patient, for assessment.

66. The Approved Mental Health Professional assessment of Ryan in the police station recorded he "*had no idea where he had been or how he had got here or where he was at this time … lacked capacity … confirmed he smokes cannabis and has significant history of drug misuse … suffering from acute mental illness*" and needed to be detained and prescribed medication. He initially attempted to abscond and was transferred to a more secure ward. His mental state was then recorded as improving through November 2010 and at the end of the month he was transferred back to the less secure ward, and it was recorded Ryan showed no evidence of psychosis and no aggressive behaviour. He was then granted leave from the ward.
67. At the beginning of December 2010 Ryan's father called the ward. As he was not attending the review meeting the next day, he wanted to pass on the information that he felt Ryan was "*showing some paranoia which highlights underlying problems even without drugs*". This information was recorded. At the review meeting the next day, Ryan was seen without his parents (at his request). He as recorded as "*getting on ok with mother*" and was not intending to use drugs. He was discharged from the inpatient unit and the Mental Health Act Section, with ongoing mediation and follow up from the EIP Team planned within 72 hours.
68. The EIP Team attended Ryan's home the day after he was discharged. There was no answer at the house, and two failed calls were made to Ryan's phone. Deborah was then called, who agreed to accept medication for Ryan. The next day, the EIP Team called Ryan's father who confirmed Ryan had his medication, but that he (Ryan's father) was unhappy with the care given to Ryan before discharge. The Team called Ryan was stated he was "*still sleeping and did not want to speak. He then hung up*".

They called back and "*Ryan spoke briefly then hung up*". A further call was made a week later, and a message left on Ryan's phone.

69. Ryan attended the police station under bail (see 2.13.65) following his discharge and the following was recorded: "*the detainee is vulnerable – felt depressed all the time, was admitted to [mental health inpatient ward] for three weeks and they stated he was fine. Doctors [General Practitioner] have seen … [him] before and issued … [anti-depressant]. Meds taken once a day when needed. … hasn't taken them today. … doesn't want to see any medic.*" Ryan was interviewed with his father present as an Appropriate Adult[53] and made no comment to questions asked of him. He was bailed to return to the police station for forensic examination and a charging decision in relation to the offences of possession of class A controlled drugs (cocaine) and cultivating/production of cannabis.
70. Two weeks after the last attempted contact from the EIP Team to Ryan, Ryan's father called the team and stated Ryan was "*smoking cannabis, 'totally psychotic' Ryan believed people could read his mind through his lips, had invisible spots on his lips and everyone else was to blame for everything (paranoia).*" The outcome of this phone call was for Ryan's family to call the CRHT Team "*in case of crisis*" and that the EIP Team would arrange a home visit at the beginning of the next month (i.e. two weeks later, after the Christmas period).

<u>2011</u>

71. Ryan's father called the CRHT Team at the start of the following month, January 2011, and was concerned about Ryan's behaviours (including threatening suicide, and "*becoming aggressive to him [Ryan's father] and mother [Deborah], becoming a danger to himself and mother*" and felt he needed hospital admission. Ryan's father was advised to call police if Ryan continued to be aggressive, and that Ryan would be visited the next day.
72. This home visit took place the next day as planned. It was recorded that Ryan refused to meet with the team, and that he was "*thinking of ways to kill himself, wanted to run someone over, paranoid, had threats from others & wanted to retaliate by beating & raping someone*". A Mental Health Act assessment was arranged for the following day.

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[53] An Appropriate Adult is responsible for protecting (or safeguarding) the rights and welfare of a child of 'mentally vulnerable' adult who is detained by police or interviewed under caution voluntarily

73. This took place, the result of which was that Ryan was deemed to be displaying psychotic symptoms (including paranoia, thoughts of suicide, isolating himself) and suffering from a mental disorder that required him to be detained under the *Mental Health Act 1983 Section 136*. During the assessment Ryan became aggressive and threatening, and the police were called. Six officers restrained him. The risks noted "*no recorded danger to others*". An early urine screening tested positive for cocaine. Ryan initially appealed the Section but then withdrew.
74. At the end of January 2011 Ryan was granted leave from the ward and visited his mother. No issues were reported, and the drugs screening was negative although he was noted to smell of alcohol.
75. Ryan was discharged from the Section and the inpatient ward at the start of February 2011. The discharge noted Ryan was "*ambivalent*" about engaging with the EIP Team, that he "*denies ever having abnormal perceptions or paranoid thoughts … ambivalent about use of drugs*". His relationship with his mother was recorded as "*improved, but concerns about drug use*". He met with a new Care Coordinator from the EIP Team. They recorded that "*Ryan [was] unsure why [he was] admitted to hospital as [he] does not believe he is unwell and everyone wants to put him into hospital … Says it is illicit substances that make him go 'crazy'. Wants to continue cannabis use but not other drugs. Asked about drug testing*". A care plan was to be devised; the discharge record stated they should be arranging random drug testing.
76. Three days after the discharge in February 2011 Deborah called Essex Police to request they remove Ryan from her home as he had been taking drugs (see 2.12.3). The outcome of this was that Ryan was convicted of drug offences and received a 12-month conditional discharge at court.
77. Deborah called the NEP CRHT Team two days after this police incident to report that Ryan had "*gone missing and threatening suicide having been begging for money for drugs; not happy [that it is a] telephone service only out of hours, wanted to know how to stop the cycle with Ryan*". Deborah was advised to notify EIP of her concerns, and they would refer Ryan if appropriate.
78. The day after Deborah's phone call, the EIP Team carried out a home visit. The record noted that they had spoken with Deborah; Ryan was recorded as joining the meeting part way through expressing frustration at having no money, and believing that police would put him back in hospital. He was noted as not trusting anyone and "*everyone is against him … Has physical changes others cannot see and brain does*

not function correctly, but if asks mother about it he is told he is unwell and will go back into hospital". Ryan was reassured that his mother could not tell police or a doctor to admit him as hospital admission was not "*easy*". The EIP Team would see him the following week.

79. The Care Coordinator completed a risk plan with the following identified risks: "*No insight into illness; Continued use of cannabis; Reluctance to engage with services; Verbal and physical aggressions; History of non-compliance with medication; Minimal support network; Poor family relations; Psychotic illness*". The plan set out that if Ryan's mental health deteriorated: "*Care Coordinator to be contacted; Increase contact if necessary; Regular communication between family & EIP; Urgent medical review to be arranged; Crisis Team input to be considered if appropriate; Informal admission to be arranged; Mental Health Act assessment to be organised; Police to be present if necessary; Hospital admission under Section; Ryan requires continuity and regular contact with EIP workers.*"
80. Later in February 2011 Ryan missed one appointment, and attended one, at the EIP Team office. At the appointment Ryan was noted to be "*fine but very drained and depressed*" but with no evidence of current thought disorder. He was recorded as "*still angry at mother at times*". The plan was to continue with anti-psychotic medication, attend his Deborah for a physical health complaint, and for the Care Coordinator to "*continue meeting with Ryan weekly*".
81. Two weeks later a home visit was made to Ryan. The draft Care Plan was reviewed and Ryan's application for benefits was discussed. Ryan was noted as not wanting "*to engage in activities put on by M[ental] H[ealth]. Happy for visits to continue but no group work*". He stated his thoughts were settled and "*continues to use cannabis*". The plan recorded was to continue weekly visits. This visit took place on the same day as Ryan's court appearance for drug offences committed in November for which he received a 12-month conditional discharge (see 2.13.76).
82. Two weeks later, at the end of March 2011, Ryan did not attend an appointment at the EIP Office. At this time Ryan's case was closed with Connexions after a period of non-contact with the service.
83. In April 2011, Ryan's father called the EIP Team twice. It was recorded that he believed Ryan was using illicit substances again. A note was added: "*Advised that Ryan not answering calls, messages or the door on planned visits*" but it did not record who stated this. In this month Ryan did not attend two appointments at the EIP

Team office. Ryan appeared to have been spoken with once, as it was recorded that he reported he had been feeling settled and was working.

84. There were two contacts in May 2011 in which Ryan's father called the EIP Team for an update on Ryan: in one no details were recorded; in the second it was noted Ryan was "*still fluctuating, occasionally displaying paranoid symptoms and aggression*".
85. In June 2011 Ryan did not attend an appointment at the EIP Team office. Ryan's father called the team a week later with a general update, for which the details were not recorded. The record noted "*no action required*".
86. At the end of July 2011 Ryan did not attend an appointment at the EIP Team office. A review was conducted of the CPA in which it was noted that Ryan was: "*refusing to engage with EIP Team; no longer taking anti-psychotic medication; continuing to take illicit substances on a regular basis; father reports Ryan still appears to be in a stable mental state*". The plan recorded was for the EIP Team to continue regular contact with Ryan's father, to arrange appointments for Ryan, and to "*cold call*" every two months. The next CPA review was scheduled for January 2012, six months later.
87. A risk plan review was recorded in mid-August 2011. It was not recorded where the information came from for the review. The same information and plan were recorded as that noted in the CPA review (paragraph above).
88. Ryan called Essex Police twice in mid-September 2011 alleging that he had been assaulted, first by Deborah and then four days later by his father (see 2.12.5).
89. Two days later, his father called the EIP Team to report "*Ryan's mental state deteriorating significantly … [sic] become more aggressive and bizarre, he is still smoking cannabis. Ryan and Deborah had [an] argument, Ryan extremely verbally abusive to mother making allegations and threatened to smash the stereo.*" The Care Coordinator contacted Deborah and recorded Deborah's view that Ryan's mental state had deteriorated but "*does not believe him to be a risk to self or others … has been worse in the past … aggression linked to cannabis … he has never hit her*". Deborah was advised to contact the CRHT Team or police if Ryan deteriorated further.
90. At the end of the month (September 2011), Ryan's father called the EIP Team to report Ryan's verbal aggression as increasing, Deborah had asked him to leave after an argument and he was sleeping in his car. The plan recorded was to continue to monitor the situation "*as it does not appear Ryan is sectionable*". Ryan had not been spoken with since April 2011. Ryan then did not attend an appointment at the EIP

Team office. Another member of the EIP Team called Ryan's father to offer support in the absence of the Care Coordinator: he reported that Ryan continued to be challenging and that "*Ryan would not accept a meeting with [the] Team. [Worker] suggests giving Ryan a chance to meet and discuss matters*". A meeting was arranged and Ryan was visited at home.

91. At this meeting Deborah and Ryan's father's feeling that Ryan was deteriorating was noted, but "*Ryan did not see any reason for visit as did not feel unwell … clear antagonism between Ryan and father*". There was no evidence of psychosis.
92. The next contact was in the last four days of October 2011. Ryan's father called the EIP Team with concerns about Ryan. The team called Deborah as a result, and Deborah reported Ryan had "*been taking drugs and worried EIP may 'lock him up' if he gets worse*". Ryan's father called the Crisis Line the next day; he was advised to take Ryan to the Emergency Department if there were concerns for the family's safety. Ryan's father stated he was "*unhappy with the support offered and hung up*".
93. The next day, Deborah called police (see 2.12.6) as a result of which Ryan was convicted of criminal damage and within two days had received a six-month community order with probation. On the day of Ryan's court appearance Ryan's father called the EIP Team to report the incident to them. No action was taken. Ryan was assessed in court by the criminal justice mental health team. They noted aggression and "*anger issues*" and that he took "*little responsibility for his actions*" (he blamed Deborah). They planned to liaise with his General Practice and the EIP Team. The EIP Team spoke with Ryan that day who declined support as he was "*not unwell*".
94. Ryan's contact with probation[54] began here. An oral report (one that is prepared on the day and presented orally to court) was produced by probation and presented in court to inform sentencing. Ryan was interviewed for the report; he was unable to tell the report writer why he had committed the offence, other than to say he was frustrated with his parents. Ryan was assessed as posing a medium likelihood of reconviction, and a medium risk of harm to others. Probation records show the Court Probation Officer did not have police information on the history of 999 calls and any

[54] Ryan's contact with Probation began prior to the creation of the National Probation Service and Community Rehabilitation Companies (created in June 2014). His first contact (from October 2011) was with the then Essex Probation Trust. His second contact (from June 2013) was with the then Hertfordshire Probation Trust, which became the National Probation Service (for Hertfordshire) during his time with them. The name 'Probation' is used to refer to all organisations.

previous incidents or offences. The report suggested interventions around Ryan's accommodation, drug use and mental health. The court had directed that they considered the offence to be of low seriousness and that the purpose of the sentence was rehabilitation, hence the proposal for a period of supervision.

95. The day after this sentencing, Ryan approached Uttlesford District Council Housing Service seeking accommodation. He was recorded as single and living with his father. Ryan reported having been "*hospitalised twice for drug induced psychosis in the past*" and that he was not using drugs or alcohol. A standard assessment by a Housing Options and Homelessness Prevention Officer led to Ryan being referred immediately on to Genesis Housing. The referral to Genesis Housing recorded that Ryan stated: he lived with his mother but did not get on with her, and that there had been a recent police incident in which he had broken a window; he had taken a mixture of drugs that had led him to be hospitalised with psychosis but was no longer taking anything; he wanted to find work. The assessment concluded that Ryan was suitable for assessment by Bromfield House; this was the end of their contact with him.
96. Genesis Housing carried out a face-to-face assessment shortly after (exact date not available) for Ryan to be housed in Bromfield House[55]. A copy of the assessment is not available due to the length of time that has passed since it took place. In interview for the Genesis Housing submission to the DHR, the worker who observed the assessment recalled that Ryan came across as being quite aggressive. When asked how he would deal with aggression if he were resident in Bromfield House and responded by saying that he would "*punch them*". This was recalled as being the basis of the refusal.
97. Ryan met with probation as part of the Community Order on three occasions in November 2011. Ryan was assessed as posing a medium risk of harm to known adults: his parents were identified as being at risk from Ryan. The following issues were identified as potentially increasing the risk posed by Ryan: further period of psychosis; conflict with parents; increased drug use; lack of engagement with services. The risk management plan outlined the following actions for the probation officer: to liaise with the police to assist in the monitoring of Ryan's relationships with

[55] A Supporting People grant funded accommodation scheme for single homeless people between the ages of 16 – 25 who have support needs (e.g. drugs, alcohol, minor mental health or other vulnerability issues). The scheme is not staffed 24 hours a day

family; to liaise with housing providers in order to assist Ryan to obtain independent accommodation; to contact mental health services and drug agencies. The objectives set for Ryan's period of supervision were to address: victim awareness; housing; agency involvement in respect of drugs and mental health (Ryan's lack of engagement and motivation were noted with regard to this last objective). From then until April 2012 Ryan attended weekly supervision appointments with the probation officer.

98. Early in November 2011 Ryan's father was called by the EIP Team who stated Ryan was "*calm and normal*", could live with him and Ryan's father did not feel at risk. The Care Coordinator agreed to call in once month.

99. At the end of November 2011 Deborah called police to report that Ryan had broken into her home (see 2.12.7). No action was taken as Ryan had left. Shortly after this Ryan did not attend an appointment at the EIP office.

100. In December 2011 the probation officer noted the following about Ryan: during victim awareness work with Ryan he had some awareness of the effect of his behaviour on his parents but subsequent to this he was noted as not receptive (later, in February 2012, they noted that Ryan "*tended to blame*" his parents). The officer noted Ryan's apparently rigid thinking about his mental health, including that it was his father who thought Ryan had mental health problems and should take his medication. Ryan was recorded as saying he would "*beat them (parents) up if they made him take them (tablets)*". The officer challenged Ryan to consider alternative ways of addressing differences of opinion.

101. During this time (mid-December 2011) Ryan's father called Hertfordshire Police and reported that earlier that day Ryan, who had mental health issues and had been "*smoking dope*" had "*grabbed him by the throat … and threatened to kill*" him. Ryan had left the scene 15 minutes prior to the call. Officers attended and established that Ryan's father had no injuries and was not willing to provide a statement. Officers also established that Ryan was apparently "*consuming alcohol in a broken down car in the driveway of [Deborah's address]*". A request was made to Essex Police to attend the location to check on the Ryan's welfare, as the address given was in Essex Policing jurisdiction. Essex Police were tasked with arresting Ryan and responded shortly stating they were unable to do this and requested Hertfordshire Constabulary to assist as the address was very close to the Hertfordshire boarder.

102. Ryan was located the following day at his father's home and interviewed. He denied the assault and claimed self-defence. Ryan's father was updated and no further action was taken. The Crime Report did not indicate any mental health or drug issues, contrary to the incident log. Procedures in relation to domestic abuse victims were followed with Ryan's father; the documentation did not mention mental health issues for Ryan, and no referrals were recorded for him. On the same day Ryan's father called the EIP Team to report the incident.

103. At the end of December 2011 Ryan's father called Essex Police reporting that Ryan had been verbally aggressive to Deborah (see 2.12.8). Ryan was asked to leave the house, which he did. Two days later Deborah called Essex Police to report that Ryan was outside her house in a car and was about to "*kick off*" as he was under the influence of drugs (see 2.12.9). Officers removed Ryan to prevent a breach of the peace.

Appendix 2: Domestic Homicide Review Terms of Reference

The original Terms of Reference were agreed at the start of the DHR in December 2015. They were updated in September 2016 following the NHS England commissioning of the Independent Mental Health Investigation. The updated Terms of Reference are included here.

This Domestic Homicide Review is being completed to consider agency involvement with Deborah, Michael and Ryan following the deaths of Deborah and Michael. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Deborah, Michael and/or Ryan during the relevant period of time 1 January 2003 – the date of the homicide (inclusive). To summarise agency involvement prior to 1 January 2003.

3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

6. To commission a suitably experienced and independent person to:

a) chair the Domestic Homicide Review Panel;
b) co-ordinate the review process;
c) quality assure the approach and challenge agencies where necessary; and
d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

8. On completion present the full report to the Uttlesford Community Safety Partnership.

Membership

9. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

10. The following agencies are to be on the Panel:
    a) ADAS (Alcohol and Drug Advisory Service)
    b) Adult Social Care, Essex County Council
    c) Community Safety, Uttlesford District Council
    d) Education, Essex County Council
    e) Essex Police
    f) Her Majesty's Prison Service
    g) Hertfordshire Police
    h) National Probation Service
    i) NHS England
    j) North Essex Partnership NHS Foundation Trust
    k) STARS (West Essex Community Drug and Alcohol Service)
    l) Victim Support
    m) West Essex Clinical Commissioning Group
    n) Women's Aid

11. The Panel recognise that the particular issues in this case are domestic abuse, mental health and drugs and alcohol. The above specialist agencies, in addition to being substantive Panel members, also agree to act as experts in relation to these areas.

12. The panel agrees to run the review in parallel to the National Probation Service Serious Further Offence investigation, and receive information gathered by that investigation as part of the NPS contribution to the DHR.

13. The panel agreed to run the review in parallel with the mental health investigation commissioned by NHS England, through the following:
    a) Share all information submitted by to the DHR with the mental health investigation (including agency chronologies and IMRs).
    b) Coordinate family contact sensitively between the DHR Chair and the investigation lead.
    c) The investigation lead to attend DHR Panel meetings where necessary, and to contribute to the DHR process and final report.
    d) The mental health investigation report to be published separately to, but linked closely with, the DHR Overview Report.

14. This was with the exception of Victim Support, who declined to share their information with the mental health investigation.

Collating evidence

15. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

16. Chronologies and IMRs will be completed by the following organisations known to have had contact with Deborah, Michael and/or Ryan during the relevant time period, and produce an Individual Management Review (IMR):
    a) General Practices for Deborah, Michael and Ryan
    b) ADAS (Alcohol and Drug Advisory Service)
    c) Education, Essex County Council
    d) Essex Police

e) Essex STaRS (Community Drug and Alcohol Service)
f) Her Majesty's Prison Service
g) Hertfordshire Police
h) National Probation Service
i) North Essex Partnership NHS Foundation Trust
j) Victim Support

17. Further agencies may be asked to completed chronologies and IMRs if their involvement with Deborah, Michael or Ryan becomes apparent through the information received as part of the review.

18. Each IMR will:
    a) set out the facts of their involvement with Deborah, Michael and/or Ryan
    b) critically analyse the service they provided in line with the specific terms of reference
    c) identify any recommendations for practice or policy in relation to their agency
    d) consider issues of agency activity in other areas and reviews the impact in this specific case

19. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Deborah, Michael or Ryan in contact with their agency.

Analysis of findings

20. In order to critically analyse the incident and the agencies' responses to Deborah, Michael and/or Ryan, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with GO/Michael/Ryan, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk; mental health issues; drug and alcohol issues.
    d) Analyse agency responses to any identification of domestic abuse issues; mental health issues; drug and alcohol issues.

e) Analyse organisations' access to specialist domestic abuse agencies; mental health agencies; drug and alcohol agencies.
f) Analyse the training available to the agencies involved on domestic abuse issues; mental health issues; drug and alcohol issues.

Liaison with the victim's and alleged perpetrator's family

21. Sensitively involve the family of Deborah (and Ryan) and Michael in the review, if it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Essex Police Family Liaison Officer.

22. Invite Ryan to participate in the review, following the completion of the criminal trial.

23. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information, specifically in relation to the Mental Health Investigation.

Development of an action plan

24. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Community Safety Partnership on their action plans within six months of the Review being completed.

25. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

26. Any enquiries from the media and family should be forwarded to the CSP who will liaise with the chair. Panel members are asked not to comment if requested. The CSP will make no comment apart from stating that a review is underway and will report in due course.

27. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

31. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

32. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
    b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime

ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 3: Mental Health Processes

Much of Ryan and his family's contact with agencies concerned Ryan's mental health. The relevant terms and processes are explained here to assist the understanding of the facts set out in the sections below.

Mental Health Act 1983
This Act concerns the "*reception, care and treatment of mentally disordered patients, the management of their property and other related matters.*"

Mental Health Act 1983 Section 2
This is the section of the Act used by professionals to detain an individual in hospital for assessment and treatment. It allows for an individual to be detained for up to 28 days and cannot be renewed; a section 3 can be used if further detention is required. Individuals have the right to appeal against a *Section 2* detention within the first 14 days of that detention.

Mental Health Act 1983 Section 136
This is the section of the Act that allows a police officer to arrest an individual they deem to be suffering from a mental disorder and to be in immediate need of care or control. The section lasts for up to 72 hours.

Approved Mental Health Professional (AMHP)
This role was created by the *Mental Health Act 1983*. An AMHP can be any professional with the required qualification to enable them to carry out assessments of individuals within the relevant sections of the Act (as outlined above).

Psychosis

The NHS website[56] states: psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions. The two main symptoms of psychosis are:

- Hallucinations – where a person hears, sees and, in some cases, feels, smells or tastes things that aren't there; a common hallucination is hearing voices.
- Delusions – where a person believes things that, when examined rationally, are obviously untrue – for example, thinking their next-door neighbour is planning to kill them.

The combination of hallucinations and delusional thinking can often severely disrupt perception, thinking, emotion, and behaviour. Experiencing the symptoms of psychosis is often referred to as having a 'psychotic episode'.

Psychosis isn't a condition in itself – it's triggered by other conditions. It's sometimes possible to identify the cause of psychosis as a specific mental health condition, such as:

- Schizophrenia – a condition that causes a range of psychological symptoms, including hallucinations and delusions.
- Bipolar disorder – a mental health condition that affects mood; a person with bipolar disorder can have episodes of depression (lows) and mania (highs).
- Severe depression – some people with depression also have symptoms of psychosis when they're very depressed.

Psychosis can also be triggered by traumatic experiences, stress, or physical conditions, such as Parkinson's disease, a brain tumour, or as a result of drug misuse or alcohol misuse.

[56] http://www.nhs.uk/conditions/Psychosis/Pages/Introduction.aspx [accessed 8 September 2016]

Appendix 4: Glossary

ADAS	Alcohol and Drugs Advisory Service
CCR	Coordinated Community Response
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurses
CPS	Crown Prosecution Service
CRHT	Crisis Resolution and Home Treatment
CRU	Central Referral Unit
CSP	Community Safety Partnership
DALO	Domestic Abuse Liaison Officer
DHRs	Domestic Homicide Reviews
DVO	Domestic Violence Officer
EIP	Early Intervention in Psychosis
EYPDAS	Essex Young People's Drug and Alcohol Service
FGM	Female Genital Mutilation
HMIC	Her Majesty's Inspectorate of Constabulary
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
HMYOI	Her Majesty's Young Offender Institution
IMRs	Individual Management Reviews
IPA	Intensive Personal Advisor
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MARAT	Multi Agency Risk Assessment Team
MDO	Mentally Disordered Offender
NCDV	National Centre for Domestic Violence
NEP	North Essex Partnership NHS Foundation Trust
NHFT	Northamptonshire Healthcare NHS Foundation Trust
NPS	National Probation Service
OASyS	Offender Assessment System

PA	Personal advisor
PSHE	Personal, Social, Health and Economic Education
ROTL	Release on temporary licence
SARA	Spousal Assault Risk Assessment
SEPT	South Essex Partnership University NHS Foundation Trust
SFO	Serious Further Offence
STADV	Standing Together Against Domestic Violence
STaRS	Specialist Treatment and Recovery Service
YOS	Youth Offending Service

Appendix 5

Dear Sir/Madam,

DHR for Deborah & Michael – July 2015

I am writing to you on behalf of Her Majesty's Prison and Probation Service (HMPPS) in response to a recommendation made as part of the Domestic Homicide Review (DHR) into the homicides of Deborah and Michael. I am the policy lead for licence conditions on behalf of HMPPS. I have been made aware of the recommendation by my colleague who sits of the Home Office DHR Quality Assurance Panel.

The DHR identified that some of the sentence plan objectives were not met during course of the sentence, and the Offender Manager did not recommend the Prison Governor include additional licence conditions to address those requirements. As a result, recommendation number 3 of the draft DHR reads "Her Majesty's Prison and Probation Service (HMPPS) to take action to ensure all prisons have adequate structures in place to communicate with the National Probation Service prior to an offender being released to ensure that licence conditions reflect sentence plans".

The current policy on licence conditions, set out in Probation Instruction (PI) 09/2015 "Licence Conditions and Temporary Travel Abroad", specifically sets out in 2.14 that the Offender Manager (OM) "must complete the PD1 form when requesting licence conditions and must provide a full explanation as to why additional conditions are deemed necessary and proportionate". This allows for the Decision Maker (i.e. either the Governor or the Parole Board) to come to a decision about whether or not those conditions are necessary and proportionate. In the case of determinate sentences the Prison Governor issues the licence for initial release, based on the OMs recommendations. While there is no ability for the Governor simply to add conditions, if they believe that the conditions do not go far enough to ensure the protection of the public, prevention of re-offending or rehabilitation of the offender but they are able to return the request to the OM for review . Likewise, there is a system in place for an offender manager to request additional conditions post release. Sentence plan objectives are stored on the Offender Assessment System (OASys) which is a risk assessment, management and sentence planning tool used by HMPS and the National Probation Service and this provides the Offender Manager with access to the prison sentence plan and this should form part of the information they use decide which additional licence conditions to request .

In this case, the fact that the licence conditions did not reflect the offender's sentence plan objectives appears to have been as a result of an omission by the offender manager which was not picked up by the prison, rather than a lack of structures to communicate prison sentence plans to community offender managers. However, we continually look at ways to refine and strengthen our processes to improve the communication between prison and probation staff. From September 2019, we will be rolling out further changes under the Offender Management in Custody (OMiC) programme, recognizing the importance of the pre-release period and the handover between the prison and the community. A handover meeting with both the Prison and Community Offender Manager will take place for any individuals whose management is the responsibility of the National

Probation Service (i.e. they are managed under Multi Agency Public Protection Arrangements , or are assessed as presenting a high risk of harm the public) or an individual who has been a looked after child. For all other individuals the Prison Offender Manager will complete a handover report which they will send electronically to the Community Offender Manager. Public protection, information sharing and relationship building between individuals and the Community Offender Manager, must be at the centre of each handover/report. The implementation of OMiC will strengthen the current process for sharing information between prison and probation staff to ensure all identified risks can be managed in the community and that the correct licence conditions are added where necessary.

Appendix 6: Action Plan:

Recommendation	Update	Further Action	
Recommendation 1 (see 3.3.1.b) West Essex Clinical Commissioning Group to ensure that training is made available to General Practices on identifying domestic abuse and risk to ensure that they are equipped to refer appropriately to the MARAC; to have reference to the materials available through the IRIS project[57] to support this.	Training dates have been made available to GP practices and has been raised as a priority.	To ensure all practices are complying with the recommendation and report back to CSP.	31.3.21

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

Recommendation	Update	Further Action	
Recommendation 2 (see 3.3.1.c & 3.5.5) West Essex Clinical Commissioning Group to work EPUT, STaRS, ADAS and other commissioned drug and alcohol and mental health services to establish a procedure for joint working with General Practices to ensure that individuals receive support in a coordinated way.	Procedure established with GPs. STaRS and Pheonix Futures working closely together to ensure a coordinated and consistent approach given to individuals with multiple needs. Better partnership working with mental health services to be established. A dual diagnosis worker post has been established but has yet to be recruited to. Links with a mental health nurse have been made.	To report to the Uttlesford Community Safety Partnership when the recruitment of a dual diagnosis worker has been recruited.	31.3.2021
Recommendation 3 (see 3.23.7) Her Majesty's Prison and Probation Service to take action to ensure all prisons have adequate structures in place to communicate with the NPS prior to an offender being released to ensure that licence conditions reflect sentence plans.	Offender Management in Custody model (OMiC), piloted in 2017 is now being Implemented across the whole service. Probation staff work in prisons on secondment for a number of years ensuring better sentence co-ordination. Focus has been given to ensure the CRCs are offering the right interventions and that sentencers are informed of what interventions are available to them which gives the judiciary more	Completed. Any further improvements to be reported through the CSP	Completed.

Recommendation	Update	Further Action	
	confidence in the offer of interventions		
Recommendation 4 (see 4.2.1.b) Essex Police, Hertfordshire Constabulary, EPUT and STaRS to review their domestic abuse training and materials to ensure that practitioners understand domestic abuse as a pattern of coercive and controlling behaviours, not as a single incident. For local commissioned domestic abuse specialist services to be involved to support this understanding. To report to the Uttlesford CSP and the Essex Southend and Thurrock Domestic Abuse Strategic Board on the actions taken.	HERTFORDSHIRE POLICE; This thread has been (and will continue to be) introduced within County multi agency training, as well as 'Constabulary only' training. Most recently, this has occurred with the multi-agency in November 2017 and will be subject of future events. ESSEX POLICE Domestic abuse training and policies are continually updated to reflect current legislation. Multi agency training takes place with partners and is a common agenda item for CSP's in the county. The website has extensive information and references other commissioned DA specialist services.		Completed Completed

Recommendation	Update	Further Action	
Recommendation 6 (see 3.5.9 & 4.2.2.f) STaRS and EPUT to review their dual diagnosis approach in light of the learning in this DHR, for example through a dip sample audit of cases, to ensure that policy is reflected in practice; and to ensure that, where a person presents with substance misuse and mental health issues, that both are addressed before a person is discharged. To take appropriate action where necessary and feed back to the Uttlesford CSP.	A dual diagnosis worker post has been established but has yet to be recruited to. Links with a mental health nurse have been made.	Report back to CSP 31.3.2020	31.3.2021
Recommendation 7 (see 4.2.3.d) The Essex Adult Safeguarding Board to review and amend where necessary, multi-agency policy and training to address the learning from this Review concerning support offered for families with caring responsibilities, specifically: conversations with those who have caring responsibilities should not be limited to offering carer's	ESAB will 1.seek assurance from its partners that support is available to carers 2.ensure that support for carers is integrated into its training, awareness raising and communications relating to safeguarding adults.	Thematic Board meeting to be held (July 2019) focussing on carers and seeking assurance from partners that support is available for carers Publicity campaign (November 2019) that will include raising awareness of safeguarding for carers	Completed

Recommendation	Update	Further Action	
assessments, and must be open, non-judgemental and avoid labelling someone as 'a carer', to allow individuals and families to express their needs and wishes, and be directed to appropriate support.			
Recommendation 8 (see 4.2.3.f) The Essex Southend and Thurrock Domestic Abuse Strategic Board to share with all members the learning in this DHR i n relation to the need for agencies to engage with individuals holistically: and for agencies to integrate this into training to ensure that all of an individual's issues and needs are identified, and appropriate referrals are made where necessary.	Learning from DHRs will be cascaded through our DHR learning events delivered across SET.	To continue to feed into future multi agency learning events on a regular basis	Completed
Recommendation 9 (see 4.2.4.g) The mental health NHS Trusts named in this Report to amend their Discharge Policies to ensure that they set out clearly	See recommendation 10		

Recommendation	Update	Further Action	
the procedure for when a patient under their care is transferred into prison (or into a different prison), and that these procedures take into account the learning from this Review.			
Recommendation 10 (see 4.2.4.g) That NHS England share nationally the learning from this review as addressed by recommendation 9, and encourage all mental health trusts to ensure their discharge policies adequately address cases where patients transfer into or between prisons.	NHS England Health & Justice central team have developed a national mental health and learning disability service specification Objective 3 of this service specification is to ensure continuity of care through the gate and within prison through a programme of service improvement initiatives, e.g. Evidence of: • Patients are aware of and engaged with their local community mental health services, learning disability services and/or any other required care services upon release or discharge.	A review and update of the Information Sharing Good Practice Guidelines has commenced. It is planned to be further expanded to include all scenarios where sharing of information is essential to the safety of patients, others and staff. A Task and Finish Group is being convened, to include HMPPS and NHS England H & J IG Lead. The good practice guidelines will include key actions for regional H & J commissioners to take to provide assurance that the regional ISA and good practice guide are implemented across the H & J residential estate.	Report progress with the guidelines to CSP 31.10.20

Recommendation	Update	Further Action	
	They have a robust discharge plan and their support needs feature in their resettlement plan also. • Support is provided through the gate to enable patients to navigate local services and access appropriate wider services e.g. housing which will support their recovery.		

Recommendation	Update	Further Action	
Recommendation 11 (see 4.2.5.h) Hertfordshire MAPPA Strategic Management Board to work with the Local Authorities to ensure that housing departments and housing associations are adequately represented at and engaged with MAPPA and that a position of flexibility in relation to housing options for offenders is taken to support the management of risk.			
Recommendation 12 (see 4.2.6.f) The Essex Southend and Thurrock Domestic Abuse Strategic Board to direct all members to review their onward referral processes in light of the learning in this DHR, and make changes where necessary to ensure that referrals are: recorded where possible; followed up to ensure they have been received; and appropriate	Learning from DHRs will be cascaded through our DHR learning events.	Learning to be fed into future learning events	

Recommendation	Update	Further Action	
action taken if referral has not been received / accepted. For member agencies to feedback to the Strategic Board on this.			
Recommendation 13 (see 4.2.7.f) STaRS, EPUT, ADAS and Victim Support to review their approach and response to people who 'don't engage' in the service, in light of the learning identified in this DHR, to ensure barriers to people's engagement are identified and acted upon, and that motivational work is done that aims to improve engagement. To take appropriate action where necessary and feed back to the Uttlesford CSP. For the learning from these agency reviews to be shared through the Essex Southend and Thurrock Domestic Abuse Strategic Board.	Learning from DHRs will be cascaded through our DHR learning events.	To take appropriate action where necessary and feed back to the Uttlesford CSP. For the learning from these agency reviews to be shared through the Essex Southend and Thurrock Domestic Abuse Strategic Board.	