BASILDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

VICTIM: DOROTHY

DIED IN SEPTEMBER 2012

EXECUTIVE SUMMARY

REVISIONS PAGE

Revisions to the DHR Executive Summary have been made in response to receipt of the Home Office letter dated 2 April 2014 advising that the Home Office Quality Assurance Panel had judged the DHR to be 'inadequate' and further discussions with the Home Office Domestic Violence Policy team.

Page	Revision / Additional Information (red text)
7	Linda Howells was appointed as the Independent Chair of the DHR Panel on 19/11/2012, the date of the first Panel meeting. *Linda has had no involvement either directly or indirectly with the delivery or management of services by any of the agencies involved in this DHR since 2003.*
13	*From the early meetings of the DHR Panel it became clear that agencies had limited contact with the victim and there was no evidence of circumstances that would suggest an abusive relationship between the victim and the perpetrator. In addition, no family members believed that there was an abusive relationship between the two until the time of this tragic event.* According to the evidence submitted to the DHR, there was very little agency contact with Dorothy during the DHR review period. Dorothy's G.P. was prescribing a number of different medications and the IMR confirms that she was seen regularly but the only identified contact was in August 2011, immediately following the death of her ex-partner. There are no records that Dorothy raised any concerns for her safety. *The DHR evidence suggests that Dorothy was unlikely to have raised concerns herself, but that at 79 years old and with both sons being drug addicts, that she may have needed support.* *There is no evidence presented to the DHR that would suggest a safeguarding referral was made.*
18	*The Essex Probation IMR identified that there was no record of liaison between Offender Managers and the Police during the course of Billy's supervision. It is expected that routine enquires will be undertaken by Offender Manager but there are no records that this occurred which resulted in Probation Officers being unaware of intelligence being held by the Police particularly in relation to weapons.*
19	*Essex Police have identified that if their Potentially Dangerous Persons Policy had been actively in use at this time, then it is possible that there could have been consideration of its use after the incident in December 2011.*
20	*The Essex Probation IMR identified that there no were records suggesting regular liaison between Police and Offender Managers, resulting in Probation officers being unaware of intelligence held by the Police, particularly regarding weapons.*
22	The G.P. prescribed diazepam to Billy in September 2009, originally for back pain but Billy was later (7/4/2011) to report that he took it for very bad rages, *so bad that he could hurt someone or even kill them*. Billy also reported bingeing on the drug to other agencies, although it is not known whether the G.P was aware of his behaviour.

25	*It is clear from the G.P.'s IMR that Billy's G.P. Considered that once Billy was being seen by the mental health team and CDAS, that it was their responsibility to deal with this aspect of his care. It would appear that the G.P. was not advised of the outcome of the referral he made to CMHT, and he assumed that Billy had been accepted for treatment. The DHR Is unaware of any further actions taken by the G.P. When Billy repeated his claim that he may hurt someone or even kill them one month after this referral was made.*
35	*Dorothy was living independently without the engagement of support services, although at times when she may have needed services these were offered to her by agencies and were declined. For example, when Dorothy was offered care support following her hip replacement surgery, she advised that her family would support her and that she did not require social services support.* As previously reported a safeguarding query may have been raised by Basildon Council if information about Dorothy's *financial* difficulties had been shared across the local authority in the Summer of 2012. *No other agency reported in their IMR's that they had given consideration to their safeguarding policy in relation to Dorothy.* *Dorothy had a complex life and character, and suffered from a variety of medical conditions but was not considered to be a "vulnerable adult" as defined by the Southend, Essex and Thurrock (SET) Safeguarding Adults Procedure.* *There was no evidence submitted to the DHR to show that any agency identified Billy as a "vulnerable adult" as defined by the SET Safeguarding Adults Procedure.*
36/37	***5.8 Management of dangerous offenders*** *The Essex Multi-Agency Public Protection Arrangements team have confirmed that Bill was never referred into the MAPPA process. MAPPA criteria are as follows:* *Category 1 offenders: All registered sex offenders* *Category 2 offenders: All violent and sexual offenders sentenced to imprisonment of 12 months or more or detained under a s37 hospital order.* *Category 3 offenders: Any other offender considered to pose a significant risk of serious harm to the public.* *Referral to MAPPA would be based on convictions for relevant offences. Billy was arrested for two notable offences before his death, but no further action was taken in relation to either.* *For offenders that fall outside of MAPPA criteria, they can be qualified as a Potentially Dangerous Person (PDP). ACPO define a PDP as follows:* *"A person who is not eligible for management under the MAPPA process but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm."* *There is further description that requires the threat of harm to be considered imminent. Billy was arrested for two serious offences prior to the murder. One of*

	these was an attempted murder, however no further action was taken in relation to this offence. *There were significant issues with the victim's credibility and there was no other corrobation that an incident had occurred. There was also information that the victim and Billy continued their friendship after the incident, thus removing any known threat or likelihood of imminent harm.* *There was also an incident in December 2011 in which Billy was arrested for wounding after being involved in an altercation with a male. Both parties were arrested, and both sustained multiple stab wounds. No further action was taken in relation to this incident. While the investigation was ongoing both parties were in conditional bail. Although these conditions may have been a deterrent it is possible that there could have been consideration for PDP following this incident.* *Although policy exists for PDP it is not something that as being utilised at the relevant time and there were no persons categorised as PDP by Essex Police at that time.* *Essex Police have now rewritten their PDP Policy. The new policy, which is to be the subject of extensive internal communication, encourages all staff to identify persons who pose a risk to the public who are then formally assessed. Once adopted as a PDP, the individual will have a nominated manager responsible for proactive work to minimise the risk that they pose.*
42	*Billy did not meet the criteria for inclusion in MAPPA and was not referred into the MAPPA process.* A multiagency meeting would have provided the opportunity for agencies to share information about Billy. Whilst recognising that the Police may not have shared the intelligence that they had received, it is quite possible agencies would have gathered information that enabled them to build a clearer picture of Billy, his lifestyle and the risks he might pose to other people. *It is also now clear that Billy could have been managed by Essex Police, under the Potentially Dangerous Persons Policy. A PDP Policy existed but was not being used by Essex Police in the summer of 2012. The newly rewritten policy encourages all staff to identify persons who pose a risk to the public. These individuals are the formally assessed. Once adopted as a PDP, the individual will have a nominated officer responsible for proactive work to minimise the risk they pose.* *It is difficult to ascertain whether management of Billy under the PDP Policy would have prevented the death of Dorothy. She was never considered to be at risk from her son by any agency working with either her or her son.*
45/46	No recommendations were included in the Essex Police IMR. *Essex Police advised that by the nature of their work they are involved in all Essex DHRs. They confirmed that they have already implemented changes to working practices to address issues raised in the DHRs since 2011.* *Essex Police did not advise the DHR of either the original official complaint from Sarah or the IPCC investigation. This was advised by Sarah to the DHR Chair who provided copies of the IPCC report to the DHR Panel.*

	Essex Police have identified that Billy could have been identified, assessed and managed under the PDP Policy, following the December 2011 incident. The Policy has been rewritten and is to be subject to extensive internal communication. *Essex Police have introduced the Athena system in 2015, a single IT system that covers intelligence, case building, custody, crime recording and investigation. This system utilises single iterations i.e. individuals only appear in the system once, with all related data attached. Prior to this, and at the time of the event covered by the DHR, Essex Police used a number of stand alone IT systems. For example, the PROtect system was used by Public Protection but access was restricted to those outside of that command. With the introduction of Athena internal data sharing within Essex Police has therefore significantly improved.* *The Crime and Public Protection Command has, since April 2015, become an active participant in a revised force tasking process. Through this process the Command, supported by analysts, identify and target individuals most likely to cause harm within the community. This falls in line with the new Force Control Strategy, which is aimed at identifying 'Hidden Harm' and contains domestic abuse as a force priority.* *The recent implementation of the Essex Force Control Strategy, the revision of the PDP Policy, and changes to the force tasking process and force-wide information sharing provide some reassurance that the circumstances of this DHR have been considered by Essex Police.* **Essex Probation Service** Offender Managers should adopt an investigative approach to offender management and seek independent verification of information pertaining to risk management. For example, checking offence / *intelligence* details with the police or that a case has been referred to MARAC.
	ENDS

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Please note that the names of individuals identified within this report have been changed. Surviving family members have chosen the names that have been used throughout the report.

1. Introduction

According to the coroner Dorothy was killed in her home, by her youngest son Billy, on either the 27th or 28th August 2012. A call from a concerned neighbour in the evening of the 3rd September 2012 led to the Police and Ambulance Service attending the property and discovering the bodies of both Dorothy and Billy inside the house.

From the evidence at the scene it is believed that Billy used an illegally possessed shotgun to kill his mother, who was found in the lounge with a gunshot wound to the head. Billy's body was found in an ensuite bathroom, with a gunshot wound to the face, and still holding a shotgun in his arms. It is thought that he killed himself on 1st September 2012. Dorothy had not been seen since the 27th August. Billy was last seen alive on the 1st September, when according to Police records; an acquaintance saw him sitting on the side of the road and was unable to attract his attention.

2. Establishing the Domestic Homicide Review

2.1 Decision Making

On the 11th September 2012 Essex Police notified the Chair of Basildon Community Safety Partnership (CSP) of the death of Dorothy on the 3rd September 2012. Following a meeting between the Chair, Essex Police and the Essex Domestic Abuse Coordinator on the 19th September 2012, the Chair concluded that the circumstances surrounding the death were such that it was appropriate to establish a domestic homicide review (DHR). The Home Office were advised of the decision to conduct a review on the 19th September 2012. In accordance with the legislative requirements it was intended that this DHR would be concluded and reported to the Home Office within six months of this date.

The complexity of this DHR did not become apparent until after its outset. The process of reviewing the breadth of information that was made available to the DHR, and the complex web of relationships between agencies and the perpetrator over a time period of more than three and a half years proved very time consuming and has taken longer than any agency had anticipated. In the end the DHR Panel and the Independent Chair chose to complete the review comprehensively to ensure that all the lessons were learned from this tragedy.

Basildon Community Safety Partnership has commissioned this review under Section 9 of the Domestic Violence, Crime and Victims Act 2004, which came into force on the 1st April 2011. It is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom he/she was related or with whom he / she was or had been in an intimate personal relationship; or
b) A member of the same household as himself / herself.

2.2 DHR Panel

Linda Howells was appointed as the Independent Chair of the DHR Panel on 19/11/2012, the date of the first Panel meeting. *Linda has had no involvement either directly or indirectly with the delivery or management of services by any of the agencies involved in this DHR since 2003.*

The DHR Panel comprised of:

Sarah Pope	Basildon and Thurrock University Hospitals NHS Foundation Trust
Paula Mason	Basildon Borough Council
Lyn Headley	Basildon Women's Aid
Gill Stephenson	Essex County Council, Adult Health and Community Wellbeing
Mandy Nightingale	Essex County Council, Schools, Children and Families
Val Billings	Essex County Council, Essex Domestic Abuse Coordinator
Denise Morrissey	Essex Police
Neeve Bishop	Essex Probation Service
Bridget Cooper	Family Mosaic
Danny Showell	NHS South Essex – General Practice (G.Ps)
Joni Thompson	Open Road
Lynn-Britt Brown	South Essex Partnership University NHS Foundation Trust, Community Drugs and Alcohol Service (CDAS)
Sue Waterhouse	South Essex Partnership University NHS Foundation Trust, Mental Health Services (MHS)
Tracy Vallis	Westminster Drugs Project (WDP)
Lorraine Brown	Basildon Borough Council (Advisor to DHR)
Paula Mills	Basildon Borough Council (Advisor to DHR)

2.3 Time Period

The time period under review is 1/2/2009 to 3/9/2012 but agencies were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dates 1/2/2009.

It was determined that agencies had very limited contact with the victim, but complex relationships with the perpetrator and there was a continual and significant relationship between one agency and the perpetrator from early 2009 until just weeks before his death.

2.4 Contributing agencies

The CSP contacted and advised local agencies of the establishment of the DHR, with a request that they identify whether they had contact with either the victim or the perpetrator. Those agencies that identified involvement were asked to secure their records.

The agencies that had involvement with the victim or perpetrator during the review period were asked to submit both a chronology, and an Individual Management Review which:

- allows the agency to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made;
- identifies how those changes will be brought about; and
- identifies examples of good practice.

Agencies that contributed to the DHR, including those who provided expert advice or scrutiny, and the nature of their contribution is identified in the following table.

Name of Contributor	Chronology	IMR	Other	Comment
Basildon and Thurrock University Hospitals NHS Foundation Trust	Y	Y		Only contact with perpetrator during review period
Basildon Borough Council	Y	Y		
Basildon Women's Aid			Independent scrutiny	
East of England Ambulance NHS Trust	Y	Y		Only identified contact was 3/9/2012
Essex County Council Adult Health and Community Wellbeing	Y	Y		Only contact with perpetrator on 28/7/2012 and with victim as his next of kin on the same day
Essex County Council Schools, Children and Families	Y		Letter	
Essex Drugs and Alcohol Team (EDAAT)			Expert opinion	
Essex Police	Y	Y		
Essex Probation	Y	Y		Contact between 27/10/2010 – 26/10/2011 with perpetrator
Family Mosaic	Y	Y		Only contact with perpetrator
HM Coroner, Essex			Transcript of the Inquest proceedings on 27/3/2013	
NHS South Essex (G.P.s)	Y	Y		
Open Road	Y	Y		Only contact with perpetrator
South Essex Partnership University NHS Foundation Trust (SEPT) Community Drugs and Alcohol Service	Y	Y		Involvement with perpetrator, contact with victim as his next of kin.
South Essex Partnership University NHS Foundation Trust (SEPT) Mental Health Services	Y	Y		Only contact with perpetrator
Westminster Drugs Project	Y	Y		Only contact with perpetrator, between 27/10/2010 – 26/4/2011

2.5 Terms of Reference

2.5.1 Purpose of the DHR

DHRs are not inquiries into how the victim died or into who is culpable. These are matters for coroners and criminal courts to determine. Nor are DHRs specifically part of any disciplinary enquiry or process, as such the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working:
- Prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

2.5.2 Specific Terms of Reference

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim, or perpetrator, subject to a MARAC?
- Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Had the victim or alleged perpetrator disclosed to any practitioner or agency and if so was the response appropriate? In particular was the victim or alleged perpetrator subject to a MARAC or MAPPA?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered, or provided, or relevant enquiries made in the light of the assessments, given what was known or should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of the options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Are there any particular factors relating to the homicide which will require specialist input to assist in the review panel's deliberations, i.e. drug and alcohol misuse by the victim and alleged perpetrator?

- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

2.6 Subjects of the Review and Others

Dorothy	White British 70+ years, victim, body found 3/9/2012
Billy	White British 30+ years, perpetrator, body found 3/9/2012
John	White British, ex-long term partner of victim and father of perpetrator, died 26/7/2011
Saskia	White British 50+ years, daughter of victim
Sarah	White British 30+ years, ex-wife of perpetrator
Paul	White British 30+ years, eldest son of victim.

The Independent Chair / Author contacted and interviewed Saskia by telephone as she lives abroad, and met with Sarah at her home. The Chair also interviewed the vicar of the church that the victim attended during the last year of her life, the victim's sister and one of her neighbours. All were very receptive and open in their responses and provided significant context to the events and considerable background information. .

3. Family Background

Dorothy was born in 1933 in East London. Dorothy married in the 1950s and gave birth to a daughter, Saskia. According to Saskia, her father was an alcoholic and gambler and spent much of his time in the pub. When she was in her early teens Saskia remembers her father left and moved back in with his first wife. Saskia's parents divorced in 1973.

Saskia remembers that after about a year Dorothy started a long term relationship with John, who the family believes was an alcoholic, and Dorothy became pregnant. Soon afterwards John moved in with Dorothy and Saskia, and Saskia became witness to his abusive behaviour from the very first day when he threw his dinner at the wall. He also was alleged to have assaulted Dorothy while she was pregnant.

Dorothy gave birth to two sons, Paul in 1974 and Billy in June 1975. John and Dorothy never married but she took his name. Their relationship is alleged to have been extremely violent and at times Dorothy suffered injuries. Dorothy's sons were witnesses to the abuse. Saskia

explained that when the boys were younger they would hide under the bed, and Billy was enuretic during the assaults.

No incident of domestic abuse between Dorothy and John was reported to the Police. Dorothy would always say to her daughter and her sister that she loved John and could not support the boys alone so she could not leave him.

It is understood that in the early 1990s Dorothy won £1.25 million on the football pools. She gave large sums of money to each of her children. In 1999 Dorothy separated from John and purchased the property where she was eventually killed. Dorothy continued to do John's cleaning, washing and ironing despite the fact that they had separated and were no longer living together.

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It is understood that by 1999 both of Dorothy's sons were addicted to heroin. The pools money made it possible for them to spend large amounts of money on illicit drugs. Billy had four drug treatment episodes between 2002 and 2007 and had been an in-patient in two residential drug treatment programmes both in 2006. Billy's expressed wish was to be abstinent from drugs and he had periods of abstinence but he also had frequent relapses.

Billy met his ex-wife, Sarah, in 1998. She had children from a previous relationship and they also had children together. They separated, and later divorced, while both were in residential rehabilitation units in 2006. The children had been placed in foster care in 2006. Billy applied to have all four children returned to his care in 2007, and it was decided that one child be returned to his custody. This child was removed in late 2009 due to Billy's illicit drug use that year. All the children were returned to the care of their mother in 2009. Difficulties over child contact were reported by Billy as a constant source of concern for him from 2009 until his death.

It is understood that around Christmas 2010 John started to become unwell and in March 2011 he was diagnosed with cancer of the gullet and liver and he moved into Dorothy's home so that she could take care of him. John died at the end of July 2011.

Billy was later to say that his father's death was when things started going downhill for him and he started using heroin again. The information provided to the DHR shows that Billy started to exhibit bizarre and worrying behaviour in January 2011, shortly after his father became ill. Billy was subject to mental health assessments on 16/2/2011, 9/3/2011, 23/12/2011 and 28/7/2012 but was not diagnosed with a formal mental health illness.

By the end of her life Dorothy was receiving financial aid from the local church. Billy had been living with her since early June 2012, although he had not given up his tenancy. He was not receiving any benefits. Her eldest son was in prison.

It would appear that Dorothy was a complex character, with a long history of domestic abuse. After her marriage ended she started a long term relationship that was violent and abusive and she was unable to break away from that partner even after they had separated. Dorothy enabled the drug use of her sons and is not known to have challenged them to stop taking drugs. Most of the people who knew her recognised that Dorothy needed to be needed. They say that she did not listen to the advice of others and believed that she could save her sons and that they needed her. In the last few months of her life Dorothy resisted the attempts made by the family to take Billy into hospital, saying that she could look after him and that he just needed his Mum.

4. Agency involvement with the victim and perpetrator

4.1 Agency involvement with the victim

From the early meetings of the DHR Panel it became clear that agencies had limited contact with the victim and there was no evidence of circumstances that would suggest an abusive relationship between the victim and the perpetrator. In addition, no family members believed that there was an abusive relationship between the two until the time of this tragic event.

According to the evidence submitted to the DHR, there was very little agency contact with Dorothy during the DHR review period. Dorothy's G.P. was prescribing a number of different medications and the IMR confirms that she was seen regularly but the only identified contact was in August 2011, immediately following the death of her ex-partner. There are no records that Dorothy raised any concerns for her safety.

The DHR evidence suggests that Dorothy was unlikely to have raised concerns herself, but that at 79 years old and with both sons being drug addicts, that she may have needed support.

There is no evidence presented to the DHR that would suggest a safeguarding referral was made.

Dorothy was seen regularly by the Council's Refuse Driver, and had some contact with the Council's Revenue and Benefits regarding payment of Council Tax. No concerns were raised at any time regarding her safety, although the Council has noted that Dorothy's financial difficulties could have triggered a safeguarding query.

There is no evidence of an abusive relationship between Dorothy and Billy and it is therefore unlikely that a safeguarding query would have identified concerns for Dorothy's safety or that she was at any risk from her son.

Council officers made site visits to Dorothy's property to check on the status of the annexes at the rear of the property. No concerns for Dorothy were raised during any of the site visits.

Essex Police received a report of a domestic incident at Dorothy's home address in July 2010. Despite being identified as the victim Dorothy refused to make a complaint and reported that the suspected perpetrator, an unrelated male, was helping rather than causing a problem.

In early January 2012 the Police provided advice to Dorothy regarding the eviction of the same male, now identified as a lodger. On 2/6/2012 the Police had contact with Dorothy as Billy's ex-wife had reported him as a missing person and he had returned to his mother's address later that evening. The Police attended the property the next day and spoke to Billy. They had no concerns for Dorothy's safety at that time.

The tables on the next two pages summarise the agency involvement with both victim and perpetrator during the DHR review period. The following is the key to agencies included in Table 2 outlining agency involvement with the perpetrator.

<u>Key to Agencies</u>

1. Basildon and Thurrock University Hospitals NHS Foundation Trust
2. Basildon Borough Council
3. East of England Ambulance NHS Trust
4. Essex County Council, Adult Health and Community Wellbeing
5. Essex County Council, Schools, Children and Families

6. Essex Police
7. Essex Probation
8. Family Mosaic
9. NHS South East Essex
10. Open Road
11. South Essex Partnership University NHS Foundation Trust (SEPT), Community Drugs and Alcohol Service
12. South Essex Partnership University NHS Foundation Trust (SEPT), Mental Health Services
13. Westminster Drugs Project

Table 1 - Summary of Agency Contact with the Victim 2009 - 2012

Year	Month	Basildon Council	Ambulance Service	ECC Adult Care	Police	G.P.
	September					
	August					
	July					
2	June					
0	May					
1	April					
2	March					
	February					
	January					
	December					
	November					
	October					
2	September					
0	August					
1	July					
1	June					
	May					
	April					
	March					
	February					
	January					
	December					
	November					
	October					
2	September					
0	August					
1	July					
0	June					
	May					
	April					
	March					
	February					
	January					
	December					
	November					
	October					
2	September					
0	August					
0	July					
9	June					
	May					
	April					
	March					
	February					
	January					

Table 2 - Summary of Agency Contact with the Perpetrator 2009 – 2012

		1	2	3	4	5	6	7	8	9	10	11	12	13
	Sep													
	Aug													
	Jul													
2	Jun													
0	May													
1	Apr													
2	Mar													
	Feb													
	Jan													
	Dec													
	Nov													
	Oct													
2	Sep													
0	Aug													
1	Jul													
1	Jun													
	May													
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	Mar													
	Feb													
	Jan													
	Dec													
	Nov													
	Oct													
2	Sep													
0	Aug													
1	Jul													
0	Jun													
	May													
	Apr													
	Mar													
	Feb													
	Jan													
	Dec													
	Nov													
	Oct													
2	Sep													
0	Aug													
0	Jul													
9	Jun													
	May													
	Apr													
	Mar													
	Feb													
	Jan													

4.2 Agency involvement with the perpetrator

Considering the breadth and complexity of agency relationships with the perpetrator, the DHR Panel agreed to consider the information submitted by agencies in relation to known risk factors in the life of the perpetrator.

The starting point for the analysis was the DASH risk assessment tool which contains questions about known risk factors for serious harm including:

- Regarding the Victim:
  - Injury to victim
  - Victim's fear / fear of violence
  - Social isolation of victim
  - Depression / suicidal ideation of victim
  - Pregnancy / recent birth of baby
- Regarding the Relationship:
  - Recent separation
  - Conflict over child contact
- Regarding the Abuse:
  - Stalking / harassment
  - Escalation of frequency or severity of incidents
  - Use of weapons
  - Threats to kill
  - Attempts to strangle / choke
  - Sexual abuse
  - Other people threatening the victim
- Regarding the Perpetrator:
  - Controlling behaviour of perpetrator
  - Violence towards others / abuse of family pet
  - Financial issues
  - Drugs / alcohol / mental health
  - Threats of suicide / suicide attempts
  - Broken bail / formal agreement including non-molestation order
  - Trouble with the Police or criminal history

In order to full understand Billy's relationships and engagement with agencies, the information has been considered in regard to his role as a domestic abuse perpetrator and the indicators of serious harm which are listed as part of the DASH, specifically:

- Domestic Abuse
- Criminal History
- Violence
- Use of Weapons
- Financial and Housing Difficulties
- Drugs / Alcohol / Mental Health

4.2.1 Domestic Abuse

Billy assaulted Sarah, his ex-wife, for the first time, on 6/1/2011 when he got her in a headlock. On 11/1/2011 he was served with a non-molestation order which he breached that day. He was arrested and taken to court where he pleaded guilty to the breach of non-molestation order and not guilty to the assault charges. Billy was convicted of the breach in May 2011. The assault charges were dropped. These incidents were assessed as medium risk in a skeleton assessment as Sarah declined to provide information to complete the DASH.

Sarah reported an incident of suspected harassment in early February 2012. This was assessed as standard risk.

Sarah reported an assault by Billy with threats to kill on 23/6/2012. A DASH was completed, with Sarah's assistance, the following day and assessed as medium risk. The DASH included reference to the threats to kill but referred to them as historic rather than current. No further action was taken against Billy.

Analysis

Essex Police have identified weaknesses in the inputting of the data following the January 2011 incidents. Since that time internal processes have been improved as a result of previous DHRs.

The actions of Essex Police officers have been subject to an internal investigation following a complaint by Sarah, and appeal proceedings by the IPCC. As a result of their investigation the IPCC have identified a number of lessons and actions that need to be addressed by Essex Police, including that more proactive action should have been taken against Billy, who was known, by Essex Police, to be a "very dangerous man". They also identified learning related to the unsatisfactory completion of the DASH which in this case may have affected the risk assessment.

The DHR Chair is concerned that the threats to kill were not recorded as current and that the risk assessment level was probably incorrect. If the incident had been assessed as high risk it would have led to a MARAC referral, which may have enabled information about Billy and his activities to be shared, which may have alerted other agencies to what now appears to be escalating risk.

Several agencies were aware of the domestic abuse incidents in early 2011 but only the Police were aware of the incidents in February and June 2012.

The Essex Probation IMR identified that there was no record of liaison between Offender Managers and the Police during the course of Billy's supervision. It is expected that routine enquires will be undertaken by Offender Manager but there are no records that this occurred which resulted in Probation Officers being unaware of intelligence being held by the Police particularly in relation to weapons.

4.2.2 Criminal History / Activities

Billy had a criminal record which included:

- 2 offences against property in 1996;
- 1 public order offence in 2001;
- 2 offences against the person (different people) in 2008 and 2011;
- 2 offences relating to Police / courts / prison in 2010 and 2011;
- 2 drug offences in 2010; and
- 1 offence relating to firearms / shotguns / offensive weapons in 2010.

During the DHR review period Billy was arrested 7 times; for the possession of cocaine, heroin and a bladed knife; for assault on a 15 year old youth; for shoplifting; after an affray in the street with his neighbour; when a search warrant for firearms was executed at his home address; for being drunk and disorderly; and for an assault on his ex-wife, followed by the breach of a non-molestation order.

Billy was also recorded as the perpetrator in a second assault on his ex-wife that did not result in his arrest and the perpetrator in a reported incident of harassment against his ex-wife.

On 13/1/2011 when Billy was arrested at his home for the first assault on his ex-wife, one of the attending officers noted there was a machete concealed in a leather sheath left on top of the radiator behind the front door which would provide immediate use by the occupier.

Analysis
Billy's criminal record, or at least elements of it, were known by a number of agencies, if Billy self reported the offences to them. Only the Police and Probation knew his full criminal record. Only the Police were aware of the intelligence they had recorded.

4.2.3 Violence

During the period of this review Billy was arrested and charged with several violent offences, including the domestic abuse offences.

At his initial assessment with Community Drug and Alcohol Services in May 2009 Billy reported he had the potential to be physically violent, particularly towards men when he thinks/feels that he is being threatened.

On 2/11/2010 Billy was arrested for an assault on a 15 year old youth. He was charged with common assault, found guilty and convicted on 7/1/2011. He had to pay costs of £85, compensation of £100 and was given a restraining order until 6/1/2012.

In the first few months of 2011 Billy told several agencies that he was in danger of hurting himself or someone else, even killing them, because of how he was feeling, that he was "boiling inside" and "full of rage".

On 22/12/2011 Billy was arrested after an affray in the street which resulted in both Billy, and his next-door neighbour, being treated for stab/slash wounds. The Police investigation was unable to determine who owned the knife, or who started the altercation. Both men required treatment, and the neighbour was detained in hospital due to a stab wound to the stomach. The Police supported Family Mosaic's decision to move the neighbour and his family away from the area immediately. A file for Grievous Bodily Harm (GBH) was submitted to the Crown Prosecution Service who concluded that there was insufficient evidence and no charges were brought against either male.

Analysis
As above, most agencies were only aware of Billy's self reporting. The Police were aware of all the incidents, as were Probation while Billy was under their supervision.

Essex Police have identified that if their Potentially Dangerous Persons Policy had been actively in use at this time, then it is possible that there could have been consideration of its use after the incident in December 2011.

4.2.4 Use of Weapons

In 2001 Essex Police searched Billy's home looking for a shotgun but no firearms were found. In August 2008 Billy was spoken to by an officer as he was seen carrying an air rifle.

On the 30/9/2010 Billy was arrested for possession of heroin, cocaine and a bladed lock knife. He was later convicted.

On 13/1/2011 Police officers attended Billy's address to arrest him for the assault on his ex-wife. Officers noted a machete was concealed in a leather sheath on top of the radiator behind the front door which would provide immediate use to the occupier.

Billy's home address was searched on 8/3/2012 after intelligence was received that he was in possession of a sawn off shotgun. No firearms were found and no further action was taken. Since the murder, Billy's ex-wife and his brother have both reported knowledge of Billy's illegal firearms, while other members of the family knew about his interest in guns but were unaware that he owned any firearms.

Analysis
Probation and WDP were aware of Billy's conviction for carrying a bladed lock knife. Billy self reported his conviction to Family Mosaic. Only the Police were aware of the intelligence regarding firearms and the machete by Billy's front door.

The Essex Probation IMR identified that there no were records suggesting regular liaison between Police and Offender Managers, resulting in Probation officers being unaware of intelligence held by the Police, particularly regarding weapons.

4.2.5 Financial and Housing Difficulties

Billy moved into his home in November 2007 with one of his children.

Billy had a history of non-payment of his Council Tax and over-payment of benefits due to changes in his circumstances not being notified to the Council, and various legal proceedings.

There are records of written correspondence relating to rent arrears of £784.50 between Billy and Family Mosaic in early 2009. The first significant contact was in February 2011 when a letter was sent to Billy advising of rent arrears due to an overpayment of Housing Benefit of more than £1,000. Contact was finally made with Billy in late July 2011 after numerous attempts by the Family Mosaic Incomes Officer. Billy was referred to the Welfare Officer but did not keep his appointments and a court application for a Notice Seeking Possession was made in late August 2011.

Billy provided bank statements in late August and self referred to the Floating Support Service in mid September asking for help.

Billy's benefits were stopped on 2/2/2012. Billy did not respond to attempts to contact him until 5/4/2012 when he advised that he would resolve the situation. Billy did not make contact and on 27/4/2012 Family Mosaic wrote to him to advise that they were planning to start court proceedings as his rent arrears were £1,062.50 as at 22/4/2012.

On 11/5/2012 Billy made contact after a card had been left at his house. Billy advised he was waiting on the outcome of a claim for Employment Support Allowance. Billy was asked to keep the officer updated. No further contact was noted.

A court application was made on the 19/6/2012 and a court letter was sent to Billy. On 25/6/2012 Billy made contact with Family Mosaic and advised that all of his benefits had been stopped. He was advised to make a fresh claim for benefits. He was referred to the Welfare Rights Advisor but he did not respond to attempts to contact him and he was advised in writing that he needed to make contact by the end of July 2012 or his case would be closed. No response was received from Billy so the case was closed at the end of July 2012.

On 25/6/2012 Billy also contacted the Family Mosaic Customer Care Line (CCL) and asked for a transfer from his property because it had a lot of bad memories for him. He stated that his child used to live with him there and he had a heroin relapse and his child was taken away. His neighbour tried to stab him. The officer tried to call him back but could not contact him.

During July 2012 many attempts were made to contact Billy but with no success. The court protocol letter was sent to Billy on 17/7/2012 advising that the court hearing was set for the 3/8/2012 and that Family Mosaic were seeking possession due to rent arrears of £2,328.26.

On 3/8/2012 Family Mosaic obtained an outright possession order granted on discretionary grounds. Possession of the property was to be given to Family Mosaic by 17/8/2012. The court outcome letter was sent to Billy on 9/8/2012.

On 13/8/2012 Billy spoke to the Incomes Officer who asked the Welfare Officer to re-open the case and see Billy on the 14/8/2012.

Billy attended on 14/8/2012 and the officer noted that he didn't seem too stressed about anything apart from his benefits. The Welfare Rights Officer supported Billy in making a new claim on-line. Billy was advised to take his original documentation to Housing Benefit to complete the claim. Billy said that he was also having problems with his ESA as it was not being paid. The officer offered to find out the current situation.

The officer advised Billy to get his Housing Benefit claim resolved, otherwise he would lose his home. Billy and the officer agreed the next steps and Billy left the office.

Billy contacted the officer on 24/8/2012 and made an appointment for that day but failed to attend. No further contact was made.

Analysis

Family Mosaic offered Floating Support services to Billy as a result of his complex needs related to his drug addiction. They followed their policies when closing his file after he missed three appointments. Family Mosaic has addressed the need to increase their efforts to maintain engagement for those clients with chaotic lifestyles who struggle to engage consistently within their recommendations.

Basildon Council was aware that Billy's benefits had been stopped.

Billy self reported to CDAS that he was experiencing social, personal, financial and benefits issues that were problematic to him when he attended on 19/4/2012 and reported that he had relapsed and was injecting heroin into his neck.

4.2.6. Drugs / Alcohol / Mental Health

It is understood that Billy had a long history of using illicit drugs and was self harming at the age of 14. He had tried cannabis when he was 13 years old, started heroin at 19 and was injecting heroin by 23. According to Paul the pools money enabled the brothers to spend up to £500 per day on illicit drugs. Billy reported his alcohol use to be social and not problematic.

Prior to the DHR review period Billy had four episodes of treatment, between 2002 and 2007, with the Community Drug and Alcohol Service (CDAS) and had been an in-patient in two residential drug treatment programmes both in 2006. Billy was in continual care with CDAS from 1/5/2009 until 25/6/2012 when he discharged himself stating that he was abstinent.

At his initial assessment in May 2009 CDAS recorded that Billy had relapsed, using heroin every day for three weeks and occasionally smoking crack cocaine but he denied any injecting behaviour. Billy stated that he wanted emotional and psychological support to get insight into self destructive patterns of behaviour and he asked for a referral for counselling.

Billy also self referred to Open Road at the same time. During the DHR review period Billy had four treatment episodes with Open Road, some were more successful than others. At times

he struggled to maintain attendance and his case was closed, in line with their policies. He attended counselling sessions in 2009 and the Structured Day Programme in 2010 and 2011. Billy accessed some ear acupuncture sessions and contacted the drop-in centre for advice periodically.

Billy completed an assessment for the Basildon Needle Exchange, delivered by Open Road, on 13/4/2011. He accessed the Needle Exchange another 19 times through to June 2012. Billy attended the Open Road Needle Exchange on 19/6/2012, 26/6/2012 and on 29/6/2012 when staff were so concerned about the frequency of his use that they asked him to discuss his increased usage with his CDAS Care Coordinator. They were unaware that Billy had been discharged by CDAS on 25/6/2012 stating that he was abstinent. This was the last time he was seen at the Needle Exchange.

The following text provides a brief summary of the many chronology entries between 1/2/2009 and 3/9/2012. There are periods of intense activity and concern and these have been highlighted.

September 2009 – Diazepam prescription

The G.P. prescribed diazepam to Billy in September 2009, originally for back pain but Billy was later (7/4/2011) to report that he took it for very bad rages, *so bad that he could hurt someone or even kill them*. Billy also reported bingeing on the drug to other agencies, although it is not known whether the G.P was aware of his behaviour.

Analysis

Billy received a number of warnings about the use of diazepam from his G.P. and CDAS and he was advised to reduce his dose and not to binge on it.

There is no information about contact between CDAS and the G.P. regarding Billy's use of diazepam, and his reported binges on it. CDAS appear to have been unaware that Billy was already being prescribed diazepam by the G.P. when, on 28/2/2011, the CDAS Consultant Psychiatrist prescribed it, albeit just for one night.

The Essex DAP Service Contract between Essex County Council and SEPT states "The service must communicate clearly with clients' G.P. G.P. must be notified on commencement and at regular interval if a prescription is issued to a client.".

October 2009 - Removal of child

Billy's child was removed from his care in October 2009, which according to Children's Services was directly related to his drug use at that time. Immediately after the removal of his child, Billy asked for a residential detoxification and admitted use of heroin and crack cocaine. He completed the medical detoxification, and at his request was discharged two days early. Two days later he was diagnosed with swine flu by his G.P. He later admitted to relapsing within one week of discharge and on 25/11/2009 a CDAS doctor prescribed an alternative 12 week treatment programme. Later, (on 3/3/2011) he told the SEPT Duty Psychiatrist that he had a breakdown after his child was removed.

Analysis

Billy was admitted to a residential detoxification programme shortly after making his request. However he was unable to remain abstinent after his discharge. There is no information as to other structured psychosocial interventions that were being offered to him at what was clearly a very difficult time for him, following a significant life event.

CDAS were aware that his child had been removed from his care.

2010 – Drug overdoses

Billy overdosed twice during 2010. The dates have not been reported but an entry in the CDAS chronology on 28/2/2011 suggests that one overdose was in May 2010. It is not known whether these were accidental or intentional overdoses. No other agencies appear to have been aware of these overdoses.

During May 2010 the courts removed the care orders from all the children and confirmed that custody lay with their mother. Contact would be determined by her, and denied if Billy was under the influence of drugs or alcohol. It is clear that contact with his children was an on-going problem for Billy for the rest of his life, and he mentioned his concerns to several agencies.

October 2010 – Start of Probation / WDP supervision

Billy was subject to 12 months supervision by Essex Probation and a 6 month Drugs Rehabilitation Requirement (DRR), supervised by Westminster Drugs Project (WDP), starting on 27/10/2010 after being arrested for possession of heroin, crack cocaine and a bladed lock knife on 30/9/2010.

Analysis

Billy's compliance with the DRR was above average, with only 8 missed appointments during the 6 months, and his drug tests were often negative. The WDP records indicate that Billy built a relationship with his practitioner and was more open with them about the challenges he was facing in his life, than is reflected in the records of some other agencies. The DRR expired at the point where Billy's father had been diagnosed with a terminal illness and was expected to live only a few weeks. It was noted in their records that Billy was emotional at the last session on 26/4/2011.

Billy was breached by Probation in May 2011 following a period of disengagement.

Concerns for Billy's mental wellbeing – January 2011 – July 2011

The first reports of bizarre behaviour were on 27/1/2011 when Billy attended Probation and claimed that an "agency" was visiting him and he thought that they wanted to kill him. His drug tests were negative. On the same day he told WDP that people were following him and that they were actors who wanted him to work for them. The WDP officer recorded that his presentation was "allusive" and he "appeared to be psychotic".

On 31/1/2011 Billy attended the local Accident and Emergency Department stating that he was unwell and believed that his father and brother were spiking his food or drink. He attended the department four times between 31/1/2011 and 5/4/2011. On 3/3/2011 he was referred on to the SEPT Duty Psychiatrist; he left without treatment on 31/3/2011; and claimed his legs kept giving way on 5/4/2011.

Probation referred Billy to the Criminal Justice Mental Health Team (CJMHT) on 31/1/2011. The outcome of the mental health assessment completed on 16/2/2011 was that Billy was floridly psychotic and expressing bizarre ideas. It was noted on the assessment that his history indicated "impulsive suicide attempts" but that he denied thoughts of suicide at that time.

During the assessment Billy reported feeling angry and stated that he was a danger to others due to what was happening to him. The risk assessment highlighted a risk to his ex-wife, and potentially to his children depending on his mental state when he had access. The assessor did not consider it appropriate to request an admission to hospital under the Mental Health Act at that time, although this decision is not explained within the MHS IMR.

It was concluded that Billy required an urgent review by a CJMHT Consultant Psychiatrist, which was conducted on 21/2/2011. The doctor concluded that Billy was "clearly mentally

unwell, paranoid and probably psychotic". He told Billy that he needed a low dose of anti-psychotic medication and that either the CDAS Consultant Psychiatrist or the G.P. could prescribe it for him. The MHS IMR does not outline whether Billy was advised of the process for the prescription to be provided to him, or how long he was told he would need to wait.

No contact was made with Billy for one week, although discussions were on-going between CDAS and CJMHT as to which agency would provide a prescription to Billy. On 28/2/2011 Billy contacted CJMHT and threatened to hurt himself or others if he did not get the help that he needed. CJMHT contacted CDAS as Billy was open to them and an emergency medical review was scheduled in CDAS for that afternoon.

Billy was seen by the CDAS Consultant Psychiatrist who assessed that there was no evidence that Billy was mentally unwell. Billy was considered to be cooperative, clear and lucid with good insight, no psychosis and no plans for self harm or aggression and he had said "I just want to be left alone". The doctor prescribed diazepam for one night and advised that Billy be reviewed the next day by CJMHT.

The CJMHT Team Manager also completed a short assessment on Billy later in the afternoon and concluded that he was predominantly angry, but that further follow up should occur due to his different presentations. During the assessment Billy reported that people mimic his behaviour and follow him around, but denied any other symptoms and he said he wanted help with his anger. He was advised to go to Accident and Emergency if he felt unwell and that he would be contacted by CJMHT the next day for follow up.

Billy took an overdose of amitriptyline and heroin that night and was not seen by any professionals until 3/3/2011. CJMHT made several attempts to contact Billy by telephone and eventually left a voicemail message with details of an appointment for him on 2/3/2011 at 12.30p.m., which Billy did not attend.

On 3/3/2011 Billy attended CDAS, WDP and Probation. He reported that he was "full of anger" and could hurt himself or someone else. He reported feeling unwell and CDAS agreed with Billy that he would attend Accident and Emergency in order to access the SEPT Duty Psychiatrist.

Billy presented to the SEPT Duty Psychiatrist with suicidal thoughts, feelings of exploding because there was a lot happening to him and he said that he may hurt someone. Billy said that he had not been able to control his rages since the age of 15 and he did not want to hurt anybody. He said he had a breakdown when he lost custody of his son and said that one minute he was crying and getting angry and then he feels numb afterwards. Billy stated that he has flashbacks of his father physically abusing his mother, of being bullied as a child, his experience of being beaten up in prison and stabbing.

The SEPT Duty Psychiatrist diagnosed anger and depression and recommended that Billy make an appointment to see his G.P. for treatment.

The following day, 4/3/2011, Billy told CDAS that his G.P. had prescribed diazepam and citalopram with a referral to anger management, psychotherapy and Improved Access to Psychological Therapies (IAPT). Billy was advised about the risks associated with diazepam and its prolonged use and dependency and caution was advised.

On 8/3/2011 Billy had made threats to his Offender Manager that he would harm himself or others if he did not get help. The Offender Manager reported these threats to CJMHT. On the same day, and also reported to CJMHT, Billy telephoned the SEPT Contact Centre asking to be admitted to hospital. CJMHT contacted him and offered him an appointment on 9/3/2011.

CJMHT completed a second mental health assessment on Billy on 9/3/2011. The two practitioners agreed that he did not present with any psychotic symptoms; that it was predominantly anger and substance misuse issues; and that Billy appeared to be preoccupied with getting more prescribed medication. A discharge letter was sent to Billy's G.P. informing him of the outcome of the CJMHT assessment, and requesting a referral for anger management. CJMHT closed their case file on 9/3/2011.

The MHS IMR reports that the psychotic symptoms described at the initial assessment could have been induced by illicit substances (drug induced psychosis). They state "It is the case that whilst under the influence of illicit drugs a person can experience similar psychotic symptoms to those who suffer from a formal mental illness like schizophrenia. The psychotic effect only lasts until they cease the drugs and the chemical substance is out of their system. The person will then often present with normal behaviours. However if they were to use the drugs again there is a possibility the symptoms will re-occur." No diagnosis of drug-induced psychosis was recorded at the time.

On 10/3/2011 Billy told his Offender Manager that CJMHT had told him that he had a personality disorder but was not mentally ill. He repeated this diagnosis to agencies in the following months.

The evidence submitted to the DHR suggests that Billy remained very volatile in the next few weeks. For example, on the 10/3/2011 he expressed an interest in a period in drug rehabilitation, while on the 17/3/2011 he reported to Probation that he "feels like he is boiling inside" and he had "tried to provoke an incident with his neighbours recently".

Billy had completed a self assessment form for Therapy for You, which the G.P, had given him on 4/3/2011, and which was received by the IAPT service on 14/3/2011. An assessment was carried out by a High Intensity Therapist on 22/3/2011 and Billy was accepted into the service.

Following Billy's appointment with his G.P. on 4/3/2011 the G.P. had also written to the SEPT Clinical Advisory Service (CAS) with the following request:

"*Kindly see and advise Billy for psychotherapy. He tells me he feels as if he is on the verge of self harming or harming others – he has taken the Therapy for You pack to refer himself for counselling but I think also he would benefit from your assessment regarding his feelings of anger and harm. Thank you. "*

It is clear from the G.P.'s IMR that Billy's G.P. Considered that once Billy was being seen by the mental health team and CDAS, that it was their responsibility to deal with this aspect of his care. It would appear that the G.P. was not advised of the outcome of the referral he made to CMHT, and he assumed that Billy had been accepted for treatment. The DHR Is unaware of any further actions taken by the G.P. When Billy repeated his claim that he may hurt someone or even kill them one month after this referral was made.

The MHS IMR states that the letter was discussed at their team meeting on 24/3/2011 and was redirected to CDAS as Billy was already receiving services from them. CAS closed the file without assessment. The MHS IMR acknowledges that an assessment should have been undertaken at this time, in line with the SEPT Dual Diagnosis Policy. CDAS arranged a medical review for Billy after their receipt of the letter from his G.P. Billy's G.P. was not advised of the decision to close the referral without an assessment.

On 23/3/2011 Billy told his Offender Manager that he wanted help with his "illness" and that he had lied to mental health practitioners in the past.

On 28/3/2011 Billy attended a medical review at CDAS and admitted to using heroin to top up his methadone, and that he was bingeing on diazepam. The review recorded no physical or mental health concerns. The discussion included tolerance to drugs, the risks of long term use of diazepam and the risk of overdose and the depressant effect on the central nervous system of all the drugs being taken. Billy was advised to gradually withdraw from diazepam, to cease all illicit drugs and his methadone dosage was increased to 40mls daily with a review in one week to increase it to 50mls if necessary.

On 30/3/2011 Billy attended his G.P. and was diagnosed with an anxiety disorder. He was again warned about the risks of taking diazepam.

A referral form for counselling within CDAS was completed on 5/4/2011, and it was agreed that counselling would be available to Billy when he was stable on his treatment plan. At that time CDAS did not generally provide counselling services but they made an exception in Billy's case. However, Billy had previously advised them of his G.P's referral to IAPT on 4/3/2011 which was also being progressed.

Billy was assigned an IAPT therapist in mid May and his first appointment was scheduled for 10/6/2011. However Billy started his counselling sessions with CDAS on 3/5/2011 and he cancelled the Therapy for You session. .

Billy started counselling sessions at CDAS on 3/5/2011. He identified the emotions of anger and rage as the most prominent issues and he wanted to be able to understand these and the relationship with his life. Billy missed some counselling sessions during May and June and became drowsy during a session on 4/7/2011. He admitted to doubling his antidepressants due to his father's illness and child contact difficulties. This was the last session he attended.

Billy was also seen by his CDAS Care Coordinator on 4/7/2011. This was the first time he had seen this particular officer whose role was to coordinate Billy's care plan since January 2011.

Analysis

The CDAS and MHS IMRs recognise that the Dual Diagnosis Policy should have been triggered in Billy's case. In addition a multiagency meeting could have been arranged under the CPA approach. There appears to have been ineffective communication between CDAS and CJMHT relating to the provision of care for Billy.

The CDAS IMR notes that the mental health assessments undertaken on Billy drew different conclusions regarding a confirmed diagnosis and treatment plan. It states that "This is not by any means unusual with mental presentation, however, it may have been useful within the context of CPA to have arranged a multidisciplinary / multiagency meeting. " There is no explanation as to why a meeting did not take place.

The CJMHT IMR reports that it was considered that Billy may be suffering from "drug-induced psychosis", which could return if Billy continued to use illicit substances. This diagnosis was not recorded in his case notes at the time, nor was Billy advised. There is no evidence of actions to manage the risk to Billy or others if Billy was to have a re-occurrence. The second half of 2011 proved to be a more stable time for Billy but by April 2012 he had reported a serious relapse of his use of heroin.

The DHR has noted that Billy first started presenting with bizarre symptoms on 27/1/2011 and was still presenting with symptoms suggesting psychosis on 21/2/2011. Seven of the WDP twice weekly drug tests were conducted in February 2011, two provided a positive result for opiates. There is no explanation in the MHS IMR relating to these contradictions and their relevance to the diagnosis of drug induced psychosis.

Other agencies have also reported a lack of liaison and communication problems between themselves and the CDAS Care Coordinator. Probation has reported communication difficulties with CJMHT in early 2011 which they are currently working to address. .

There appear to have been a lack of continuity in Billy's care coordination, with a period, of approximately 6 months, when Billy did not see his Care Coordinator at all. During that time he had two mental health assessments, four attendances at Accident and Emergency, took an overdose, was diagnosed with an anxiety disorder, reported that he had been told he had a personality disorder; had repeatedly stated that he would hurt himself or others if he did not get help; and his father had received a diagnosis of terminal illness.

Changes were made to contracted service provision across Essex in April 2012. Open Road are now contracted as care coordinators for clients in drug and alcohol treatment services. They are responsible for liaison between agencies to ensure that care plans are shared and information is available to all agencies working with a client.

There was a gap of 16 days between the Probation referral and Billy's first mental health assessment, which considering the level of concern and the fact that the client was already in the criminal justice system is worrying. No information was provided to the DHR regarding the number of days expected between referral and appointment.

The gap between the G.P.'s referral to IAPT and the first appointment was longer than expected due to the demand on the service at the time. Billy had started counselling with CDAS before the first appointment had been scheduled. CDAS have confirmed that a recent review of the pathway between CDAS and IAPT has resulted in IAPT now offering sessions on CDAS sites, and referrals being discussed for suitability between teams in advance.

No specific actions appear to have been taken following Billy's overdose on 28/2/2011. There appears to have been a lack of structured psychosocial interventions during 2011 with the exception of the counselling which Billy attended during May and June 2011.

CDAS, CJMHT, WDP and Probation were all aware of concerns for Billy's mental health in early 2011.

<u>26th July 2011- Death of Billy's father</u>
Billy's father died on 26/7/2011. Billy reported his death to CDAS on 3/8/2011.

The CDAS IMR states "High risk trigger events are managed through increased levels of care coordination, increased inter-agency communication and the ... referral to other professionals within the multidisciplinary team. Thus the impact of high risk trigger events is managed not so much via pharmacology but through the care coordination process of psycho-social interventions."

It has become clear during the DHR process that Billy faced a number of difficult life events during the review period. The loss of custody of his child, his father's serious illness and subsequent death, his on-going difficulties over contact with his children all appeared to have caused great concern for Billy. There is some evidence in the CDAS submissions to the DHR that additional psychosocial interventions were put in place, particularly in 2009 – 2010, when Billy was also accessing services at Open Road. However with the exception of the counselling sessions which started in May 2011 there is little evidence of structured psychosocial interventions after January 2011 which appears to have been when Billy was most in need of support.

Probation and CDAS were aware of John's death in July 2011.

September 2011 – Asking for support

On 15/9/2011 Billy self referred to Family Mosaic Floating Support Service. Billy advised that that he was known to CDAS, Open Road, Probation and CMHT, that he was methadone dependent and had a personality disorder. He requested help with a range of subjects including budgeting and benefits, getting back into the community, meeting people, volunteering and possibly wanted help with a referral to mental health services.

On 19/9/2011 Billy contacted the CDAS counsellor and asked to restart the counselling sessions. She advised that she would discuss this request with his CDAS Care Coordinator but there is no information in the IMR reporting additional sessions, the result of the discussion, or the reasons for that decision.

On 26/9/2011 Billy completed an assessment with Family Mosaic Floating Support and Billy reported that he could suffer with anger management issues and that he felt that he would benefit from anger management courses. Billy was placed on a waiting list for floating support. He was advised that there would be a delay in support commencing due to demand for the service.

On 21/12/11 Billy received his first visit from his allocated Floating Support Officer and signed the support agreement with Family Mosaic.

Analysis

There is no evidence that the counselling sessions restarted after Billy's request in mid September.

One of Billy's children moved in with him in early September 2011, and the next few months appear to have been more stable for him.

CDAS were aware that Billy had self referred to the Family Mosaic Floating Support Service.

22nd December 2011 – Mental health assessment following affray in the street

Billy was arrested on 22/12/2011 after an affray in the street when both Billy and his neighbour were stabbed. While Billy was in custody he was referred to CJMHT due to Police concerns about his presentation. The CJMHT CPN contacted CDAS who reported that they had no concerns about Billy's mental health.

Following an assessment the CJMHT CPN concluded that Billy was not suffering from a mental illness; there was no evidence of a thought disorder or any psychotic illness other than "the odd idea of being investigated by the police". Billy denied any thoughts of self harm and stated that he had a split personality where he describes becoming very angry. Billy reported that he felt he needed help for this "split personality" but feels that the support he was receiving from CDAS was important to him.

The CPN discussed the assessment with the Police Sergeant and completed a report for Billy's file so that if he were to be remanded to prison his treatment plan from CDAS would be known to relevant professionals. The CPN highlighted that Billy could be suffering from a personality disorder and if proceeded to court a full psychiatric report may be advised. The CPN did not feel that input from CJMHT was required at that time as he was receiving services from CDAS and his G.P. He was discharged from CJMHT and a letter was sent to his GP.

Analysis

Family Mosaic, CDAS and CJMHT were aware of this incident. It is not known whether Family Mosaic were aware of the mental health assessment that was undertaken on 23/12/2011.

January 2012 – Request for mental health referral
Billy met with his Family Mosaic Floating Support worker on 25/1/2012 and 27/1/2012 and they recorded that Billy was aware that he had a problem with aggression towards others, and they agreed to make a referral to CMHT following his request.

Billy did not attend any further meetings with Family Mosaic Floating Support. The evidence submitted to the DHR indicates that no further action was taken on Billy's behalf, including the referral to CMHT which was not progressed.

Analysis
Family Mosaic has addressed the need to increase their efforts to engage clients with chaotic lifestyles in their recommendations.

March – May 2012 – Non compliance with CDAS treatment / report of relapse
Billy attended CDAS one day late for his appointment on 13/3/2012. His recent urine tests were discussed and he was returned to daily supervised dispensing although the CDAS IMR does not explain the reason for this decision.

Billy attended CDAS on 17/4/2012 reporting that he had missed his prescription for one week. An appointment was made for Billy to see the CDAS doctor on 19/4/2012.

At his appointment on 19/4/2012 Billy reported that he had relapsed and was injecting into his neck. Billy reported social, personal, financial and benefit issues that were problematic to him. The CDAS team doctor considered Billy to be physically fit with full mental capacity and a good level of motivation. Billy denied any suicidal / self harm ideation.

Billy was seen again on 25/4/2012 and he denied any illicit drug use. He stopped collecting his prescribed medication on 26/4/2012. Billy attended CDAS on 3/5/2012 and his urine test was positive for opiates. He was prescribed a different drug treatment programme.

Analysis
There is no evidence of psychosocial interventions in addition to the treatment programme prescribed for Billy. His report that he was injecting into his neck was the most serious relapse he had reported since 2009. No information was submitted to the DHR relating to his overall care plan.

His medical review on 19/4/2012 was his first medical review for a year. Under CPA all clients should be medically reviewed every 6 months. The CDAS IMR states that there is no clinical rationale for the 12 month gap.

By this time Billy had disengaged from all agencies.

May 2012 – Depression
On 18/5/2012 Billy attended his G.P. and reported a one month history of depression.

Analysis
No information was available to the DHR regarding any treatment in response to this report.

2nd June 2012 – Missing Person report
Sarah reported Billy as a missing person on 2/6/2012. She informed Police that he had undiagnosed mental health problems. Billy had missed a child contact visit which was very unusual and Sarah was very concerned. Billy returned to his mother's home later that night. He was seen by a Police officer the next morning.

Analysis
The Police followed their procedures, and attended Dorothy's home on 3/6/2011 to check on the welfare of Billy. No other agency was aware of this incident.

25th June 2012 – Discharge from CDAS
On 25/6/2012 Billy first telephoned and then attended CDAS. He stated that he had not received their welfare letter, which had been sent after he missed an appointment on 24/5/2012, but he wished to discharge himself. He reported that he had not used illicit substances for 6 weeks. A urine test proved negative and Billy was reviewed and discharged with a letter to his G.P. and an aftercare plan that included Narcotics Anonymous

Analysis
The CDAS IMR does not contain information about policies or procedures relating to what must surely have appeared to be a high risk client disengaging from a protective service so soon after reporting a serious relapse.

CDAS has confirmed that they have no reason to disbelieve patients who self report sustained recovery but that they do always make patients aware of other support available to them and that they are welcome to re-refer at any time.

Clients are not compelled to attend CDAS or receive services from them. However this may well have been another missed opportunity to convene a multiagency meeting that would have identified that Billy had disengaged from all services and that he was experiencing a range of risk factors that would suggest that he was at high risk of harm to himself or that others might be at high risk of harm from him.

CDAS have confirmed that with effect from 1/4/2012 patients are no longer discharged from treatment when their CDAS interventions finish as they remain under the care of Open Road or WDP (if they are Class A drug users and criminal justice clients) as those agencies now have responsibility for care coordination. Their identification of high risk clients disengaging from services will be one factor in reducing the risk of similar tragedies in the future.

14th July 2012 - Hoax call to the Police
On 14/7/2012, the birthday of one of his children, Billy made a 999 phone call to the Police that was later categorised as mental health – concern. He asked the Police to attend an address which did not exist, stating that he was the son of God and his daughter had passed; his wife had crashed the car and his children were alone. As the address did not exist no further action was taken.

Analysis
This incident was input as "Mental health – concern". No further action was taken. Essex Police have identified that although the address was false, further checks could have been made which may have led to a welfare check on Sarah and her children. Only the Police were aware of this incident.

28th July 2012 – Drunk and disorderly and a Mental Health Act assessment
Billy was arrested on 27/7/2012, the day after the first anniversary of his father's death, for being drunk and disorderly. Billy was taken to a Police station where he told the Custody Sergeant that he was the son of God and he believed that he was half human and half intergalactic being. When asked what he had consumed in the last 24 hours he said 10 cans of lager, crack cocaine and heroin.

After a doctor's examination he was deemed fit to be detained in custody. He was subject to 30 minute welfare checks all night and a second doctor's examination the following morning led to a formal Mental Health Act (MHA) assessment being undertaken in the afternoon of the 28/7/2012.

The three man team, two Section 12 doctors and an Approved Mental Health Professional (AMHP) agreed that Billy did not have an identifiable mental health illness and hospital admission was not appropriate. They concluded that he had a problem with drugs but did not want to change that situation. He was advised to seek support from CDAS for illicit drug use. They concluded that Billy was not a risk to himself and/or others.

Billy explained that he had collected his medication the day before, on 27/7/2012, and had taken 40mg diazepam and was "completely wasted and could not remember anything". He also reported that he took heroin once a week and had never had any mental health issues, had been violent in the past and had received loads of help." The team did not feel that Billy was showing any symptoms of mental illness and "whilst Billy had a strange presentation this was most likely the result of illicit drug use". The conclusion was "connected to community services, no psychosis observed". Billy was not detained under the Mental Health Act 1983.

Billy confirmed that he would have the support of his mother when he went home. The assessor had a long discussion with Dorothy and she confirmed that she also felt that there was no mental health problem and that she was happy for him to return home to live with her and did not view a hospital admission as helpful to her son. She stated that she felt that his issues were related to his relationship with his ex-wife and about not having access to his children.

They concluded that, as Billy had previous connections with Community Mental Health Services that they should be notified of the incident. The outcome of the assessment was passed by the EDS to the Basildon CMHT requesting them to action accordingly. Due to an administrative error the report that was sent to CMHT did not include a request for follow-up care. Basildon CMHT did not contact either Billy or Dorothy, as his carer. Due to the lack of a diagnosis CMHT would not have expected to follow up and therefore no further action was taken.

<u>Analysis</u>
This event raises a number of concerns. It is unlikely that the AMHP would have had access to the necessary records and he was therefore dependent on self reporting by Billy and his mother. The inaccessibility of records is a national issue and needs to be speedily addressed.

The Caldicott review of information governance was originally commissioned in 1997, and it was updated in April 2013. It was an independent review of how information about patients is shared across the health and care system. The 1997 report included 6 Caldicott principles and the recommendation that organisations appoint someone, a Caldicott Guardian, to take responsibility for ensuring the appropriate security for confidential information. The 2013 report includes one additional principle, which is that "The duty to share information can be as important as the duty to protect patient confidentiality."

The AMHP was not aware that Billy was disengaged from all community services, and it is unlikely that he was aware of Billy's medical history, previous mental health assessments, G.P. diagnoses of anxiety and depression or the previous concerns about personality disorder or drug induced psychosis.

No carer's assessment was provided to Dorothy and due to the mistake on the report sent to CMHT no follow up care was actioned. EDS confirmed that they assumed that CMHT would provide a carers' assessment but this did not happen.

5. Other issues for consideration

A number of other issues have also been considered in this review. These are:

5.1 Being a victim of domestic abuse

Dorothy's family have provided background information relating to Dorothy's experience as a victim of domestic abuse. However she never reported any incidents of domestic abuse to the Police or any other agency.

According to the Home Office's Homicide Index, in 2011/2012 there were 172 female victims of homicide in England and Wales. 135 (78.5%) of those victims knew the suspect; 12 were the son or daughter; 9 were the parent of the suspect; 88 were the partner or ex-partner; 10 were other family members and 16 were a friend or acquaintance of the suspect.

Domestic abuse is now seen as a priority issue for the UK Government as part of its work on Ending Violence Against Women and Girls (VAWG) in the UK. The Home Office recognises that fewer than 1 in 4 women who suffer abuse at the hands of their partner will report it to the Police.

5.2 Being a child witness of domestic abuse

Billy was open about his childhood experience of witnessing serious domestic abuse. He reported his childhood experiences to those agencies that completed the EDAAT comprehensive assessment forms, (CDAS, Open Road and WDP) and others such as Family Mosaic when he was applying for support from their Floating Support service.

No evidence was provided to the DHR that would link Dorothy's death at the hands of her son, to his childhood experiences of witnessing domestic abuse. However, the long term impact of witnessing serious domestic abuse and the associated trauma may have been a causal factor in the issues and difficulties that Billy faced as an adult and the choices that he made.

The DHR Chair contacted Professor David Gadd who is leading the From Boys to Men research and he advised that "one factor that makes a difference to children more generally is the capacity of other adults to offer care in the aftermath of violence. Obviously, some abused mothers are so stressed and traumatised by repeated violence that they are unable to deal with the confusion and upset felt by children. Sometimes other adults step in; sometimes they don't." The research shows that this support can be provided by teachers, family members, or other adults but that it is seen as key to the ability of the child to heal.

Addressing domestic abuse is a priority of the UK Government. It would appear to be important that all professionals working with children and young people have the skills and experience to identify those who are experiencing or witnessing domestic abuse and to provide high quality support to enable them to recover from their experiences.

Billy's children have suffered a double family tragedy and the DHR Chair is aware that although some support has been available to them, more specialised and longer term help is required. It is vital to the wellbeing of Billy's children and stepchildren that specialist support is available to them so that they can heal from this tragedy in their lives.

5.3 Mental Wellbeing and Risk of Suicide

Billy did not receive a diagnosis of a formal mental illness**.** Billy asked a number of agencies for help with his mental health problems after the initial presentation of bizarre symptoms on 27/1/2011. The following table highlights those requests, and his response to his involvement with mental health services:

Date	Agency	Request
1/2/2011	Probation	Billy was aware of referral to CJMHT and was positive about it.
10/2/2011	Probation	Billy acknowledged that he needed help with his mental health.
22/2/2011	WDP	Billy talked about his recent mental health assessment and that he was pleased to be getting help.
25/2/2011	Probation	Billy was concerned that no-one had contacted him from CJMHT. He claimed that he was told that he needed further assessments and welfare checks.
28/2/2011	WDP	Billy asked for help in clarifying progress since his mental health assessment.
28/2/2011	CJMHT	Billy threatened to kill himself, or others, if he did not get help.
28/2/2011		Billy took an overdose after attending appointments with the CDAS Consultant Psychiatrist and CJMHT practitioners and being told that he did not have a mental health illness.
3/3/2011	CDAS	Attended CDAS stating that he was “full of anger” and could hurt himself or someone else. CDAS referred Billy to Basildon Accident and Emergency who referred him to SEPT Duty Psychiatrist who referred him back to G.P. The G.P. referred him to CMHT.
8/3/2011	Probation	Billy made threats to himself or others if he did not get help.
8/3/2011	SEPT Contact Centre	Billy asked to be hospitalised.
9/3/2011	CJMHT	Billy attended appointment with CJMHT. They concluded that there was no evidence of formal mental illness.
10/3/2011	Probation	Billy told his Offender Manager that CJMHT had told him that he had a personality disorder but was not mentally ill.
15/3/2011	CDAS	Billy provided a personal statement as to why he wanted to go into a residential rehabilitation unit.
17/3/2011	Probation	Billy said that CJMHT were not taking his problems seriously.
23/3/2011	Probation	He told his Offender Manager that he wanted help with his “illness” and that he had lied to mental health practitioners in the past.
30/3/2011	G.P.	Billy was diagnosed with an anxiety disorder.
7/4/2011	G.P.	Billy advised G.P. that he took diazepam due to very bad rage – so bad that he could hurt people or even kill them.

Date	Agency	Request
3/5/2011	CDAS	Billy started counselling with CDAS, identifying anger and rage as most prominent issues and he wanted to be able to understand these emotions and the relationship with his life.
16/5/2011	CDAS	Billy stated that "he had enough of going round in circles". He said he wanted to change, wanted to stop using and move on with his life.
17/8/2011	CDAS	Billy reported that he had a bad day yesterday and apologised for missing his appointment.
6/9/2013	Probation	Billy reported that he was struggling to come to terms with his father's death.
15/9/2013	Family Mosaic Floating Support Service	Billy self referred and asked for assistance with a mental health referral
19/9/2011	CDAS Counsellor	Billy contacted the counsellor and asked to restart sessions. She advised that she would discuss with his Care Co-ordinator but no further action is recorded.
26/9/2011	Family Mosaic Floating Support Service	Initial assessment completed. Billy asked for help with a mental health referral.
21/12/2011	Family Mosaic Floating Support Service	Initial appointment with Floating Support Officer. Billy reported that he had a personality disorder.
25/1/2012	Family Mosaic Floating Support Service	Support meeting mainly focused on financial, benefit and issues relating to Billy's son.
25/1/2012	Family Mosaic Floating Support Service	Billy was aware of his anger issues and agreed a referral be made to the relevant agency. Billy indicated he wanted more support around his mental health and behaviour issues. No further action was taken.
18/5/2012	G.P.	Billy reported a one month history of depression.

In addition Sarah, Billy's ex-wife reported him as a missing person on 2/6/2012 and reported her concerns about his undiagnosed mental health problem. She repeated her concerns to the Police on the 23/6/2012 after Billy had assaulted her and made threats to kill her.

The CPA approach used in both CDAS and CMHT puts the patient at the centre of treatment plans and decisions, but there does not appear to be a mechanism for dealing with clients who report mental health issues but are not formally diagnosed. The G.P. confirmed that his assumption was that once he had referred Billy to CMHT that they were responsible for that element of his care.

The lack of a multi-agency meeting resulted in agencies not sharing the information that was included in their own files. Probation and CDAS have confirmed that there were missed opportunities for them to call a multi-agency meeting or make a referral to MARAC, which may have lead to a sharing of information relating to Billy, although the MARAC is victim focused. Billy did not meet the criteria for discussion at MAPPA. There does not appear to have been any other mechanism for agencies to share information about a man who was involved with

many agencies, taking up considerable time, causing concern for agencies, expressing thoughts of hurting people and asking for help himself

5.4 Safeguarding Adults

Dorothy was living independently without the engagement of support services, although at times when she may have needed services these were offered to her by agencies and were declined. For example, when Dorothy was offered care support following her hip replacement surgery, she advised that her family would support her and that she did not require social services support.

As previously reported a safeguarding query may have been raised by Basildon Council if information about Dorothy's *financial* difficulties had been shared across the local authority in the Summer of 2012.

No other agency reported in their IMR's that they had given consideration to their safeguarding policy in relation to Dorothy.

Dorothy had a complex life and character, and suffered from a variety of medical conditions but was not considered to be a "vulnerable adult" as defined by the Southend, Essex and Thurrock (SET) Safeguarding Adults Procedure.

There was no evidence submitted to the DHR to show that any agency identified Billy as a "vulnerable adult" as defined by the SET Safeguarding Adults Procedure.

Family Mosaic have reported that Billy met the criteria for their Floating Support Service as it was considered that he required support due to difficulties in his life. Family Mosaic has identified that there need to be stronger links internally to support clients who disengage with the Floating Support Service. However their housing services appear to have worked hard to support Billy to save his tenancy, re-opening his case and providing him with the support of the Welfare Rights Team after they had been granted a possession order.

Other agencies did not, however, consider that Billy required additional support. Essex Police have confirmed that they would have expected CDAS or CMHT to have identified Billy as a vulnerable adult if that had been the case.

The National Treatment Agency for Substance Misuse (NTA), now part of Public Health England is responsible for funding drug treatment services across the country. An article on their website published in 2008, states that the NTA knows it has "to overcome barriers among society – not excluding parts of the public sector – that treats users as criminals, rather than people with complex health and personal needs."

Billy may not have fit the definition of a "vulnerable adult" but he was at risk and Billy's problems escalated during 2012; his increasing social isolation, financial, benefit and housing difficulties, a serious drug relapse where he was injecting into his neck, binges on alcohol and drugs, including prescribed drugs, and the impact of his father's death.

Consideration of suicidal risk indicators would suggest that Billy was at high risk of taking his own life. By the end of July 2012 Billy had disengaged from all agencies except Family Mosaic who were about to repossess his home. Billy did not keep his appointments with staff who were trying to help him with his benefits and ultimately his home.

5.5 Safeguarding Children

Billy reported concerns about his ex-wife's lifestyle and concern for the welfare of his children to two agencies, Probation and CDAS, who recorded his concerns but neither agency reported the concerns to Children's Social Care or the Police. Both agencies offered Billy the use of the telephone in their offices so that he could report the concerns himself. Billy did report his concerns from the Probation offices to Children's Services, who investigated his concerns and concluded that there was no need for further action.

However the Child Protection Procedures require that all professionals report concerns directly. All agencies need to ensure that staff are aware of and comply with Child Protection Procedures.

5.6 Risk Assessments / Initial Assessments

Drug treatment agencies use EDAAT approved risk assessment and initial assessment forms. The DHR has the benefit of hindsight and recognises that none of the drug treatment agencies had identified Billy's mental health concerns at the time of his initial assessments. Agencies had recorded Billy's difficult childhood experiences. Only the Open Road IMR identified that Billy aimed for abstinence but was also "vulnerable to family pressures, stemming from being raised in an abusive family environment." There was no mention in the IMRs of a link between his childhood experiences and his adult life challenges, and how tailored interventions used as part of his treatment plan could assist him in achieving abstinence from illicit drugs.

WDP have addressed the lack of a robust initial assessment and the lack of probing into family relationships. This is not mentioned in the other IMRs from drug treatment agencies. The DHR Chair considers that these questions need to be asked and answered by EDAAT and the drug treatment agencies to reduce the risk of similar tragedies in the future.

5.7 Drug testing

Two agencies were undertaking drug tests on Billy to corroborate his self reporting of his use of illicit drugs. It would appear that results are unreliable as a true measure of abstinence. There was also no evidence of results being shared between drug treatment agencies.

The DHR Chair does not feel that comprehensive evidence was provided to the DHR as to the effectiveness of drug tests. However the DHR Chair believes that the issue needs to be raised and reviewed by the appropriate agencies so that a consistent approach can be developed across agencies. This may lead to improved effectiveness, improved cross agency working while comparing results and reduced costs in individual agencies.

The DHR recognises that the EDAP Service Contract 2012 – 2014 between Essex County Council and SEPT states "Appropriate testing will be undertaken by the Specialist Prescribing service as part of the assessment process and will be ongoing whilst the Specialist Prescribing service is involved. Where testing is undertaken results should be shared appropriately with other agencies such as Criminal Justice Services, Integrated Recovery Management Service and Social Care."

5.8 Management of dangerous offenders

The Essex Multi-Agency Public Protection Arrangements team have confirmed that Bill was never referred into the MAPPA process. MAPPA criteria are as follows:

Category 1 offenders: All registered sex offenders

Category 2 offenders: All violent and sexual offenders sentenced to imprisonment of 12 months or more or detained under a s37 hospital order.
Category 3 offenders: Any other offender considered to pose a significant risk of serious harm to the public.

Referral to MAPPA would be based on convictions for relevant offences. Billy was arrested for two notable offences before his death, but no further action was taken in relation to either.

For offenders that fall outside of MAPPA criteria, they can be qualified as a Potentially Dangerous Person (PDP). ACPO define a PDP as follows:

"A person who is not eligible for management under the MAPPA process but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm."

There is further description that requires the threat of harm to be considered imminent. Billy was arrested for two serious offences prior to the murder. One of these was an attempted murder, however no further action was taken in relation to this offence.

There were significant issues with the victim's credibility and there was no other corrobation that an incident had occurred. There was also information that the victim and Billy continued their friendship after the incident, thus removing any known threat or likelihood of imminent harm.

There was also an incident in December 2011 in which Billy was arrested for wounding after being involved in an altercation with a male. Both parties were arrested, and both sustained multiple stab wounds. No further action was taken in relation to this incident. While the investigation was ongoing both parties were in conditional bail. Although these conditions may have been a deterrent it is possible that there could have been consideration for PDP following this incident.

Although policy exists for PDP it is not something that as being utilised at the relevant time and there were no persons categorised as PDP by Essex Police at that time.

Essex Police have now rewritten their PDP Policy. The new policy, which is to be the subject of extensive internal communication, encourages all staff to identify persons who pose a risk to the public who are then formally assessed. Once adopted as a PDP, the individual will have a nominated manager responsible for proactive work to minimise the risk that they pose.

5.9 Provision of Information to the DHR

There was considerable variation in the quality of the IMRs and chronologies submitted to the DHR. Some agencies submitted huge amounts of information but little analysis, and did not address the questions contained in the Terms of Reference, even when prompted to do so. One agency's chronology was missing entries from one of its service areas. Some IMRs did not use the Essex DHR template.

Guidance needs to be more detailed to provide support to both IMR authors and the Overview Report author that the required information has been provided.

6. Conclusions

Evidence submitted to the Basildon Domestic Homicide Review (DHR) has shown that Dorothy was a complex character who loved her sons very much. Dorothy had been the victim of domestic abuse for most of her adult life, and her sons had been witnesses from their early

years onwards. It would appear that Dorothy had never reported any incident of domestic abuse to any agency.

Both of Dorothy's sons were heroin addicts. Essex Children's Services had identified that Dorothy did not understand the risks her grandchildren faced; neither had she protected her own sons in their childhood. Dorothy's family told the DHR that Dorothy needed to be needed and she acted as if she could cope with anything that life threw at her. It was reported that just a few weeks before she was killed by her son, she had said that he just needed his Mum.

The DHR did not receive evidence that suggested that there was an abusive relationship between Dorothy and her son Billy. No agency that had contact with Dorothy identified that she was at risk of harm from her son. No evidence was submitted to the DHR to suggest that any agency working with Dorothy could have identified that she was at risk from her son.

It has been reported that the Council now believes that a safeguarding query relating to Dorothy could have been raised, but there is no evidence that this would have led to the identification that she was at risk of physical harm from her youngest son. Therefore none of the agencies that were in contact with Dorothy could have predicted her death.

However, the DHR identified information that was available to agencies working with Billy during the last years of his life and which has led the Independent Chair of the DHR to the conclusion that there was the potential for Billy's risk to himself and others to have been identified.

Billy had started using alcohol and drugs in his early teens and was reported to have been self harming by the age of 14 years. Billy spent some time in prison and in 2001 the Police suspected that he had access to a firearm. Billy had previous treatment episodes with Community Drug and Alcohol Service (CDAS) and a long spell in a residential rehabilitation unit in 2006. Soon after his discharge in 2007 Billy applied for residency of all of his children but this was refused, and just one of the children was returned to his care.

Billy relapsed and started using heroin in 2009 and his child was removed from his care in October of that year. Billy took two overdoses during 2010 although it is not known whether these were accidental or intentional. In October 2010 Billy was convicted of possession of heroin, cocaine and a bladed lock knife and was subject to a Drugs Rehabilitation Requirement and supervision by Probation and Westminster Drugs Project (WDP).

At Christmas 2010 Billy's father became ill, and he subsequently was diagnosed with a terminal illness and died in July 2011. The first presentation of bizarre symptoms from Billy was recorded by two agencies, Essex Probation and WDP on 27/1/2011. Billy was referred to the Criminal Justice Mental Health Team (CJMHT), part of Basildon Mental Health Services (BMHS), who are part of South Essex Partnership University NHS Foundation Trust *(*SEPT). Billy was subject to twice-weekly drug tests at the time, the majority of which were recorded as negative.

The evidence available to the DHR suggests that Billy may have been advised by practitioners from BCMHS that he had a personality disorder, although this is not included in the IMR from MHS. According to the SEPT Procedure for Dual Diagnosis for South Essex a service user with a personality disorder and substance misuse issues is considered to have a psychiatric co-morbidity resulting in complex needs. These service users are provided with care and treatment under the Procedure for Dual Diagnosis. Billy was not provided with care or treatment under the Dual Diagnosis Policy.

The DHR also received evidence that BCMHS practitioners in CJMHT identified that Billy may have been suffering from drug-induced psychosis, which they recognised could re-occur if

Billy continued to misuse illicit drugs. Agencies recorded that Billy's expressed intention was always to be abstinent from illicit drugs, but in reality the same agencies recorded Billy's use of illicit drugs on a regular basis. On 19/4/2012 Billy reported that he had relapsed and was injecting heroin into his neck. This was the first time he had reported this type of use of heroin to any agency during the DHR review period. Billy was last seen by Community Drug and Alcohol Services (CDAS), after an appointment in early May 2012. He discharged himself on 25/6/2012, claiming that he was abstinent. No actions were taken to address the risk that Billy would pose if there was a re-occurrence of the drug-induced psychosis.

BCMHS has identified that Billy should also have been assessed under the South Essex Partnership University NHS Foundation Trust *(*SEPT*)* Dual Diagnosis Policy after his G.P. referred him for assessment and support from the service in March 2011.

It would appear that opportunities were missed to assess Billy and to provide him with the care and treatment he required. His initial assessments, completed at the start of every treatment episode did not identify the mental health symptoms that have been reported to the DHR by his ex-wife. Although Billy's childhood experiences were recorded, there does not appear to have been specific work undertaken to address those issues or the long term implications of those experiences. Billy reported his reasons for self medicating with both illicit drugs and prescriptions drugs over the years, stating that he used them to calm him down and control his rages. Billy was aware that he had a problem with anger and he described being fearful that he would hurt himself or someone else. He stated that he would rather kill someone than hurt them if they wound him up but very few, if any, actions were reported to the DHR to address his rage.

When Billy started to present with symptoms of mental health illness in early 2011 he was referred and seen by mental health professionals. He initially reported being pleased that he was getting help. However just days later a different doctor told Billy that he was not mentally ill and he went home and took an overdose.

Evidence submitted to the DHR suggests that if Billy had been diagnosed with a formal mental health illness or a personality disorder, then he should have been treated under the Dual Diagnosis Policy. This might have ensured a level of care and treatment that would have supported him, rather than the lack of care and treatment that resulted in him repeatedly asking agencies for help with his mental health during the last 18 months of his life, as has been outlined previously in this report.

SEPT has confirmed that clients treated under the Dual Diagnosis Policy must, in addition to a substance misuse problem, have been diagnosed with a severe and enduring mental illness or serious personality disorder and Billy did not receive these diagnoses.

Another consequence of Billy being diagnosed with a mental health condition, whether a personality disorder or a formal mental health illness, would have been his identification as a vulnerable adult, according to the Southend, Essex and Thurrock Safeguarding Adults Guidelines. This may not have made a substantial difference to his everyday life but it would have been known by the Police and other agencies, and would have been raised at points when that information might have affected the outcome of an assessment.

For example, on 28/7/2012 Billy was subject, when in Police custody, to a Mental Health Act assessment. An Approved Mental Health Professional (AMHP) and two Section 12 approved doctors attended the Police station to complete the assessment. The AMHP is expected to gather information, from a variety of sources that might be relevant to the assessment before it commences.

The breadth of information relating to Billy that was available to the AMHP on 28/7/2012 has not been submitted to the DHR. The DHR understands that much of the information would not have been available as the AMHP does not have access to computerised records for out of hours' assessments.

The AMHP would also have gathered information from Billy and his mother, who was present as his next of kin. The last time Billy reported that he had a personality disorder was in December 2011, when he asked for assistance with a referral to mental health services, that was not actioned. There is no evidence that Billy told the AMHP or the two attending doctors of the personality disorder, or his previous mental health assessments or issues. Billy had been arrested for being drunk and disorderly at 8.30p.m. the previous day and had been in custody for 19 ½ hours by the time the assessment was completed. Billy had also disengaged from all services by that time.

According to BCMHS, the AMHP wrote on the assessment report that Billy was "connected to community services". The DHR is aware that this was incorrect and can only presume that the information was therefore provided by Billy or his mother and that his connection with community services could not be denied as that information was unavailable to the AMHP.

Billy had been connected to community services since May 2009 when he self referred to CDAS and until his discharge from CDAS on 25/6/2012. His Care Coordinator at CDAS was also responsible for coordinating Billy's care at other drug treatment agencies including Open Road. Billy had several treatment episodes at Open Road and they have reported difficulties in communication links with Billy's Care Coordinator. Communication difficulties and a lack of information sharing are repeated issues in many of the agency IMRs.

In addition many agencies appeared to rely on Billy's self reporting without verification of the facts and it would appear that Billy would often report contact with another agency when he was not engaged at all. It is unlikely that Billy's CDAS Care Coordinator was able to monitor Billy's treatment effectively as there is little recorded liaison between him and the other agencies.

In December 2012 the National Treatment Agency for Substance Misuse (NTA) published a report "Falling Drug Use: The Impact of Treatment". The report outlines the evolution of drug treatment services in the UK through the 1990s, describing it as uncoordinated and inconsistent". By 2000 drug treatment experts had identified evidence based treatment protocols, and had reported that what worked for heroin dependency was "ready access to treatment that provided maintenance methadone alongside psychosocial interventions." The UK Government invested in this evidence based treatment approach to drug dependency and the report highlights the success of this approach.

There was evidence submitted to the DHR showing Billy's participation in some psychosocial interventions, for example, the Open Road Structured Day Programme. There is little evidence that these interventions were planned as part of Billy's treatment plan and little evidence to suggest that interventions were put in place in response to the life events that occurred during the DHR review period, particularly in 2011 - 12.

There were a number of life events during the DHR review period which were significant and yet the CDAS records do not contain actions that reflect the impact on Billy. In response to his G.P's referral in March 2011, CDAS offered counselling to Billy. He started the sessions in May 2011 but did not attend any sessions after early July 2011. His father died in late July 2011 and in September 2011 Billy contacted the counsellor to ask if he could restart the sessions. He was advised that the counsellor would discuss his request with the Care Coordinator. There is no record of any further counselling sessions being offered to Billy, which

is perhaps surprising considering that Billy was reporting that he was struggling to come to terms with the death of his father.

Research has shown the long term impact on a child of witnessing serious domestic abuse, and it is of concern that this knowledge appears to have had little impact on Billy's treatment or the support he received at times of distress.

A number of mental health charities publish information about personality disorders and mental health problems on their websites. It is all too easy to find links with childhood trauma, and in later life issues of anger management and violent outbursts. These links, between Billy's childhood experiences and his issues in his adult life do not appear in the analysis section of the IMRs submitted by either CDAS or MHS.

In addition CDAS have been unable to explain why Billy was not subject to any medical reviews between 19/4/2011 and 19/4/2012. Medical reviews are expected to take place as a minimum every 6 months for patients being treated under the Care Programme Approach (CPA). Other agencies who were involved with Billy at that time were recording his emotional state, and his difficulties, particularly in the summer of 2011, during which time his father had died. Billy was only seen by a doctor when he reported that he had relapsed and was injecting heroin into his neck on 19/4/2012.

By the time of his death Billy had disengaged from all services, except for sporadic contact with his landlord who was about to take possession of his home.

The DASH risk assessment contains a range of risk factors that are considered to be relevant to the risk of future harm to a victim of domestic abuse. There was no evidence of a domestic abuse relationship between Billy and his mother but serious domestic abuse was significant in both of their lives. This report considered Billy's life in relation to the risk factors pertinent to a perpetrator and that are included in the DASH. This included a past history of domestic assaults, child contact difficulties, a criminal record, violence and use of weapons, drug, alcohol and mental health and wellbeing, including the risk of suicide, and financial and housing difficulties.

This report has shown that there was evidence of each of these factors in Billy's life at the time of Dorothy's death. There was also evidence of a high risk that Billy would commit suicide in the summer of 2012. Billy had a long history of depression and had reported misusing his prescribed drugs although he had received warnings about this behaviour.

The DHR review period was agreed as 1/2/2009 to 3/9/2012. During the review it became clear that there was a period in early 2011 when Billy had caused concern in several agencies. Following his report of a heroin relapse on 19/4/2012 there appears to have been an escalation of "incidents" involving Billy's physical or mental wellbeing.

In May 2012 Billy visited his G.P. and reported a one month history of depression. On 2/6/2012 and again on 23/6/2012 the Police received reports of concerns for Billy's mental health. On 14/7/2012 Billy made a hoax 999 call to the Police that was filed as mental health concern; and then following his arrest for being drunk and disorderly on 27/7/2012 he was subject to a Mental Health Act assessment on 28/7/2012.

An escalation in domestic abuse incidents is seen as a criterion for referral to the MARAC by agencies that use the CAADA (Coordinated Action Against Domestic Abuse) version of the DASH. However, these were not domestic abuse incidents, neither were they all reported to the same agency. The DHR has not been made aware of any mechanism for identifying individuals who are escalating into a crisis, requiring support but are not currently connected to any community service.

The DHR has noted that some risk assessments completed during the review period did identify Billy's risk to himself, although was usually around his continued use of illicit drugs. There was no specific evidence that indicated that the risk assessments reflected that Billy had a higher than average risk of suicide, due to his childhood trauma, his possible personality disorder or a mental health illness. There appeared to be little action taken to address any risk of suicide.

Billy was disengaged from all services by the end of his life. A common pattern for Billy was to engage and then miss scheduled appointments, resulting in the agency triggering their policy for clients who miss appointments and then closing his file. Family Mosaic and Open Road have addressed this issue in their IMRs and have included recommendations for future service provision and more efforts to retain clients who are at risk if they disengage due to their chaotic lifestyles. Billy's vulnerability, whether identified as a "vulnerable adult" or not, does not seem to have been taken into account.

There appeared to be many occasions in Billy's life when he was referred on to another agency. On 3/3/2011, for example, Billy attended CDAS and was referred to Basildon Hospital Accident and Emergency, in order to be referred to the SEPT Duty Psychiatrist, who referred Billy back to his G.P. who referred Billy for counselling and assessment to BCMHS. This would appear to be a costly exercise for a range of agencies in order that a client already referred to BCMHS should be re-referred to the same service. Current research shows that a high percentage of people who are in drug treatment also have mental health issues and will at times require mental health services.

In early February 2011 there was a delay of 16 days between Billy's referral and his first appointment at CJMHT. Considering that Billy was already in the criminal justice system this appears to be a high risk strategy. Billy was then seen twice within 5 days, but waited 7 more days without any contact until he threatened to hurt himself or others, which triggered an emergency medical review at CDAS. These issues are not addressed in the MHS IMR.

No agency referred Billy to the MARAC as a perpetrator following the assaults against his ex-wife. Probation has acknowledged that they should have considered a referral to the MARAC, and there was an opportunity to call a multiagency meeting due to their concerns. The CDAS IMR states that they too could have arranged a multiagency meeting under the CPA approach. There appears to have been reluctance due to the difficulties of getting partner agencies to attend such meetings. *Billy did not meet the criteria for inclusion in MAPPA and was not referred into the MAPPA process.*

A multiagency meeting would have provided the opportunity for agencies to share information about Billy. Whilst recognising that the Police may not have shared the intelligence that they had received, it is quite possible agencies would have gathered information that enabled them to build a clearer picture of Billy, his lifestyle and the risks he might pose to other people.

It is also now clear that Billy could have been managed by Essex Police, under the Potentially Dangerous Persons Policy. A PDP Policy existed but was not being used by Essex Police in the summer of 2012. The newly rewritten policy encourages all staff to identify persons who pose a risk to the public. These individuals are the formally assessed. Once adopted as a PDP, the individual will have a nominated officer responsible for proactive work to minimise the risk they pose.

It is difficult to ascertain whether management of Billy under the PDP Policy would have prevented the death of Dorothy. She was never considered to be at risk from her son by any agency working with either her or her son.

By the end of August 2012 there was evidence of known risk factors, although not all the agencies knew all the facts. Billy had disengaged and therefore none of the agencies was taking an overview of his situation. Billy was suffering from depression. His G.P. had prescribed drugs to help him and he was known to have been bingeing on the diazepam previously. Billy had had no contact with his children since the end of June 2012. He was living at his mother's house while his own home was subject to a possession order. Billy was not receiving any benefits. His mother was in financial difficulties and was receiving weekly aid from the local church. The weather in the summer of 2012 was thoroughly miserable and it rained throughout the summer months.

Billy killed his mother and then he killed himself, but that certainly is not the whole story. Shortly after this review commenced it became evident that this was a complex family, with a complicated web of contributing factors which escalated over the last few months and resulted in a family tragedy. Although as the IPCC report states "Thankfully, on this occasion, Sarah and her children were not near or with Billy when he shot himself and his mother." This tragedy could have been even worse.

The surviving family have grieved for both Dorothy and Billy and struggled to find any meaning in this tragedy. As the Independent Chair, I would like to take this opportunity to thank those family members and friends who contributed to this review. I was grateful for their honesty and their commitment to the DHR process. I know that they wanted the review to identify how services could be improved, the lessons that could be learned so that no other family would need to experience the challenges that they have faced in the last year.

The DHR Chair would like to highlight the need for all members of the families affected by domestic homicide to receive support, which may require long or short term provision, or specialist services for children or adults. The surviving members of this family will have to live with the consequences of the events in 2012 for the rest of their lives. Specialist support and care provided now may help the healing process and provide tools that will guide them through their grief.

7. Recommendations

Basildon and Thurrock University Hospitals NHS Foundation Trust

No recommendations relating to the victim's or perpetrator's involvement with the Trust have been included in the IMR.

The Independent Chair believes that information about Billy's attendance at Accident and Emergency, particularly that he was not a regular attendee but that he attended 4 times in 9 weeks; that he was making bizarre claims and reporting strange activities, for example being poisoned or walking into a wall; the fact that on one occasion he was referred to the Mental Health Unit, should all have been available to other agencies as incidents of concern for the mental wellbeing of a patient. See Recommendation 3.

Basildon Borough Council

- To set up a working group with key services to consider how best to raise awareness of possible safeguarding issues when they are identified and implement a mechanism for sharing information with relevant officers within other services. This will not only assist in ensuring that we provide the appropriate support and services to vulnerable individuals but that we protect Council Officers by ensuring they are fully aware of all the relevant information, providing duty of care to officers in the course of their duties.

- Identify process for sharing of information amongst internal departments with regards to victims and perpetrators who are subject to MAPPA and MARAC arrangements. This will not only assist in ensuring that we provide the appropriate support and services to vulnerable individuals but that we protect Council Officers by ensuring they are fully aware of all the relevant information, providing duty of care to officers in the course of their duties.

- Raise awareness with 3rd Tier Service Managers of the importance of accurately checking records and databases, including liaising with officers who are out on the ground, when requests for information are received.

- 3rd Tier Service Managers identifying their service has been involved with the victim and/or perpetrator to provide an analysis of this involvement to the officer leading the IMR, this is in addition to the provision of records and is to include an executive summary of the effectiveness of the service delivery, chronology, conclusion and if necessary recommendations for improvements to be made. A template to be produced by Community Safety Manager to aid this process.

- Identify a process for 3rd Tier Service Managers to notify Basildon Council's Manager of Audit & Risk, when officers are asked to give statements directly by the Police or other agencies, relating to incidents which occur during the course of their Council duties.

- Consider and review Basildon Council's domestic abuse and vulnerable adult policies with a view to identifying training needs and requirements of all staff, including enhanced training for key officers and front line services and regular refresher training.

- Council Tax Visiting Officers to carry QB50 (note books) to record details of their visits, including not only the result of the visit, but who was present at the property at the time of the visit.

- Council Tax Visiting Officers to undertake property detail checks of Council's databases prior to carrying out site visits to reduce risk of harm to themselves and others. This is to take place with immediate effect.

- Raise awareness amongst all staff of the process for providing information directly to the Police and other agencies relating incidents which occur during the course of their Council duties.

East of England Ambulance NHS Trust

No recommendations were included in the East of England Ambulance Service NHS Trust IMR. Their reported contact was limited to attendance on the 3/9/2012 and no issues were raised that would require a recommendation.

Essex County Council, Adult Health and Community Wellbeing

That consideration should be made at all Mental Health Assessments to incorporating Domestic Abuse questions/enquires, whether there is a previous history or not. Deliberation would also need to be given to follow-up visits for the completion of the DASH risk assessment tool, and who would be responsible for doing that, if the person is not detained and/or declines a service.

The other area previously identified is a more joined-up approach to Domestic Abuse training for AMHP's. These actions would need to be led by the Mental Health Service and discussed

in a multi-agency forum, there would need to be evidence provided as to the advantages or disadvantages of adopting this approach to Domestic Abuse and Mental Health Assessments.

The Chair of the DHR believes that consideration should also be given to the following:

- The AMHP's access to historical and relevant information relating to the client prior to MHA assessments, including current involvement with local community services. See Recommendation 14.

- The review of the AMHP reporting system to ensure that checks are put in place so that the receiving agency receives the same instruction as has been recorded in the EDS files.

- The provision of carer's assessments to ensure that carers have support and access to services if required.

Essex County Council, Schools, Children and Families

No recommendations were submitted to the DHR. However the DHR Chair considers that improvements be made to data searches to ensure that future DHRs are provided with all available information at the outset.

Essex Police

No recommendations were included in the Essex Police IMR. *Essex Police advised that by the nature of their work they are involved in all Essex DHRs. They confirmed that they have already implemented changes to working practices to address issues raised in the DHRs since 2011.*

Although there were few incidents of domestic abuse involving Billy, the Police did receive other reports about his behaviour and concerns for his wellbeing. Whilst recognising that Billy was never formally diagnosed with a mental health illness, the DHR Chair is concerned that other reports of concerns for his mental health, and that he was dangerous, were not highlighted when he made the hoax call, and that a welfare check on his family was not undertaken. At that time the Police had also received intelligence reports suggesting that Billy could be a risk to others through his activities and his suspected use of weapons.

The DHR Chair also considers that Billy should have been arrested for making the threats to kill during the assault on 23/6/2012. The IPCC report identifies that Police should have been more proactive when dealing with this "very dangerous man".

Essex Police did not advise the DHR of either the original official complaint from Sarah or the IPCC investigation. This was advised by Sarah to the DHR Chair who provided copies of the IPCC report to the DHR Panel.

Essex Police have identified that Billy could have been identified, assessed and managed under the PDP Policy, following the December 2011 incident. The Policy has been rewritten and is to be subject to extensive internal communication.

Essex Police have introduced the Athena system in 2015, a single IT system that covers intelligence, case building, custody, crime recording and investigation. This system utilises single iterations i.e. individuals only appear in the system once, with all related data attached. Prior to this, and at the time of the event covered by the DHR, Essex Police used a number of stand alone IT systems. For example, the PROtect system was used by Public Protection but

access was restricted to those outside of that command. With the introduction of Athena internal data sharing within Essex Police has therefore significantly improved.

The Crime and Public Protection Command has, since April 2015, become an active participant in a revised force tasking process. Through this process the Command, supported by analysts, identify and target individuals most likely to cause harm within the community. This falls in line with the new Force Control Strategy, which is aimed at identifying 'Hidden Harm' and contains domestic abuse as a force priority.

The recent implementation of the Essex Force Control Strategy, the revision of the PDP Policy, and changes to the force tasking process and force-wide information sharing provide some reassurance that the circumstances of this DHR have been considered by Essex Police.

Essex Probation Service

Offender Managers should adopt an investigative approach to offender management and seek independent verification of information pertaining to risk management. For example, checking offence / *intelligence* details with the police or that a case has been referred to MARAC.

Offender Managers to review the risk assessment and risk management plan after a significant event, for example a domestic violence incident.

Managers-Offender Management in South Delivery Unit to continue to monitor the working arrangements with CJMHT to ensure that there is appropriate liaison.

Children and Families Policy in respect of Schedule 1 and Risk to Children procedures should be followed in all relevant cases and decisions are appropriately recorded on the case record.

Offender Manager (Courts) to follow the relevant practice instruction when offenders who are subject to current order/licence appear in court.

Family Mosaic

- Protocols regarding signing off customers for non engagement to be reviewed. Complex cases to be escalated to Head for approval as with evictions.

- Incomes policy to include referral to floating support provider after rent arrears have been triggered at first formal stage.

- Lessons learnt and recommendations arising from report to be agreed with Safeguarding Advisory Group.

- Family Mosaic to consider how they manage complex cases where there is multi-disciplinary involvement internally.

- Investigation required into why the neighbourhood dispute was not recorded in front office/Northgate.

NHS South Essex PCT Cluster (G.P.)

No recommendations were included in the IMR.

The DHR Chair recommends that the Clinical Commissioning Group conduct a review into how care and support can be provided to vulnerable adults in the community (those adults

who are vulnerable due to their life circumstances rather than the definition as per the legislation); and to the risk factors that might create vulnerability (including living alone, adult children with serious complex needs, financial difficulties etc.).

The DHR Chair considers that a review of safeguarding policies in relation to those individuals with complex needs, including drug addiction and mental health wellbeing issues, even if undiagnosed, should be undertaken.

In addition a review of how the role of the care coordinating G.P. is supported by other health agencies should be considered.

Open Road

1. External communications

    - Review the current EDAAT contractual arrangements with all involved partner agencies by May 2013 to ensure that the Open Road's co-ordinating role is effectively communicating overall Action Plans, which include and reflect the work of other drug service agencies such as CDAS's and WDP, and also contain evidence of joint assessments, reviews and decision making.

2. Internal communications

    - Open Road to undertake a review of its case file procedure by April 2013 to ensure that there is an improved co-ordination between files kept on the same individual partaking in different interventions.

3. Domestic Violence

    - Open Road to pursue whether it is appropriate to develop a greater and deeper understanding and knowledge of Domestic Violence, particularly in relation to safeguarding victims and assessing and managing the risks posed by perpetrators, and decide by end of March 2013 the level of future involvement.
    - Open Road to consider possible involvement in all Community Safety Partnerships Domestic Violence Forums across Essex by February 2013 with a view to having new arrangements in place by April 2013.
    - Open Road to look at Domestic Violence training opportunities for managers, staff and volunteers by March 2013 for possible inclusion in Open Road's Training Plan for 2013/4.

South Essex Partnership University NHS Foundation Trust (SEPT), Community Drugs and Alcohol Service (CDAS)

No recommendations relating to CDAS were included in the IMR.

The DHR Chair considers that there are areas of concern highlighted by this report that need to be addressed by CDAS. These include the lack of communication between the Care Coordinator and other agencies; the lack of joint working with both CMHT and external agencies; the lack of psychosocial interventions in the last 18 months of Billy's life with the exception of counselling which was not restarted after his request and following his father's death; the need for a discharge policy that addresses the risk of harm to long term clients known to struggle with abstinence and who have only recently reported relapsing, suddenly request discharge.

The DHR Chair recommends that consideration be given to information sharing protocols between agencies not covered by the EDAP ISAs, so that information can be verified, in order to reduce the risk to staff, patients and others.

In addition the lack of contact with Children's Social Care following Billy's expression of concern for the welfare of his children needs to be addressed.

South Essex Partnership University NHS Foundation Trust (SEPT), Mental Health Services

- The Trust should ensure that the principles of the dual diagnosis policy are being followed by the Criminal Justice Mental Health Team and the Basildon Community Mental Health Team so that a person who has substance misuse issues but is presenting with mental health needs should be assessed and provided with appropriate interventions by the assessing clinician from Mental Health Services.

- The Basildon CMHT Manager must ensure that the referrer and the G.P. are always informed of the outcome of a referral regardless of the outcome.

The DHR Chair believes that recommendations are also required to address the following issues:

- The delay between Billy's first referral and first appointment

- The lack of timely follow-up after Billy's appointment with the Consultant Psychiatrist

- The possible discrepancies in diagnoses provided to Billy, including the diagnosis of a personality disorder.

- The missed opportunities to arrange a multiagency meeting, to gather information from other agencies involved with Billy and to build a more comprehensive picture of his needs

- The lack of a joint treatment plan with CDAS.

- Poor communication between CJMHT and other agencies, particularly Probation as the referring agency

- Consideration for follow up for unreturned anger management course application packs for high risk clients.

- Actions to address Billy's risk of suicide

- Provision of a carers' assessment for carers of all patients subject to a mental health assessment within 24 hours of the assessment.

- A follow up check to be provided to all patients subject to a mental health assessment as part of their discharge plan, and particularly to those whose MHA assessments were completed out of hours

- Provision of relevant and accessible information for AMHPs conducting mental health assessments out of hours

- The long term effects of childhood abuse are considered in the treatment of patients and appropriate measures are put in place to address those impacts

Westminster Drugs Project

- Reinforce restrictions on children being brought to services
- That risk assessment training is provided
- That risk assessment documentation is reviewed and its implementation is clarified through specific training
- That DASH tools and processes are introduced into the standard working practices and is supported by training provided following a clear analysis of need
- That partnership working between the Inside Out team and MARAC is explored and defined
- That a schedule of audits across the project is planned and includes an examination of the case notes
- That the quality of case management and record keeping is more effectively monitored and managed through clarified expectations of the supervision process

The DHR Chair believes that WDP also need to consider recommendations relating to exit plans, information sharing and communication routes between drug treatment agencies, less reliance on the self reporting of clients and the retention of clients who respond well to the WDP approach.

Recommendations from the DHR Chair

1. That the appropriate Essex-wide partnership / board monitors;
    - the number of patients in drug treatment services in south Essex who are also being treated for a personality disorder and / or a diagnosed mental health illness; and
    - the number of patients in drug treatment and who have an identified personality disorder and are receiving an appropriate treatment.
2. That the Essex Health and Wellbeing Board consider the issues raised in this DHR and in particular the vulnerability of those people who have not received a formal mental health diagnosis, but may be suffering from a personality disorder or a mental health illness as a result of known childhood trauma.
3. That in light of the findings of this DHR, the Essex Safeguarding Board considers reviewing and broadening the definition of a "vulnerable adult" to include adults with complex needs.
4. That consideration be given to the establishment of a national database which records all incidents related to mental health concerns. This might include reports of concern to the Police (hoax calls, victims of domestic abuse expressing concern), mental health assessments undertaken by CMHS or agencies working out of hours, diagnoses of mental health issues including anxiety and depression. This database would allow local CMHS to identify residents where the frequency of incidents was increasing or the severity and risk was increasing above established thresholds and triggering an automatic welfare check or care response to the patient and potentially also the carer.

5. That EDAAT consider the findings of this DHR, with particular reference to the risk assessment forms and comprehensive assessment forms that are completed by drug treatment agencies across Essex; and that they ensure that all staff are aware of the importance of identifying the underlying concerns of the client; and have the training and experience to link the history of the client to the current issues in order that the treatment plan can fully address the needs of the client.

6. That all agencies involved in programmes with perpetrators of domestic abuse consider joint working with tailored drug and alcohol programmes, specifically designed for domestic abuse perpetrators.

7. That a tailored drug and alcohol treatment programme is delivered to those clients who present for treatment and are identified as having been childhood witnesses of serious domestic abuse.

8. That a review is undertaken into drug testing protocols to ensure that the most effective methods are being used in south Essex, and that results are shared between agencies in accordance with the current contract arrangements.

9. That all agencies address internal processes that are currently dependent on the self reporting of the client, without checks or verification processes in place.

10. That efforts are made to progress the establishment of the Essex Multi-Agency Information Sharing Hub (MASH) to enable health and care agencies to share appropriate information that may help to identify individuals in crisis in future.

11. That information sharing protocols are developed between agencies not included in the MASH project, to enable the sharing of relevant information that may reduce the risk of harm to staff, clients and others.

12. That all agencies take opportunities to arrange appropriate multiagency meetings to discuss clients causing concern and are themselves committed to attending or contributing to multiagency meetings when their partner agencies invite them to attend.

13. That all agencies commit to support the current care coordination roles of the G.P. so that the G.P's are aware of all mental health concerns identified by other health professionals, even if no formal diagnosis is identified.

14. That arrangements are put in place to ensure that AMHPs are able to access relevant and timely information prior to Mental Health Act assessments, including those completed out of normal working hours.

15. That all agencies review their processes to identify when the next of kin might be providing information that reflects their own lack of understanding of the situation faced by their family member, rather than a true picture of the needs of the client.

16. That arrangements are put in place to offer specialist care and support to all families, including any children that experience a domestic homicide, for as long as they need it, in order that they may heal from their experiences and not suffer long term consequences that could blight the rest of their lives.

17. That the Essex Domestic Abuse Strategy Group builds a strong relationship with HM Coroner's Office to support the joint working of DHRs and HM Coroner in future DHRs.

18. That the Essex Domestic Abuse Board considers the learning from this DHR process and uses it to inform the Essex guidance for future DHRs.