SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Overview Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Braintree Community Safety Partnership

A Review into the death of Heidi in December 2017

Report Author: Christine Graham
August 2019

Braintree District Community Safety Partnership

Preface

The Braintree Community Safety Partnership wishes at the outset to express their deepest sympathy to the family of Heidi. This review has been undertaken in order that lessons can learned; we appreciate the engagement from her family throughout this difficult process.

We are also grateful to the family of James. Their engagement has helped us gain an insight into the difficulties he faced. Their desire to make a difference is acknowledged and their challenge is taken in a positive contribution to improve services.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Braintree Community Safety Partnership on receiving notification of the death of Heidi in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review, the process and timescales.

Section 2 of this report will **set out the facts** in this case **including a summarised chronology** to assist the reader in understanding how events unfolded that led to Heidi's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will address **other issues** considered by this Review

Section 5 will provide the **conclusion** debated by the Panel and will consolidate **the recommendations that were made.**

Contents

Section One – Introduction

1.1 This Domestic Homicide Review report examines the circumstances surrounding the death of Heidi, a 33-year-old female and resident of the Braintree Community Safety Partnership area. She was killed by her partner, in the home they shared, in December 2017.

1.2 This review will examine agency responses and support given to Heidi and her partner. It will also examine the past to identify any relevant background, or trail of abuse before her death. It will look at whether support was accessed within the community and whether there were any barriers to accessing such support. By taking a holistic approach the review seeks to identify the appropriate solutions to make the future safer for others.

1.3 The review will consider relevant past agency contact and involvement with Heidi and James and in particular will focus on the time from January 2000 until the time of the incident that took her life.

1.4 The key purpose for undertaking a Domestic Homicide Review is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.5 This Review has taken place alongside a criminal investigation which followed James' arrest and subsequently his charge for the murder of Heidi. That judicial process resulted in a trial of facts (held in January 2019) after it was agreed that he was incapable of standing trial due to his severe mental ill-health. That trial of facts established that he was responsible for Heidi's killing. He was subsequently committed to psychiatric care as a result of a Hospital Order, together with an accompanying Special Restrictions Order that is without time limit.

1.6 Alongside this Review there has also been two investigations by the Independent Office of Police Conduct (IOPC), a Serious Incident Review by the mental health trust who provided care to James, and an NHS England Independent Review of the mental health care provided to James.

1.7 As this Review was drawing to a conclusion HM Coroner made a decision to undertake an Article 2 Inquest, with a jury. This is scheduled to take place in March 2020.

1.8 This whole process has been and now, following the decision of HM Coroner, continues to be distressing for Heidi's family. This Review has attempted to draw together the different inquiries to ensure that nothing is missed. Domestic Homicide Review Panel meetings have included representation from the IOPC[1] and NHS England and joint interviews have been held where possible. However, the different legal processes that support the IOPC regime and that of NHS England necessarily mean that those reports stand alone. This report has drawn information from the other processes where that information pertains to the relationship between this couple.

1.9 As a result, this report concentrates upon the focus of DHRs, i.e. the relationship between the couple. It seeks to establish whether domestic abuse was a feature of that relationship and if it was, to find that trail of abuse. Moreover, it seeks to look at what can be learned

[1] Independent Office for Police Conduct

and what changes can be made to better protect others in the future. It will not repeat specific single agency learning, in particular in relation to James' clinical care as this will be covered in detail by the NHS England review. It will, though, look to make recommendations that are cross agency or where it is clear that a different approach may better protect others.

1.2 Summary of circumstances leading to the Review

1.2.1 At 7pm in the evening two days before the incident, James made a 999 call and reported that someone had broken into his flat. A police officer made contact with him within an hour of his call and recorded on the incident log that local units should attend and assess whether a dwelling burglary had occurred. The police were thereafter unsuccessful in their attempts to contact James to progress this.

1.2.2 At around 9.30pm the next day, James's mother called the police to express concern for her son and his partner. James's mother made the call from her home abroad. Her call to the police had been prompted by a call she had received from Heidi, who is the victim in this case. James's mother said that during that phone call 40 minutes earlier, she could hear Heidi crying and she said, 'he's hurting me'. Her son had been heard shouting. She had heard her son shouting in the background, the call was hung up and she was then unable to get hold of them. She advised the police that her son had a diagnosed mental health condition and had been taking medication for the past 10 years.

1.2.3 The call was graded as Priority 3 (response within 60 minutes) and recorded as a concern for safety. At 11.30pm James's father called Essex Police for an update. At 11.35pm a unit was allocated to attend and arrived at the address at 12.14am. They immediately called for another unit to support them. Heidi was found with multiple stab wounds to her head and neck. James was detained at the scene, with blood on his hands, and arrested for murder. He was subsequently charged with her murder.

1.2.4 James's mental capacity was assessed, and he was detained in a secure mental health unit where he received treatment. He has a diagnosis of paranoid schizophrenia and was deemed unfit to stand trial. As a result, a trial of facts was held between 14th and 16th January 2019 at which the jury came to the conclusion that he had killed Heidi. He subsequently received a Hospital Order under Section 37 of the Mental Health Act 1983 with a Special Restrictions Order (Section 41 Mental Health Act 1983) placed on it due the danger that he would present to the public if he were released. The Special Restriction Order is without limit.

1.3 Reason for conducting the review

1.3.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.3.2 The review must, according to the Act, be 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 was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.3.3 A court case has established that James took the life of Heidi and therefore, the criteria for a review was met.

1.3.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice.

1.4 Timescales

1.4.1 The police notified the Community Safety Partnership of the death on 18th December 2017. On 12th January 2018 a meeting of the Southend, Essex and Thurrock Domestic Abuse Core Group was held. It was decided that a Domestic Homicide Review would be undertaken, and the Home Office was notified of the decision on 17th January 2018. This demonstrates a timely response to the death.

1.4.2 The independent Chair and Report Author were appointed at the beginning of January 2018 and the Review Panel met for the first time on 2nd July 2018. There followed three further panel meetings and individual meetings between the Chair of this Review, the IOPC and NHS England appointed investigators

1.4.3 The review was completed in August 2019.

1.4.4 It was not possible to complete the review within the six months set out within the Home Office Statutory Guidance for the following reasons:

- As a result of on-going criminal proceedings and following liaison between the Chair of the Review and the senior police investigator it was agreed that the Review would continue in limited scope until the conclusion of those proceedings. This was due to the nature of the evidence that was likely to be needed in any forthcoming trial. Due to the medical condition of James this was delayed for some time.
- The review continued in limited scope whilst waiting for the outcome of the IOPC investigation and the independent review undertaken by NHS England.

1.4.5 It was intended to include the NHS England Review within the body of this report. However, the legal process that surrounds it means that the timescales for the completion of that report remain unclear and thus this review is submitted with the acknowledgement that a detailed review of James' clinical care will follow. However, wXe have included what we feel are recommendations that include the mental health service providers and that we feel are pertinent to this DHR. It is James's care that is the focus of the forthcoming inquest.

1.5 Confidentiality

1.5.1 The findings of this review are confidential. Information is available only to participating officers and professionals and their line managers until the review has been approved by the Home Office. Following approval, the report should be shared appropriately within and between organisations in order to disseminate the learning.

1.5.2 To protect the identity of those involved the following pseudonym has been used throughout this report:

Heidi was 33 years old at the time of her death. She was of white British ethnicity.
James was 36 years old at the time of the incident. He was of White/North European ethnicity.

1.6 Terms of Reference

Terms of Reference for the Review into the death of Heidi

1 Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by Braintree Community Safety Partnership (BCSP) in response to the death of Heidi which occurred in December 2017.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the BCSP has appointed Mr Gary Goose MBE to undertake the role of Independent Chair for this Review. Mr Goose will be supported by Mrs Christine Graham who will be the Overview Author in this case. Neither Christine Graham nor Gary Goose are employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2 Purpose of the review

The purpose of the review is to:

2.1 Consider the circumstances surrounding the death of Heidi and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of her death; suggesting changes and/or identifying good practice where appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse; and

2.6 Highlight good practice.

3 The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with:

- The criminal investigation being undertaken by Essex Police into the death of Heidi.
- An inquiry by the Independent Office for Police Conduct into the police handling of the incident and a call made by the other person suspected of involvement in the death to police in days leading up to the incident.
- An independent review by NHS England into prior care provided to the person suspected of involvement in the death by Mental Health services

3.3 The review will liaise with the other parallel processes named above to: where possible, avoid duplication; minimise the impact upon the families involved in the case; appropriately share information to ensure cross-agency local, regional and national learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4 Scope of the Review

The review will:

4.1 Seek to establish if the death of Heidi could have been reasonably predicted or prevented.

4.2 Consider the period from the beginning of January 2000.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding where domestic abuse is a feature.

4.6 This DHR will not cover the specific areas being reviewed by other processes set out 3.2 above, rather it will draw upon the information and learning identified by those processes to inform its outcomes. This Review will thus look at the totality of information available to agencies and services and report accordingly.

4.7 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5 Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6 Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then BCSP will be the first point of contact.

7 Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

ADDITIONAL HEALTH RELATED TERMS OF REFERENCE FOR 2017/*****

The investigation is to be conducted in partnership with the Domestic Homicide Review into the death of ‘Heidi’ Terms of Reference.

The investigation will examine the NHS contribution into the care and treatment of the service user from his first contact with specialist mental health services up until the date of the incident.

- Critically examine and quality assure the NHS contributions to the Domestic Homicide Review
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway
- To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families
- To provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone

1.7 Methodology

1.7.1 Braintree Community Safety Partnership were notified of the death on 18th December 2017. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest possible opportunity.

1.7.2 As a result of the notification, a meeting was held on 12th January 2018. The meeting was chaired by the Southend, Essex and Thurrock Domestic Abuse Partnership Co-ordinator. At this meeting, the police provided a summary of the incident and, at this point, it was believed that there was no history of domestic abuse, but James was known to mental health services. The meeting agreed that the criteria had been met and that a Domestic Homicide Review would be undertaken.

1.7.3 Once the decision to hold the review had been taken, the Home Office were advised of the decision on 17th January 2018.

1.7.4 Gary Goose and Christine Graham were appointed to carry out the review in January 2018. A planning meeting had been held in March 2018.

1.7.5 The first review panel meeting took place on 2nd July 2018. The meeting was used to set out the purpose of a Domestic Homicide Review, the standards and ethos by which it would be undertaken and to discuss the information known to that date. The following organisations were present at this first meeting:

- Southend, Essex and Thurrock Domestic Abuse Partnership
- Essex Police
- Braintree Community Safety Partnership
- Safer Places
- Essex Partnership University Trust
- Independent Office for Police Conduct
- Consultant undertaking mental health review on behalf of NHS England

1.7.6 The meeting were advised that criminal proceedings had been established in this case and that a trial was unlikely to take place until January 2019 due to James receiving medical treatment in a secure mental health unit. As a result of this the Chair of this Review discussed the issue of disclosure with the senior police investigator and it was agreed that the Review would continue in limited scope until the conclusion of those proceedings or until such time that the issues in the criminal case were sufficiently known as to allow the Review to continue in its full scope. Agencies were, however, asked to ensure that all records were secured in preparation for a chronology and Individual Management Review (IMR).

1.7.7 The second panel meeting was held on 19th September 2018. At this meeting it was acknowledged that the delay to the trial due to James still being unwell had resulted in the review not being able to proceed significantly at this stage. It was acknowledged that it was not possible to talk to the family ahead of the court case but concern was expressed about whether the family understood about the review and so it was agreed that the Chair would meet with the Family Liaison Officer to not only explain the process but also ensure that the family were aware of the specialist support available to them through AAFDA (Advocacy After Fatal Domestic Abuse).

1.7.8 This meeting reviewed the progress of the parallel reviews and the information that agencies had identified. At this point there was no suggestion of previous domestic abuse within the relationship, but the panel was clear that this needed to be discussed with the families when the time was right.

1.7.9 James was deemed to be unfit to stand trial and therefore on 14th January 2019 a trial of facts was commenced and on 16th January the jury came to the conclusion that he had killed Heidi. He received a Hospital Order under Section 37 of the Mental Health Act 1983 with a Special Restrictions Order (Section 41 Mental Health Act 1983) placed on it due the danger that he would present to the public if he were released. The Special Restriction Order is without limit.

1.7.10 A chronology was prepared with the information known by the different agencies and IMR[2]s were commissioned from:

- Essex Police
- Essex Partnership University (NHS) Foundation Trust (EPUT) in the form of a Root Cause Analysis Investigation Report
- Heidi's GP

In addition, a report was requested from Open Road (specialist substance misuse service).

The IOPC reports and the information gathered by the Independent NHS Investigation were also considered as part of this review process.

1.7.11 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the

[2] Individual Management Review

apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

1.7.12 The review's active inquiries concluded in August 2019. The report was completed in August 2019 with a final panel meeting on 5th August 2019.

1.8 Involvement of family, friends, work colleagues and the wider community

1.8.1 It was agreed by the panel that the Chair and Overview Report Author would seek to meet with both families and an introduction would be made by the police Family Liaison Officers.

1.8.2 The Chair wrote to the parents of Heidi shortly after appointment introducing and setting out the purpose of the review, the letter included the Home Office prepared leaflet for family and friends, as well as details about AAFDA. The letter also explained that the review would continue in limited scope until the conclusion of the criminal proceedings. A further letter was sent to Heidi's sister at the end of July 2018, having been advised that she was the single point of contact for the family. On 7th November 2018 the Review Chair met with Heidi's sister. In early March 2018, the report chair and author met with Heidi's family. At this meeting, they were again reminded about the support that could be provided to them by AAFDA. The Chair and the NHS England investigator met Heidi's family again in October 2019 to update them on the review and following this a referral to the National Homicide Service was made on their behalf.

1.8.3 The Review Chair and NHS England investigator travelled abroad to meet with James's family, early in March 2018. Regular contact has been continued since that time.

1.8.4 Both the Chair and Report Author would like to thank the families for their engagement and contribution that they have made to this review. It has been invaluable and has helped significantly in our understanding of Heidi and her relationship with James.

1.8.5 Heidi and James' family were both provided with a copy of the report before it was concluded to allow them to consider this in private and without time pressures.

1.8.6 The Chair considered whether an approach to James was appropriate in this case. Given his acute on-going mental ill-health a decision was made not to make such an approach.

1.9 Contributors to the review

1.9.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.9.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the review and referenced the statutory guidance.

1.9.3 However, it must be noted that whilst a person or body can be directed to participate, the Chair and the Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.9.4 The agencies who contributed to the review and the nature of their contribution is listed below:

- Essex Police – Chronology and IMR
- Essex Partnership University (NHS) Foundation Trust (EPUT) – Chronology and IMR
- Heidi's GP – Chronology and IMR
- Heidi's employer – written response
- IOPC – made available their two investigation reports
- NHS England – made available their independent investigation draft report

1.9.5 The following individuals contributed to the review:

- Heidi's family
- James' family

1.10 Review Panel

1.10.1 The members of the review panel were:

Braintree Community Safety Partnership	Tracey Parry	Community Sevices Manager
Essex Partnership University Trust (EPUT)	Tendayi Musundire	Head of Safeguarding EPUT
Essex Police	Alison Hooper	Detective Inspector Strategic Centre, Crime and Public Protection Command
Independent Office for Police Conduct	Rachel Dwek	Lead Investigator
Mid Essex Clinical Commissioning Group	Leila Francis	Safeguarding LEad
Niche Consultancy	Carol Rooney	Independent Investigator
Safer Places	Jo Majauskis	Director of Practice and Development
Southend, Essex and Thurrock (SET) Domestic Abuse Board	Val Billings	SET Domestic Abuse Coordinator
West Essex Clinical Commissioning Group	Philippa Uren	West CCG

1.10.2 The review panel met four times, with significant correspondence by email to keep members abreast of developments.

1.11 Chair and Overview Report Author

1.11.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary has been employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework. Gary has undertaken a number of Domestic Homicide Reviews as Overview Report Author or combined Overview Report Author/chair.

1.11.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Christine was seconded to the Home Office for 12 months as part of their Tackling Violent Crime Programme. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine also served, for seven years, as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine is Chair of the Safer off the Streets Partnership in Peterborough.

1.11.3 Working together, Christine and Gary have worked on a number of reviews across the country in the capacity of Independent Chair and Author. In addition, Gary has completed six reviews working alone. These reviews have included may different circumstances including murder/suicide, murder, manslaughter, suicide, male victims and many where mental health was a factor.

1.11.4 Christine and Gary are independent of, and have no connection with, any agencies in the Braintree Community Safety Partnerships or the county of Essex.

1.12 Parallel Reviews

1.12.1 The following parallel reviews were undertaken:

- Independent Office for Police Conduct (2 investigations)
- NHS England Mental Health Review

1.12.2 The Coroner held an initial inquest and, towards the end of this review, the Panel was advised that the Coroner intended to hold an Article 2 Inquest, with a jury, in March 2020.

1.12.3 The Review Chair and Report Author worked closely with these reviews to reduce duplication.

1.13 Equality and Diversity

1.13.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.13.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.13.3 Whilst not registered as disabled, Heidi suffered from multiple health issues which some may consider would have made her more vulnerable, but her family are very clear that these did not impede her life and she would not, in any way, consider herself to be vulnerable. She was also the carer for James. This Review has considered specifically whether Heidi's health and her position as carer for James caused any barriers to reporting. These are considered throughout the report.

1.13.4 James was being seen by the mental health services and had a number of diagnoses – Paranoid Schizophrenia, Generalised Anxiety Disorder and Mental and Behavioural Disorders due to the use of alcohol, dependence syndrome, episodic use (Dipsomania). The effect of these issues upon his behaviour and the couple's relationship is featured in detail throughout this report.

1.14 Dissemination

1.14.1 The following individuals/organisations will receive copies of this report:

- The family of Heidi
- The family of James
- Senior managers of all participating agencies
- The Office of Police, Fire and Crime Commissioner

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)
4 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction to the facts of the case

2.1.1 Both Heidi and James had long-standing family ties to Essex. They had been living together for approximately ten years at the time of Heidi's death.

2.1.2 Heidi worked as a nursery nurse and worked well with the children in her care. She was described as always having a good bond with them all and she was a favourite to many of them. She was seen as a valued member of the nursery team and described as being liked by everyone she worked with.

2.1.3 Heidi was described by one of her friends as one of the kindest people she had met and always had a positive attitude to life and any difficulties she faced.

2.1.4 Whilst James did not have a permanent job because of his ongoing health problems he managed to build up a small window cleaning round, which he worked at when his health allowed.

2.1.5 In May 2017 the couple moved to a flat in mid-Essex, which they purchased with the help of James' parents. They both continued with their existing work and did not seek jobs in their new home town.

2.1.6 A full chronology of events and a summary of information known by family and agencies will follow within this report.

2.2 Chronology

2.2.1 **Background information**

2.2.2 At the time of her death Heidi was 33 years old.

2.2.3 She had lived in their new flat with James since May 2017.

2.2.4 James was 36 years old at the time of the incident. He had experienced mental health problems since he was 17 years old and this was exacerbated by illicit drug use whilst at university. At the time of this incident, he had several diagnoses which include Paranoid Schizophrenia, Generalised Anxiety Disorder and Mental and Behavioural Disorders due to the use of alcohol, dependence syndrome and episodic use (Dipsomania).

2.3 Detailed chronology from 2000 to December 2017

2.3.1 **Prior to 2000**

2.3.2 James described the onset of mental health issues when he was 17 and that he started taking illicit substances to overcome being bullied at school. He said his mental health worsened when he moved to university and continued to take illicit drugs.

2.3.3 At the age of 18, James was discovered in bed with a girl by the girl's mother. They were part of a group that had been drinking, and neither apparently had any recollection of events. He was, however, reported to the police by her parents and then James was arrested

on suspicion of rape. He was not charged with any criminal offence but it is noted in health records that he remained shocked and extremely anxious following that incident.

2.3.4 One of James's psychotic episodes related to fears that two men who ran a club in Birmingham had found out about the rape allegation, and he was going to be kidnapped, tortured and killed by these people. He believed they may have recruited others, and he thought Chinese 'triads' may be involved. These delusional beliefs continued through until the incident.

2.3.5 **2000 - 2002**

2.3.6 In 2000 James was admitted voluntarily to the Acute Mental Health Unit in the east of the county for two weeks due to drug induced psychosis. This was his first admission. He was discharged after two weeks.

2.3.7 Following his discharge, he was followed up by the community drug and alcohol service who referred him to the Community Mental Health Team and a joint assessment was undertaken. It was concluded that he was not exhibiting any evidence suggestive of a psychotic process. It was identified that he was struggling to cope with various stresses in his life and he was recommended to continue with counselling. He was also referred for Stress and Anxiety Management training.

2.3.8 He attended two outpatient appointments in 2000 where it was documented that he continued to misuse both drugs and alcohol.

2.3.9 From December 2000 to March 2001 he failed to attend subsequent follow up appointments and was eventually discharged from Mental Health Services to the care of his GP.

2.3.10 In 2001 he reported to the police that he had been the victim of an assault by a number of unknown assailants during which he received a black eye and cuts. The police raised a crime report which was later re-classified to 'no offence'.

2.3.11 In December 2002 he was referred for review at the Psychiatric outpatient clinic and he was prescribed an antidepressant by his GP. His father also raised concerns about his deteriorating mental state. When he was spoken to, James confirmed feeling low in mood with some delusional beliefs such as his computer had been hacked and that his personal details had been shared. He did not report feeling suicidal and did not feel that he needed to be seen urgently. He was referred for a follow up appointment in the new year.

2.3.12 **2003 - 2017**

2.3.13 From 2003 until the beginning of 2017 James was almost entirely under the care of specialist mental health services. It is summarised within this paragraph because appointments were voluminous. A diagnosis of paranoid schizophrenia was first considered in early 2003 when he reported feeling people were watching him, checking his computer, sending messages and planting his garden lawn with microphones. Thereafter, he was admitted to psychiatric wards on six separate occasions. His paranoia and delusions grew stronger and he was diagnosed additionally with persistent delusional disorder. He reported at times a decline in his functioning which affected sleep, eating and feeling unsafe at home because he believed that he was being watched. He believed that people were saying he was a rapist and that his mobile phone was bugged. During this period he was often non-compliant with

his medication and admitted alcohol and drug misuse (cocaine). During 2008 he was started on clozapine[5] which he took until just before the incident. It was noted that he did not seem to be making progress on clozapine and, at the time same time, his parents were concerned that he was worsening and responded to his delusion by flooding the house. By 2015 James was considered to be increasingly anxious. This was after two triggers – the death of his grandmother and a serious health issue for his girlfriend, Heidi (this victim). In 2016 James and Heidi had the opportunity to move to a new flat in another part of Essex. This was done with the financial assistance of his parents. It was something that was discussed by James and Heidi at his mental health appointments during 2016.

2.3.14 In 2003 James was arrested for driving whilst unfit through drink or drugs and taken into custody where he was later charged. He appeared in court and received a Community Rehabilitation Order for 12 months and was disqualified from driving for 24 months reduced by 6 months at the conclusion of his Rehabilitation Order.

2.3.15 In 2006 James received a formal caution by the police in Essex for criminal damage following an incident where he was seen to smash the window of a residential property. The police records suggest that 'he was upset as the daughter of the home owner refused to go out with him'. He said, in interview, that he suffered from paranoia which caused him to become delusional and commit the offence which he greatly regretted. Medical records suggest that he said that he had deliberately smashed the window because he believed the woman was an impostor and was part of a conspiracy to harm him. He described feeling paranoid and had some beliefs that appeared delusional but did not want to discuss these.

2.3.16 Heidi and James began their relationship some time in 2006.

2.2.17 In mid-June 2007 there was an incident, recorded in health records, when James reportedly hit his parents. This was not reported to the police.

2.3.18 In April 2008 James made a non-emergency call to the police to say that he was being stalked by two males. He told the police that he had left his flat earlier that day with the TV switched on to a particular channel. Upon his return to the flat he found that the channel had been changed. Before the police could despatch an officer to his address, James called the police again to say that he did not now believe that anyone had been into his flat but that his mental state was not as it should be, and he would be seeking professional help.

2.3.19 **2017[6] - This is now a detailed date driven chronology in the build up to the incident**

2.3.20 By 2017 James had several diagnoses including Paranoid Schizophrenia, Generalised Anxiety Disorder and Mental and Behavioural Disorders due to the use of alcohol, dependence syndrome and episodic use (Dipsomania).

2.3.21 James was monitored at the clozapine clinic throughout 2017, initially at the clozapine clinic in the West of the county and was then moved across to the East of the county as a result of the house move. The move of service is relevant and thus this report will continue to use the terms West and East to denote the two different service areas. He was also seen regularly by his Care Co-ordinator West and, latterly, by his Care Co-ordinator East. He was also seen by a Consultant Psychiatrist for regular reviews.

[5] Prescribed to treat schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs

[6] From 2017 James was in regular contact with mental health services. The medical details of these interactions are covered in detail in the independent investigation and are not explained in detail here

2.3.22 In May, Heidi and James moved to their new home. He was seen by his Care Co-ordinator on 8th June, after attending the East clozapine clinic. Future attendance at the clozapine clinic in mid-Essex was discussed with him, and he seemed unsettled by this. He told his Care Co-ordinator that since the move about four weeks earlier he had been feeling *'about the same*' but also feels better about himself now that he is a home owner. He said he felt more able to be free in mid-Essex, as he felt '*under siege*' in the West and felt less worried about who he may bump into. He did, however, still express anxiety and concern about being stopped by the police and followed by Chinese people. He apparently saw a Chinese person when driving back to the East after picking up the flat keys and wondered about this. He continued to sleep until lunchtime most days, then usually watched TV until Heidi came home from work.

2.3.23 On 10th July Heidi transferred back to her original GP in the West.

2.3.24 James was seen regularly by the Care Co-ordinator West. On 3rd August he reported feeling very anxious, which was agreed was usual for him. However, he reported feeling that this anxiety was different somehow; he appeared more aware of the physical symptoms of anxiety such as dizziness and shortness of breath, rather than his usual paranoid thoughts. James disclosed some personal relationship issues between himself and Heidi and was asked if it would be helpful for them to be assisted to discuss this as a couple. James was noted to say they don't talk about it, and he said he might talk to his GP about seeing Relate locally. James identified that the stressors he was feeling at the time were around his parents moving abroad, and Heidi having an upcoming operation. He said he was unsure how he felt about this, as it may impact on their ability to have children. He said Heidi was optimistic, although he said that he was '*barely able to look after myself*'.

2.3.25 In August, James was referred to the East Specialist Psychosis Team. It is known that James was very anxious about moving his care from the team in the West to the East Psychosis Team and that this featured in many of his conversations with his Care Co-ordinator at this time.

2.3.26 James was seen again in late August by his Care Co-ordinator. He reported ongoing severe anxiety, and difficulty getting to sleep, although then sleeping late. He had been referred to a gym by his GP and was due to start, which he was looking forward to. He reported trying to reduce his alcohol intake, and had not drank any that week so far, and was doing some part time window cleaning. He was also anxious about a planned operation for Heidi and visiting his parents abroad; he said he didn't like flying or going on the Eurostar. James was referred to the East Specialist Psychosis Team.

2.3.27 James was seen by his Care Co-ordinator West on 21st September when he spoke about a number of people that he knew who had died of cancer recently. He felt that life was short, so he was thinking of proposing to Heidi at Christmas. He also said that her mother did not like him, and someone may object at the wedding.

2.3.29 On 2nd October James was first seen by the East Psychosis Team in the clozapine clinic. On 4th October he rang his Care Co-ordinator West saying he was finding it stressful and asking if he could attend the previous clinic or just fill in a form.

2.3.30 James had a number of blood tests between 5th and 7th October when he was told to stop taking clozapine and his parents were contacted too.

2.3.31 James told the psychiatrist on 9th October that he had an appointment with Open Road[7] for support for his alcohol use. That day, Heidi contacted the Care Co-ordinator West as James had been having a bad week. It was arranged for James to be seen by the psychiatrist that day as an emergency. James was then followed up by Care Co-ordinator West on 11th and 13th October.

2.3.32 On 12th October James referred himself to Open Road as he had concerns around his drinking and an assessment was undertaken.

2.3.33 James called NHS 111 on 24th October stating he was worried because his feet were ice cold and had been for three days, and he had unexplained bruises on his shin. He was advised to see his GP in the next three days. He saw his usual GP on the 25th October, nothing untoward was found and he was advised to wear thicker socks.

2.3.34 On 25th October James met with his Care Co-ordinators from both the West and East team. James then called the Care Co-ordinator East on 1st November.

2.3.35 On 31st October James attended his first key working appointment at Open Road and reported being alcohol free for one month. He said that he did not want to attend any groups and had tried AA in the past but did not feel comfortable attending these meetings. James reported to his Care Co-ordinator East on 1st November that the Open Road advisor suggested a joint meeting to discuss plans and possible anti-craving medication, which was to be discussed further.

2.3.36 He attended a further key working appointment with Open Road on 2nd November 2017.

2.3.37 Also on 2nd November James had his last meeting with his Care Co-ordinator West and he was discussed at the Multi-Disciplinary Team (MDT) meeting in the East Psychosis Team.

2.3.38 When he met with his Care Co-ordinator on 8th November, he reported that he had a very bad day, the day before, describing racing thoughts which were not necessarily bad or paranoid in nature. James said he had spoken to his parents, as he called them frequently, and that he could talk to Heidi about his concerns. He said he often called her at work and her employer understands that he has mental health issues. He said he only felt comfortable talking to people he can trust and would be reluctant to call his Care Co-ordinator West.

2.3.39 On 10th November his keyworker (at Open Road) tried, unsuccessfully, to contact him by phone to arrange another appointment and a letter was sent offering him an appointment on 14th November.

2.3.40 On 11th November an unscheduled home visit was conducted by the Care Co-ordinator following concerns from Heidi. It was observed that James was visibly anxious, reporting that he was experiencing racing thoughts that had been negative. He felt that he had been going downhill with regards to his mental health for the past few days. It was noted that, since ceasing clozapine, he should have been taking a higher dose of Quetiapine, but he had, because of the side effects, stayed on the lower dose. He reported experiencing fleeting thoughts of suicide which was not unusual for him and they had not increased over recent

[7] Open Road provides drug and alcohol treatment services across Essex and Medway in Kent. They work on behalf of authorities and agencies including local, district and County councils, NHS Clinical Commissioning Groups, other charities, Community Safety Partnerships, the Police and crime reduction agencies.

days. He said that he was able to keep himself safe and that Heidi had returned from work the previous day to support him and this was beneficial. He did not have any plans or intention to act on these fleeting thoughts. He said he felt that he was not fully in a crisis but that he might be heading for one. Following this conversation, a medical review was arranged with the Consultant Psychiatrist and James and Heidi were reminded of the numbers to call for help.

2.3.41 On 14th November he contacted his keyworker at Open Road about his appointment that morning and it was rearranged for the afternoon. He attended this appointment and reported that he had not drunk alcohol for 6 weeks. He disclosed that his mental health was not good but that he was engaging with the mental health team and that he had an appointment with them the next week. He confirmed that going forward he would like weekly telephone appointments.

2.3.42 On that same day, Heidi contacted his Care Co-ordinator West saying James was having a very bad day. The Care Co-ordinator West went to their home to see them, James was visibly anxious and said he felt his mental health had gone downhill. He said he had racing thoughts all day which have turned negative. He was easily moved to tears earlier in the day and had called Heidi who came home from work to be with him. He said he had fleeting thoughts of suicide but although not unusual these had increased over the last few days. He said he could keep himself safe with Heidi's support, and had no plan or intent. The Care Co-ordinator West planned to arrange an urgent review with the psychiatrist and request further diazepam. Crisis numbers were provided, and the couple were advised if they were really concerned about a crisis they could go to A&E.

2.3.43 On 15th November James' Care Co-ordinator East called him. He was provided with a further prescription and an urgent appointment with the psychiatrist was arranged.

2.3.44 The next day James called his Care Co-ordinator West. He explained that he understood that his Care Co-ordinator had changed but he wanted to talk it through. James was also called by his Care Co-ordinator East and he said that he planned to write everything down so that he could discuss it with the psychiatrist.

2.3.45 James saw his GP for a medication review on 17th November.

2.3.46 On 20th November James called his Care Co-ordinator West as he had tried to call his Care Co-ordinator East, but he could not get hold of him. He said that he wanted to write to the Care Co-ordinator West rather than attend the appointment. He also said that his parents had offered to pay for him to attend the Priory or see a private counsellor. James was encouraged to discuss this with his Care Co-ordinator East.

2.3.47 James called on 21st November and spoke to his Care Co-ordinator East. He said that he wanted to make complaints about the clozapine clinic, and he offered to support him with this. It was confirmed to James that a medical review was going ahead on 27th and had not been cancelled as James thought.

2.3.48 James' mother called the West Psychosis Team as she wished to speak to his Care Co-ordinator West. She was concerned that moving teams and coming off the clozapine had been too much for James. He was feeling as though he should not have moved to his new flat. His Care Co-ordinator West explained to her that James needed to take more responsibility for dealing with and managing his problems. There was, it was explained, only

so much that the service could do beside prescribing medication if someone does not want to engage with managing their problems.

2.3.49 James was discussed at the East MDT meeting and it was noted that he had stopped taking clozapine and had a review scheduled for 27th November.

2.3.50 James did not answer the phone for his weekly appointment with Open Road on 23rd November.

2.3.51 On 25th November James called the duty team asking for extra support but there is no record of what was offered or given.

2.3.52 During the weekend of 26th and 27th November, after having called NHS 111 James attended the Accident and Emergency Department at a hospital in the East of the county with complaints of urinary retention and constipation. He was given medication to aid his discomfort and it is noted that the catheter had been fitted for two weeks at this point.

2.3.53 On 27th November, his Care Co-ordinator East called James in order to obtain feedback from the medical review. He explained that he had not attended due to some physical health issues over the weekend. On 28th November Heidi contacted the Care Co-ordinator East to say that James had become anxious as he realised that he had accidentally taken double the dose of Quetiapine the week before. This had been worrying him as he felt that this might have contributed to his urinary problems.

2.3.54 Also on 28th November, the Consultant Psychiatrist contacted James as he had not attended his medical review. She wanted to check on him as she was concerned that he was showing signs of relapse. At this time, he was at his father's in Norfolk. For the first time, he mentioned bouts of rage that he had not suffered with after he gave up illicit drugs 10 years previously. During this conversation, James also asked for a carer's assessment to be undertaken for Heidi.

2.3.55 He did not answer the telephone for his weekly appointments with Open Road on 28th November. When a call was made on 30th November it was answered by a lady who said that he was not well, and it was agreed that the keyworker would call again next week.

2.3.56 On 29th November, he and Heidi were visited by his Care Co-ordinator East. The carer's assessment for Heidi was completed. The Care Co-ordinator East recorded that James was at risk of a decline in his mental state following his physical issues.

2.3.57 James had his monthly meeting with his Care Co-ordinator West planned for 30th November but he called to cancel this at the last minute. Heidi spoke to the Care Co-ordinator West and said that James had seen his GP who thought that he was physically and mentally drained. James then came to the phone and asked the Care Co-ordinator West not to speak to his parents about his care as they kept calling him to ask how he was and what was happening. The same day, Heidi phoned the Care Co-ordinator East and said that they were happy with the support they were receiving from the East team. She requested that staff do not discuss James' care with his parents. James was offered a medical review with the psychiatrist on 8th December.

2.3.58 On 2nd December James called NHS 111 as he had a rectal lump and swelling, and he was given advice. He called back later as he had now had a rectal bleed. He was seen by an out

of hours GP at home who gave advice, but James wanted to go to A&E which he and Heidi did, attending Hospital. He was given medication for constipation and he requested a mental health assessment due to his anxiety. James and Heidi were seen by a Community Psychiatric Nurse on behalf of EPUT. James was looking for a change in his medication, but he was advised to discuss this at his review on 8th December and staff agreed to see if he could be seen sooner.

2.3.59 James spoke to his Care Co-ordinator East and told him that he had been to A&E. He did say, however, that he could manage until his review, but he needed a prescription for diazepam. The prescription was given, and the medication was taken to the flat.

2.3.60 On 7th December the GP received a referral for catheter care for James and he attended the next day. (His catheter was now recorded as having been in for three months).

2.3.61 James and Heidi were seen by the psychiatrist on 8th December. James gave him four written pages which had taken him three hours to write. This detailed all that had happened going back to university days. The psychiatrist noted that this appeared to indicate that James was having a relapse. James again said that he did not believe that he had paranoid schizophrenia but was due to his substance misuse. The psychiatrist explained that the diagnosis was well established. It was agreed that the Care Co-ordinator East would continue to see James in the community. Later that day, after midnight, James called the out of hours team and said that he was experiencing bad mood swings. He was advised that this would be passed to the Access & Assessment Service (AAS).

2.3.62 The next day, 10th December, James called AAS again. He asked the staff to speak to Heidi as she said he was behaving oddly. After speaking to her, he was advised to take extra medication. Heidi agreed that she would telephone the East Specialist Psychosis Team the next day and also seek help from the GP.

2.3.63 James' Care Co-ordinator East telephoned to see how he was on 11th December and James identified that he was feeling unwell and asked for a change to his medication. The Care Co-ordinator East agreed to email the psychiatrist and said he would see him at home later in the week. James left a message with his Care Co-ordinator West to call him and he spoke to her for about 15 minutes. No follow up meetings were planned as James was not well enough to travel to the East team.

2.3.64 On 11th December, in a telephone appointment with Open Road he explained that he had experienced a reaction to his medication and that he was still not drinking. He said that he would like his case closed as he was no longer drinking. The case was closed on 14th December 2017.

2.3.65 On 14th December the Care Co-ordinator East visited James's home but there was no response. He contacted Heidi at work who reported that he was 'up and down' but that she had no immediate concerns about his mental state. The Care Co-ordinator East advised Heidi that he was on leave next week and that they should contact duty, or the Crisis Team as needed. The same day James called 999 and said that he wanted to make serious allegations and requested an escort to the police station. When asked for more information he was reluctant to give this but stated that someone had been coming into his house. He stated that he saw someone, noticed the door was open and that things had been moved around whilst he was asleep. James was provided with advice about preserving the scene and was advised that an officer would attend. He asked for the name of the call handler and

asked if he would need a legal representative present and was advised that this was not usually the case.

2.3.66 The call was classified as a residential burglary which required police attendance within 48 hours and James was told officers would be round as soon as they could. At 7.51pm hours the officer in the case called James. She introduced herself and he said that he needed to get legal representation and he would get it in the morning. When asked by the officer why he needed legal representation if he was a victim of crime, James said that he had confidential medical issues and needed legal representation. He then thanked the officer and hung up. Over the next few hours a number of officers tried to call James but there was no reply.

2.3.67 The day of the incident

2.3.68 Just after midnight, James rang the contact centre to speak to his Care Co-ordinator East and provided Heidi's mobile number stating that if he was sleeping, they could speak to her as she had taken the day off. He explained that she could not take any more time off work, so he needed to speak to his Care Co-ordinator East.

2.3.69 At some point during the day, the Care Co-ordinator East went to see James at home. He explained that he had called the police the night before because he felt that someone was moving things in the flat. He reported having no thought of suicide or self-harm. The Care Co-ordinator noted that James appeared to be suffering a relapse in his mental state. It was agreed that Heidi would supervise his medication at home. It was also agreed that James would go on to stepped care[8] with the East Specialist Psychosis Team. James would not accept daily visits but would accept daily phone calls with a joint visit booked for the 4th January 2018.

2.3.70 In the evening James' father called the Crisis Team from Spain stating that he had tried to call his son to no avail, and he suspected that he may be having problems. He requested that someone check on him at home. The nurse explained that if he had concerns and he thought he might be in danger, or putting other people in danger, he needed to call the police.

2.3.71 About 30 minutes later James' mother dialled 999 and spoke to a call handler in Essex Police Force Control Room. She said that she had been told by the Crisis Team to call the police. She explained that she was calling from a European country and was calling about her son who had mental health problems. She said that Heidi had called her about 40 minutes earlier was hysterical and she could hear her son shouting in the background. She said that Heidi had hung up the phone and that she had tried repeatedly to ring Heidi and James. She was not able to get through to them and both phones were now switched off and she was worried for their safety.

2.3.73 James's mother was asked if there had been any problems other than his mental health and she said that he had been very ill recently. When asked if James had ever tried to harm himself, she said, 'not really, no' but then went on to state that he had recently stopped taking his medication and since then his health had deteriorated. She said that his psychiatrist and social worker were aware but that this was a critical situation. James' mother asked for a call back to tell her what was happening as she was 'really, really worried'.

[8] The NHS Independent Investigation could find no reference to a description of what this entails in the Mid Essex policy

2.3.74 Immediately after this call from James' mother, the incident was allocated to an officer to attend but then it was immediately unallocated as it had been assigned in error. The call handler completed a THRIVE risk assessment[9] in which the risk was classified as high. The call was classified as 'concern for safety' and given a 'priority 3' grading requiring police attendance within 60 minutes. The officer linked this entry to the report of the burglary the day before and stated that 'when CID made contact with him, he was not making much sense so this could all be mental health related'. The call was then allocated to the night shift but at this point it was not allocated to an officer.

2.3.75 About an hour later James' mother called the police again to chase attendance at her son's home and was told police had not yet attended. She stressed how important it was for them to attend.

2.3.76 At 11.30pm James' father called to request an update. He was told that the police would call him when they had attended.

2.3.76 At 11.34 pm a police unit was assigned to attend. Two officers arrived at the address at just after midnight. They found Heidi with multiple stab wounds and she later died at the scene. James was arrested at the scene and later charged with murder.

2.3.77 A few minutes after the police unit had been assigned, James' father called the police and requested an update. He was told that officers would call him when they had attended.

2.3.78 When officers attended the scene at just after mid-night, they found Heidi deceased. She had been stabbed multiple times. James was arrested and the criminal investigation commenced.

[9] This is a risk assessment used by Essex Police which looks at Threat/Harm/Risk/Investigation/Vulnerability/Engagement/Prevention + intervention

Section Three – Overview and Analysis

3.1 Summary of information known to agencies, family, friends and colleagues

3.1.1 Heidi was a woman who came from a loving and close family. She had been born with under-developed kidneys which necessitated a kidney transplant when she was 13 years old. She experienced ongoing medical issues and was experiencing medical problems up to the time of her death. We know from her family and her work colleagues, that although her pain had an impact upon her life, she did not allow this to limit her life. She was 'always smiling and never complained'. She went to work every day and if she was in severe pain, she would just ask the GP to increase her pain relief.

3.1.2 Heidi had a lot of contact with her family and with nieces and nephews; regularly having them to stay over with her and James. They have been left devastated by her loss.

3.1.3 Her relationship with James will be discussed in more detail later in the report; as will the impact of James' illness upon her.

3.2 Detailed analysis of agency involvement

The chronology set out in Section 2 details how the information known to agencies evolved. This section summarises the totality of the information known to agencies and others with influence during the years leading up to Heidi's death. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement. The timeframe considered in the Individual Management Reviews was 12th May 2001 to 14th December 2017.

3.2.1 Essex Police

3.2.1.1 The IOPC investigation into Essex Police's handling of this issue covered the period from the report of burglary the day before the incident, through to the incident itself. They have made a number of police only recommendations relating to control room procedure. They are contained within their now published reports and are not repeated here as they are largely procedural and do not consider the relationship between Heidi and James.

3.2.1.2 During the relevant period, Essex Police had only five contacts with Heidi and James prior to 14th December 2017 which are detailed in the chronology. Only two of these contacts resulted in an investigation and these therefore were analysed.

3.2.1.3 The criminal damage investigation of 28th July 2006 has been analysed. It is noted that when James declared to the Custody Sergeant that he was taking medication a healthcare professional was contacted and attended and examined James. He was declared fit to be interviewed without the need for an appropriate adult. It was noted by the IMR author that it was not recorded in the custody record if the healthcare professional suggested a referral to be made to a Mental Health Team or his GP. It is not clear from the records if this was considered or done by the case officer. That said, it is acknowledged that the paperwork in relation to this incident has been weeded and such a referral or consideration may have been made.

3.2.1.4 The incident of 25th April 2008 met the National Standard of Incident Recording (NSIR).

3.2.1.5 It is acknowledged that although these two incidents were two years apart and were nine years, or more, prior to the homicide. That said, the IMR does acknowledge that both have the mental health of James at their root.

3.2.1.6 Since these incidents, Essex Police has undergone a fundamental review with regards to how it approaches all aspects of vulnerability including mental health and the training for all officers has now been enhanced.

3.2.1.7 Essex Police has introduced the Mental Health Street Triage Team (MHST) with police officers working alongside staff from the Essex Partnership University Trust (EPUT) providing support to frontline officers when dealing with an individual who may be experiencing a mental health crisis[10].

Recommendation One

The review reiterates the recommendation made in previous DHRs published in 2017 that a formal process should be developed by which the police can notify mental health professionals of an individual's deteriorating mental health where it does not meet the threshold for Section 135/136 of the Mental Health Act 1983 or the Mental Capacity Act 2005.

3.2.1.8 James called the police on 14th December and this call was categorised as a burglary which necessitated a 48-hour response. The 48 hours had not elapsed at the time of the call from James's parents on 15th December. It is noted that the police did try, on a number of occasions, to make further contact with James but that he did not answer his phone.

3.2.1.9 The call from James's mother at 9.28pm on the night of the incident was categorised as a 'concern for safety' and NOT as a domestic incident.

3.2.1.10 Following categorisation the call was given a priority grading which required attendance within 60 minutes. A priority grading can include circumstances where there is 'a genuine concern for someone's safety' including domestic incidents.

3.2.1.11 It was also identified by the IOPC that because the call was not categorised as a domestic incident this may have affected how it was resourced. Specifically, it meant that the call was not flagged to a control room supervisor, the domestic violence auto template questions were not asked and the assessment team did not receive a notification so that the incident could be risk assessed at the time of reporting.

3.2.1.12 The police accept that this was an error and that it should have been categorised as a domestic incident. This review agrees with the IOPC, given the fact that James' mother said that Heidi was hysterical, James was shouting in the background and he had a mental illness that had recently deteriorated an emergency rating would have been more appropriate, which would have required a response within 15 minutes. The IOPC found that although she did not specifically say that she believed that there was a danger to life or serious injury, the officer did not ask further questions to establish whether this was her concern.

3.2.1.13 The police, and the officer who categorised the call, accept that the call from James' mother should have been categorised as a domestic incident. The IOPC and this Review have considered why that error was made and if it is indicative of a training need in respect of control room staff and other officers recognising the signs of domestic abuse. Having

[10] Between April 2017 and April 2018, the MHST assessed 2,384 people to ensure that they received the appropriate treatment, prevented 543 attendances at A&E and prevented more than 390 people being sectioned under Section 136 of the Mental Health Act

reviewed the available documents in this case we come to the conclusion that the call from James' mother appeared to centre around her concerns for her son's safety and wellbeing. The officer who took that call followed that line of conversation and asked about his state of mind, thoughts of self-harm etc. They were aware that James' mother had spoken with the mental health team and also that the call from Heidi to her had happened around an hour previously. The questions asked focussed upon James, none of the questions appeared to consider the risk to Heidi. Vitally, the fact that James' mother could not longer get any response from Heidi seems to have been missed. This seems to have been a tragic but genuine error.

3.2.1.14 The fact that this was not categorised as a domestic incident with an emergency grading meant that officers were not dispatched in a timely manner. The fact that the systems in place for alerting officers that the 60 minute target time was then subsequently missed is also considered by the IOPC within their report but that is not a matter for this review.

3.2.1.15 Essex police have a procedure in place within their control room specifically for domestic abuse and its initial grading and attendance. They will want to ensure that this case reinforces that procedure.

3.2.1.16 The review notes that the Police National Computer (PNC) record for James contained warning markers for 'Ailment (claims to have panic attacks)' and 'Ailments (claims to suffer from psychosis)' which were added to the record when he was arrested in 2003. Although this information was held by Essex Police it was not accessed until after the incident. It is noted that IOPC report states that, whilst it is there it is a responsibility to check PNC, the procedure[11] does not state the point at which this should be done. If, however, the call had been classified as a domestic incident, there would have been a responsibility for 'all necessary intelligence checks are completed to assess prioritisation'.

The review concludes that, had the phone call by James' mother, been classified as a domestic incident then more information would have been available, and a more immediate response could have been provided which may have resulted in officers arriving at the home some two hours earlier than they did. This was a missed opportunity.

3.2.1.17 Moreover, this review comes to the conclusion that under current arrangements the police are asked to make decisions about dispatch based upon wholly incompete information. They had no access to records that may have helped them understand the deterioration in James' condition and thus the danger that Heidi faced. A simple check of James' mental health team's record would have flagged up that this was a case that required an urgent attendance by either the police, or in fact the police together with an appropriately trained mental health practioner to intervene. This is a situation that should not continue. This review comes to a very clear conclusion that a greater access to an individual's whole circumstances would enable a more considered and informed response and thus afford all a greater level of protection. This review does not advocate police having access to an individual's mental health record, however, it does recommend that mental health staff with access to mental health records should be sited in police control rooms to aid in decision making. This has been trialled successfully in other police force areas (including a neighbouring police area of Cambridgeshire) and Essex police should examine it for introduction in its force area.

[11] Essex Police Procedure – Responding to Incidents

Recommendation Two

Whilst acknowledging the work of the Mental Health Street Triage Team, the review recommends that Essex Police and EPUT consider basing a mental health practitioner in the force control room with access to mental health records. Had this been in place on the night of the incident, then the force control room would have been able to assess the concerns of James's parents alongside his mental health history enabling a much more informed decision about the urgency of attendance by officers.

3.2.2 Mid Essex Clinical Commissioning Group (CCG)

3.2.2.1 James was registered with the same GP in West Essex from 2005 to 2017 when he transferred to a GP in Mid Essex in July and remained with this GP until the time of the incident.

3.2.2.2 The details of interactions with James are set out within the chronology (section 2) and the analysis of his mental health (section 3.3).

3.2.2.3 The IMR provided by the CCG makes clear that James was fully supported by the West-Essex GP for many years with his mental health issues. He made contact with the surgery and attended appointments with this GP or practice nurse regarding 'general' health issues. There is little evidence of James not attending appointments that had been made.

3.2.2.4 Within the GP records there is no evidence of a mental health capacity assessment having been undertaken at any point.

3.2.2.5 There is no evidence in the GP records of them having been advised when James did not attend appointments with other services.

3.2.2.6 As James had only been registered with the GP in Mid Essex for six months relationships had not become fully established and it appears that the mental health services were in the early stages of development within Mid Essex. It is clear that James was determined that these services should continue following his move.

3.2.2.7 His medical records show a deterioration in his physical health during late 2017 following his move to Mid Essex. This deterioration may have affected his mental and emotional health. It is noted in the IMR that his medications and drug and alcohol dependence will have also impacted on his physical health. The IMR notes that there appears to be a reduction in information sharing following the move to Mid Essex.

3.2.2.8 The review notes the effective practice highlighted in the IMR. He received a continuity of care from the GP in West Essex who made referrals to appropriate services with James' consent. James was well-known by the GP practice and appears to have been involved in his plan of care according to his current health status.

3.2.2.9 The IMR notes that the Care Package Approach (CPA) in West Essex had provided James with support for his mental health/recovery. This resulted in good information sharing between the GP and mental health services which, in turn, led to actions required of the GP being implemented. That said, the IMR identifies that there are times when expected feedback to the GP from agencies was not provided. Had this been done, the GP would have had an even greater picture of James from the perspective of those agencies involved in his care.

3.2.2.10 The IMR identifies a number of lessons learned from this case:

- GPs have an important role to play in the support, management and treatment of patients with mental health and chronic illness.
- Continuity of care from GPs (and other core services) is imperative to patients who have been diagnosed with mental health illness as this will provide trusting relationships and provide a good knowledge base for all professionals involved.
- Involvement of family – take into consideration the concerns that family members/partners may express/highlight to those health professionals involved with vulnerable adults with complex mental health issues as they will know their relative/s well.
- The significance of information sharing between professionals following each episode/new episode of care from all agencies. It is of equal value to share information surrounding any non-attendance at appointments or discharge from services. These issues are of great importance especially to those who are vulnerable in society.
- When a patient leaves a GP practice, the services involved with that patient are not automatically 'transferred' with them to their new location. Therefore, a patient will require their 'new' GP to re-refer them to the appropriate service in the locality.

Recommendation Three

That NHS England and CCGs remind primary care services to complete a transfer summary in the electronic medical records (regarding patients with mental issues) when a surgery becomes aware that a patient is moving to a new locality.

Recommendation Four

That all health agencies are reminded of the significance of information sharing with primary care services (GPs) to ensure clarity of information and continuity of care. It would be helpful if GPs are made aware when patients do not attend (DNA) appointments with other services.

Recommendation Five

That NHS England and CCGs remind GPs to complete a mental capacity assessment when there appears to be a lack of capacity.

3.2.3 Essex Partnership University NHS Foundation Trust (EPUT) and the NHS Independent Investigation

3.2.3.1 The care provided to James by EPUT is subject of an Independent Investigation carried out by Niche Health and Social Care Consultants commissioned by NHS England. That report will consider in detail the care (clinical and support) that was provided to James and make recommendations to the organisation involved. The Chair of this Review though, has been involved in joint meetings with both families and the Niche investigator and information has been appropriately shared between the Reviews. At this stage that Investigation has still to be published.

3.2.3.2 Whilst this Review will not comment upon the clinical care provided to James, it is aware of the level of investigation carried out by the NHS Investigator. A number of joint discussions have been held to determine whether any information existed within the medical records, medical staff's interactions with James and Heidi, and the organisations practice and policy that would assist this Review in identifying a trail of abuse or other factors that could assist this Review. Any relevant information has been included within the body of this report.

However, we both agree that the adoption of Recommendation 2 (aforementioned at 3.2.1.12) could make risk assessments by the emergency services more informed and thus better protect others in the future.

3.2.3.3 This Review is grateful, however, for sight of the conclusions of the Independent Investigation and they are documented here for completeness:

Findings (NHS England)

It is clear that James had a serious mental illness that was treated over many years by the Trust. He was never symptom free but had access to medical and psychological care which supported him to maintain a level of wellbeing and independence. He was provided with consistent care for over 10 years.

He continued to abuse alcohol until October/November 2017, and his engagement with psychological care tended to focus on coping skills rather than attitude change. He continued to question his diagnosis and suffered ongoing anxiety as a consequence of his paranoia.

James had a supportive partner and family who provided emotional and practical assistance. He was able to maintain independent living with his partner, although the choices he made about the use of alcohol could be said to be unwise.

The move to the Mid Essex team took place months after they moved house, and this was largely because of James' anxiety about change. The handover was not structured, and was not supported by a full care plan and risk assessment review. Because of service changes, he did not have a medical review between September 2016 and October 2017.

The management of the cessation of clozapine (medication) following the red result in October 2017, did not offer sufficient support to James and Heidi. It was recognised that he was relapsing in November and December 2017, this should have triggered MDT discussion, and a clear care and risk management plan that considered the presenting risks.

3.2.4 Open Road

3.2.4.1 Open Road is a drug and alcohol recovery support charity providing services in Essex and Medway, Kent. James self-referred himself to the service in October 2017 and a level 2 assessment was undertaken. He reported that he had concerns about his drinking and recent blood test results. He had, when the assessment was undertaken, not drunk for 8 days.

3.2.4.2 Initially James attended two key working sessions on 31st October and 2nd November. He was offered an appointment (by letter) for 14th November. Having rearranged the time of this appointment, he attended and reported that he had not drunk for six weeks. He disclosed that his mental health was not good, but he was engaging with CMHT. It was agreed that he would have weekly telephone appointments from this point. However, he did not answer when called on the next two weeks. When Open Road called on the third week, a woman answered the telephone and said that James was not well, and it was agreed that they would ring again the following week.

3.2.4.3 When James spoke to his keyworker on the phone the following week, he said that he had experienced a bad reaction to his medication, and that he was still not drinking. He said that he would like his case to be closed as he was no longer drinking.

3.2.4.4 On 14th December his case was closed, at his request, as he was no longer drinking.

Given the limited interaction with James by Open Road, there are no specific recommendations for the organisation.

3.3 Information from family and friends about Heidi and her relationship with James

3.3.1 Key to this Domestic Homicide Review was the desire to identify if there was a trail of domestic abuse that existed in Heidi and James's relationship. It has been decided to consider this after the review of James's mental health as his illness is key to understanding their relationship and identifying any indicators of abuse that might exist.

3.3.2 The review is grateful to the family and friends of both Heidi and James who have helped us to understand their relationship.

3.3.3 James and Heidi met on a night out and their relationship developed quickly. Heidi knew about James' mental health issues and this did not deter her from entering into a relationship with him.

3.3.4 Heidi's family found that James was quiet and quite withdrawn at family events. They attributed this to his illness and accepted that Heidi loved him. Given that Heidi was such a caring person, she did not feel that James's illness was a burden and did not consider that she was 'caring' for him. She was very supportive of him and we can see, from agency records, that she was very involved in his care planning and attended many appointments with him. Her friends also said that, although there were pressures due to James's illness, she never complained about this and showed no resentment for the things that she, or they as a couple, could not do.

3.3.5 One of the questions that the review has sought answer is whether this was an abusive relationship prior to the events that led to Heidi's death. Her family were asked directly if they thought he had ever been physically abusive towards her and they were adamant that James loved her and would not do anything to hurt her. There are no records of Heidi disclosing to anyone that James was violent towards her. Heidi's manager (who was also a close friend) also told the review that she never had any reason to believe that James was physically abusive towards her. She says that they never saw any signs of physical abuse.

3.3.6 There was no sense of Heidi hiding from her family and friends (some of whom were also work colleagues) the extent of James' illness. She was always open and honest about what he was going through and if he was having a difficult time.

3.3.7 We know that domestic abuse is much more than just physical violence and it was noted, when talking to her family, that they referred to him not liking them visiting the flat. They would go around when he was out. They also talked about times when Heidi went out without him saying that he would ring her constantly, every five minutes or so. She would seek to reassure him about when she was coming home but, sometimes, she would say something along the lines of 'I have told you when I will be home, please don't ring me again'.

3.3.8 Heidi's employer also referred to James ringing Heidi at work. She said that he would always ring at some point during the day, but it was usually only once or twice. She did say that, at times, it could become more frequent and leading up to the incident there were days when multiple calls were made. If he did call at an inappropriate time, he would be asked to call back and this did not cause any difficulties. This review has considered whether this behaviour could be an example of control and coercion by James. Equally though, they could be symptoms of his paranioa caused by his level of mental ill-health. There is little other evidence of other examples of control and coercion.

3.3.9 Heidi's colleagues referred to her not attending social functions because James was not well. There was no sense, in the way that they spoke of this, of her being 'prevented' from going out with her friends but, rather, that she wanted to stay with him to make sure he was OK.

3.3.10 There is a reference in Heidi's medical notes to her moving GP when they moved from West Essex and then returning to this GP saying, 'it did not work out'. The review considered if this might indicate that Heidi had moved away from James at some point but is satisfied that this is not the case. Her sister was able to inform the review that she had wanted to go back to her original GP because she was still working in the area. Her sister had told her to say this so that she could go back to the GP and she gave her sister's address who lived in the catchment area of that GP.

3.3.11 Earlier in this report, reference has been made to the medical staff feeling that the stress of moving had an impact on James and was responsible for his relapse. Both families do not accept this view and believe that James was stable when they moved and that it was not the stress of the move that caused him to deteriorate but the change in his medication.

3.3.12 Whilst not wishing to doubt or undermine the evidence of Heidi's family and friends, this must be held against the evidence that we have of James having been violent in the past. We also know that victims of domestic abuse will often hide this from everyone, even those who are closest to them.

3.3.13 The review concludes that we cannot say with certainty whether James was abusive towards Heidi. There are indications of troubling behaviour but these are undoubtedly exacerbated by James mental ill-health (see section 3.5). There are only two people who know what went on within that relationship. What we can say is that everyone who knew the couple described them as very much in love and that Heidi was very supportive of James during his illness.

3.4 Heidi's employer

3.4.1 As has previously been discussed in this report, Heidi worked for a local children's nursery. Her employer was very supportive of the stress and pressure that James's illness had on Heidi, but they were clear that Heidi was always open and honest with them about what was going on in her life.

3.4.2 The nursery does not have a specific domestic abuse policy but there are references to it within their safeguarding policies. It was very clear that Heidi's colleagues had been very supportive of her but are keen to ensure that they do all that they can to support members of staff in the future who may disclose domestic abuse. The Chair and Report Author have

therefore shared with the nursery the details about the materials and support available from the Employers Initiative on Domestic Abuse[12].

3.4.3 In addition, this Review is aware of the work being done within Essex to raise the awareness of domestic abuse to employers and the tools available to them. This is contained within Section 5 of the comprehensive Southend, Essex & Thurrock Domestic Abuse Boards Domestic Abuse Strategy 2020-2025 https://setdab.org/about-us/

3.5 James' mental health

3.5.1 James' first presentation to mental health services was in 2000 when he was 19 when he was admitted voluntarily to an acute inpatient unit in East of the county for two weeks. After discharge he was referred to a Community Mental Health Team (CMHT) in the East of the county. At this assessment, it was concluded that James was not showing evidence of a psychotic disorder but was struggling to cope with various stresses in his life.

3.5.2 The review is aware that James had a long history of 'mental and behavioural problems' dating back to 1990[13] when he was 9 years old. He was diagnosed with depression in 1997 at the age of 16.

3.5.3 The onset of James' mental health problems seemed to start in earnest when he was 17 years old when he started taking illicit drugs to overcome being bullied at school. His mental health worsened when he moved to university and continued to take illicit drugs. At the age of 18 James was discovered in a compromising position with a girl in bed by the girl's mother. They were part of a group that had been drinking, and neither apparently had any recollection of events. He was, however, reported to the police by her parents and then arrested on suspicion of rape. Nothing further came of this allegation, but James remained shocked and extremely anxious. There is no suggestion that the girl was under 16 years of age.

3.5.4 Whilst James was at university his experienced a psychotic episode related to fears that two men who ran a club in Birmingham had found out about the rape allegation, and he was going to be kidnapped, tortured and killed by these people. He believed they may have recruited others, and he thought Chinese 'triads' may be involved. These delusional beliefs continued through until 2017.

3.5.5 The events surrounding his initial breakdown at university continued to disturb him, and he was regularly preoccupied with concerns about people who had been involved in clubs and drug use in Birmingham. He spoke of wanting to move to other towns, hoping to make a fresh start and avoid the people he believed were following him. He made at least one trip to Cambridge while considering a move there, but said he saw a Chinese man who gesticulated at him.

3.5.6 James also has a history of deliberate self-harm having first been identified as taking a deliberate overdose of paracetamol in 2000.

[12] https://eida.org.uk/

[13] The earliest that medical records are available

3.5.7 In July 2006 he was admitted to the Princess Alexander Hospital following his arrest for the incident at a previous girlfriend's home[14]. At this time, he said that he had 'smashed his girlfriend's window in the context of his persecutory delusions'. He was released without charge and without an assessment being carried out. He was seen by the Crisis Resolution Team the following day and noted to be 'floridly psychotic with homicidal thoughts'. There was evidence of 'thought disorder along with acute and intense persecutory delusion'. On this occasion he believed his girlfriend to be 'an imposter and part of a conspiracy to hurt him'. He was then admitted to the Derwent Centre on a voluntary basis. This is the first record of him receiving inpatient treatment. He stayed as an inpatient for two weeks and, on discharge, he received an initial diagnosis of 'persistent delusional disorder'. He was given a range of appointments to be seen on a regular basis.

3.5.8 James had the following diagnoses:

- Mental and Behavioural disorder due to the use of alcohol
- Paranoid schizophrenia
- Generalised anxiety disorder

3.5.9 James was not comfortable with the diagnosis of paranoid schizophrenia, preferring to consider that he had developed a psychotic illness as a result of drug usage.

3.5.10 James received services from a wide range of clinicians including Consultant Psychiatrists, Psychologist, Psychotherapy, Community Psychiatric Nurse (CPN) or Community Mental Health Team (CMHT), Alcohol and Drugs Advisory Service (ADAT), Community Drug and Alcohol Team (CDAT), Consultant Neurologist and the Clozaril (anti-psychotic) clinic. He declined a referral to the National Psychosis Unit (national treatment centre for patients with schizophrenia and other psychotic disorders at the South London and Maudsley Hospital).

3.5.11 He was known to the Crisis Resolution and Home Treatment Team (CRHT) and would be admitted to a mental health ward if he required care as an in-patient (due to a deterioration of his mental health). A care plan package would be implemented upon discharge.

3.5.12 James' ongoing anxiety was seen as a response to his psychotic and paranoid thoughts, which affected his daily life. He continued to suffer from anxiety and paranoid symptoms which were never fully controlled by medication or psychological therapy. He continued to believe that he was being watched and followed and had particular concerns about being targeted by the police and by Chinese people. He would not talk to Heidi in their flat if their mobile phones were switched on because he believed they were being recorded by phone. When Heidi was at work or out at her parents he would phone her regularly saying there were people breaking in to get at him.

3.6 Southend, Essex and Thurrock's approach to tackling domestic abuse[15]

3.6.1 Southend, Essex and Thurrock's Domestic Abuse Board (SETDAB) is made up of representatives from agencies and organisations working to join up and better facilitate Southend, Essex and Thurrock's vision where everyone lives a life free from domestic abuse. The Board is responsible for designing and implementing the Joint Domestic Abuse

[14] This is detailed within the chronology
[15] https://setdab.org/about-us/

Strategy for Greater Essex. SETDAB provides strategic leadership to address domestic abuse by providing a multi-agency framework, common ethos and co-ordinated approach to innovate, drive change and address domestic abuse across Essex, Southend and Thurrock.

3.6.2 The Southend, Essex and Thurrock Domestic Abuse Strategy was launched in 2015 and informed by the 2015 Joint Strategic Needs Assessment, domestic abuse chapters and stakeholder consultations. The strategy is segmented into five high level outcomes:

- Young people enjoy healthy relationships;
- Victims (Adults and Children) and those at risk of experiencing domestic abuse feel and are safe;
- Victims (Adults and Children) are able to recover and move on to live independently;
- Perpetrators are prevented from causing physical and emotional harm;
- Communities have a greater awareness of what an abusive relationship is and how to report it and as a consequence feel safer.

3.6.3 The aim of this Strategy is to lead to consistent and coordinated action, bringing our collective resources together to address the issues of domestic abuse. The Domestic Abuse Board monitors the implementation of the Strategy and its underpinning action/ delivery plans.

3.7 National Confidential Inquiry into Suicide and Safety in Mental Health[16]

3.7.1 The NCISH database is a national case series of suicide, homicide and sudden unexpected death (SUD) by mental health patients over 20 years. The current suicide database stands at almost 127,000 suicides in the general population, including over 33,500 patients. This large and internationally unique database allows NCISH to examine the circumstances leading up to and surrounding these incidents and make recommendations for clinical practice and policy that will improve safety in mental health care. It must be remembered that the majority of violent crimes and homicides in the UK are committed by people who do not suffer from diagnosed mental ill-health. From the period of 2006 – 2016 11% of people convicted of homicide were mental health patients. Across countries, this figure was higher in Scotland and Wales where the general population homicide rates are also higher. 6% of the homicides were by people with schizophrenia (compared to a population rate of schizophrenia of around 1%). The number was broadly similar across the UK countries, taking into account population size.

3.7.2 **Patient homicide**

During 2006-2016, 11% of homicide convictions in the UK were by mental health patients, a total of 785 patient homicides over the report period, an average of 71 homicides per year. 6% were by people with schizophrenia, an average of 37 per year, including both patients and non-patients. In England, the number of patient homicides since 2009 has been lower than in previous years.

3.7.3 Detailed analysis of patient homicide since 1997 has highlighted:

- The victim is most likely to be an acquaintance and less likely to be unknown to the perpetrator than in homicides by non-patients.
- Most patients had a history of alcohol or drug misuse.

[16] https://sites.manchester.ac.uk/ncish/

- Homicide in the absence of comorbid substance misuse is unusual, around half of patients were not receiving care as intended, either through loss of contact or non-adherence with drug treatment patients are also at high risk of being victims of homicide.
- Most victims of patient homicide were an acquaintance (45%) or a family member including spouse (40%).

3.7.4 Research has found patient homicides where the victim was a stranger has fallen over the years and stranger homicides (15%) were less likely to be committed by patients compared to the general population (24%). In a previous study, it was found that patients were 2.6 times more likely to be a victim of homicide compared to the general population.

3.7.5 The most common primary diagnosis was schizophrenia and other delusional disorders (29%), followed by drug dependence/misuse (16%). Most patients (89%) convicted of homicide also had a co-existing problem of alcohol or drug misuse.

3.7.6 Almost half of all patients (628, 48%) were non-compliant with treatment or had lost contact with services. In a recent study, homicide offenders diagnosed with schizophrenia were more likely to have been disengaged with services prior to the offence. Therefore, services can help by being aware of the risk of losing patient contact as well as the problems of substance misuse and the higher risk of patients being victims of homicide.

3.7.7 Sadly, this case mirrors a number of the statistical findings of this valuable study.

Section Four – Lessons Learnt

4.1 That, despite it being a recommendation in a DHR published in 2017 there is still not a formal process by which the police can notify mental health professionals of an individual's deteriorating mental health where it does not meet the threshold for Section 135/136 of the Mental Health Act 1983 or the Mental Capacity Act 2005.

4.2 Had the incident been correctly graded as a domestic incident then greater priority would have been given to the police response.

4.2 If a mental health practitioner had been based in the force control room on the night of the incident, with access to mental health records, then the force control room would have been able to assess the concerns of James' parents alongside his mental health history.

4.3 A transfer summary in the electronic medical records (regarding patients with mental issues) was not completed when James moved to a new area.

4.4 James' GP was not kept informed the interaction with other medical services with him and was not made aware when when he did not attend (DNA) appointments with other services.

4.5 James' GP did not complete a mental capacity assessment at times when, due to his relapse, he may have appeared to lack of capacity.

4.6 It is clear that James had a serious mental illness that was treated over many years by the Trust. He was never symptom free but had access to medical and psychological care which supported him to maintain a level of wellbeing and independence. He was provided with consistent care for over 10 years.

4.7 James continued to abuse alcohol until October/November 2017, and his engagement with psychological care tended to focus on coping skills rather than attitude change. He continued to question his diagnosis and suffered ongoing anxiety as a consequence of his paranoia.

4.8 James had a supportive partner and family who provided emotional and practical assistance. He was able to maintain independent living with his partner, although the choices he made about the use of alcohol could be said to be unwise.

4.9 The move to the Mid Essex team took place months after they moved house, and this was largely because of James' anxiety about change. The handover was not structured, and was not supported by a full care plan and risk assessment review. Because of service changes, he did not have a medical review between September 2016 and October 2017.

4.10 The management of the cessation of clozapine (medication) following the red result in October 2017, did not offer sufficient support to James and Heidi. It was recognised that he was relapsing in November and December 2017, and this should have triggered MDT discussion, and a clear care and risk management plan that considered the presenting risks.

Section Five – Recommendations

5.1 That a formal process should be developed by which the police can notify mental health professionals of an individual's deteriorating mental health where it does not meet the threshold for Section 135/136 of the Mental Health Act 1983 or the Mental Capacity Act 2005. The review reiterates the recommendation made in previous DHRs published in 2017.

5.2 That Essex Police and EPUT consider basing a mental health practitioner in the force control room with access to mental health records. Had this been in place on the night of the incident, then the force control room would have been able to assess the concerns of James's parents alongside his mental health history.

5.3 That NHS England and CCGs remind primary care services to complete a transfer summary in the electronic medical records (regarding patients with mental issues) when a surgery becomes aware that a patient is moving to a new locality.

5.4 That all health agencies are reminded of the significance of information sharing with primary care services (GPs) to ensure clarity of information and continuity of care. It would be helpful if GPs are made aware when patients do not attend (DNA) appointments with other services.

5.5 That NHS England and CCGs remind GPs to complete a mental capacity assessment when there appears to be a lack of capacity.

Section Six – Conclusions

6.1 This review has considered all of the information gathered together across a range of statutory and voluntary agencies, from employers, friends and family of both Heidi and James. There is no doubt that Heidi loved and cared for her partner and did everything she could for him to help him cope with his illness.

6.2 It is also clear that James suffered from severe mental illness. The fact that he is unfit to stand trial and is likely to spend the rest of his life in a hospital setting is testament to that fact. There was no dispute between the prosecution and defence in this case about the level of his illness, nor that a hospital order was the correct form of 'disposal', nor, indeed, that he should be subject to a lifetime special restrictions order. There is rarely such a level of agreement. It must be noted however, that at times James did not take his medication, and did abuse alcohol and controlled drugs; these were choices he made.

6.3 Heidi was killed in what the Judge described as a 'frenzied and awful killing'. The fact that she called her partner's parents for help illustrates that those last few minutes of her life must have been mystifying and terrifying.

6.4 This review has sought to establish whether prior domestic abuse was a feature of the couple's relationship. There are indicators of behaviour which may have been indicative of control but equally they may have arisen from this perpetrator's level of illness, we are simply unable to say.

6.5 The police had no additional information about the level of illness from which James was suffering at the time his mother called them for help. Had they known that he was a person who may be descending into crisis it may well have resulted in a quicker despatch, or indeed a referral for immediate attendance by specialist mental health nurses, or both. This highlights a gap that continues to exist in our emergency response to people with serious mental health issues. It is the understandable advice given by mental health staff to carers that if they fear for their or their loved one's safety then they should call for emergency help, yet, the police are not afforded that information to allow them to properly risk assess for appropriate deployment. More needs to be done. The recommendations within this review are aimed at protecting others who may find themselves in similar circumstances.

6.6 This review, in common with others, demonstrates that the level of risk of harm to, or by, those with mental illness increases at the time of significant events in a person's life. In this case a house move also meant a change in the mental health team supporting James. This must be recognised in care plans and crisis plans discussed fully with all those involved in that person's life.

6.7 This tragic loss of life has left two families devastated. It's ripples go far wider than those immediately involved. We hope that the lessons learned and the changes made as a result of this review are able to give them some comfort in that others will be better protected. Our thoughts are with both families.