Supplementary Report following the Mental Health Homicide Investigation into the death of Mr RM

This report was commissioned by the Bournemouth, Christchurch and Poole Safeguarding Adults Board.

The report author is David Mellor and the report was presented to the Board in February 2021.

The report is to be read alongside the Niche report entitled *'An independent investigation into the care and treatment of a mental health service user Mr P in Dorset'*

February 2020

Which can be found at:

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2020/07/Final-report-Mr-P-Dorset-28.7.20.pdf

Background to the Report

In August 2016 Mr RM, a former patient of mental health services in Dorset, was killed by another patient Mr P. A Mental Health Homicide Investigation was undertaken which reported in February 2020.

The Bournemouth and Poole (now BCP) Safeguarding Adults Board agreed that the death of Mr RM had met the criteria for a Safeguarding Adult Review. This was however deferred until the completion of the MHHI.

Mr P was for many years a Category 2 violent offender under the Multi Agency Public Protection Arrangements (MAPPA) until his Community Treatment Order was discharged in November 2014. The terms of reference for the MHHI included a requirement to 'determine whether there were any missed opportunities to engage other services/agencies, in particular Housing providers, to support Mr P and manage any presenting risks for example MAPPA or vulnerable adult processes'.

On reviewing the final report it was felt by the SAB that this aspect of Mr P's supervision and support had not been covered in sufficient depth. It therefore commissioned this supplementary report into the MAPPA related aspects of Mr P's care and treatment.

There is a link to the NHSE website which will take the reader to the MHHI and provide more detailed background and chronology of the circumstances leading to Mr RM's death.

Members of the Board express their sincere condolences to the family of Mr. RM and are grateful for their contribution to this report. I am pleased that they feel that the supplementary report has added to their understanding of what could have been done differently in managing the risks posed by Mr P. The MHHI is prefaced by their description of their son and what his loss has meant to the family.

By far the majority of MAPPA cases are now managed at Level 1 by a single agency. This includes men such as Mr P who pose a continuing risk of harm to others. The supplementary report provides an important reminder of the responsibilities of MAPPA Duty To Cooperate agencies in supervising such offenders at this level.

Barrie Crook

Independent Chair

Bournemouth Christchurch and Poole Safeguarding Adults Board

March 2021

Bournemouth, Christchurch and Poole Safeguarding Adults Board

Dorset MAPPA Strategic Management Board

Multi-Agency Public Protection Arrangements (MAPPA) Review

1.0 Introduction

1.1 On 14th August 2016 the perpetrator killed a man in whose flat he had previously spent some time staying whilst homeless. The perpetrator was later acquitted of murder but convicted of manslaughter by reason of diminished responsibility. He was sentenced to a hospital order under the provisions of Section 37 of the Mental Health Act, together with a restriction order without limit of time.

1.2 The perpetrator has a substantial criminal history, including offences of violence. He also has an extensive mental health history, first coming into contact with mental health services in May 1996 and later spending more than 13 years in various secure mental health hospitals prior to being discharged into the community in November 2013 on a Community Treatment Order (CTO). This Order was formally rescinded in November 2014 and thereafter care was provided to the perpetrator on an 'informal' or voluntary basis.

1.3 NHS England commissioned an independent Mental Health Homicide Investigation (MHHI) which are undertaken when a homicide is committed by a patient being treated for mental illness. These investigations are separate from criminal and Coronial proceedings and are intended to identify what – if anything – went wrong with the care of the patient, minimise the possibility of recurrence and make recommendations for the delivery of health services in the future. The MHHI was completed in October 2019 and published in July 2020.

1.4 However, having reviewed the MHHI report, Bournemouth Christchurch and Poole Safeguarding Adults Board decided that the application of Multi-Agency Public Protection Arrangements (MAPPA) to the perpetrator needed to be addressed in greater depth than was achieved in the MHHI report in order for learning to be fully identified and recommendations made. The Safeguarding Adults Board and the Dorset MAPPA Strategic Board decided to commission a further short review to review the MHHI and provide the Boards with a second opinion and a more detailed perspective of the MAPPA elements.

1.5 The Boards commissioned David Mellor to conduct the review. He is a retired police chief officer who has experience of the management of the risks presented by violent and sexual offenders and over eight years' experience of conducting statutory reviews. He has no connection to services in Bournemouth, Christchurch and Poole.

2.0 Multi-Agency Public Protection Arrangements

2.1 Multi-Agency Public Protection Arrangements (MAPPA) were established in each of the 42 criminal justice areas of England and Wales by the Criminal Justice Act 2003. These arrangements are designed to protect the public from serious harm by sexual and violent offenders and require the local criminal justice agencies and other bodies dealing with offenders to work together in a co-ordinated manner.

2.2 There are 3 categories of offender whose risk of harm to the public is managed through MAPPA:

Category 1 – Registered Sexual Offender

Category 2 – Violent or Other Sexual Offender

Category 3 – Other Dangerous Offender

2.3 MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at Level 1 - ordinary agency management – which involves the sharing of information but does not require multi-agency meetings. The others are managed at Level 2 if an active multi-agency approach is required

including MAPPA meetings, or at Level 3 - if senior representatives of the relevant agencies with the authority to commit resources are also needed.

3.0 Methodology

3.1 The author of this review has had access to the MHHI report together with information gathered from agencies in Bournemouth, Christchurch and Poole following the perpetrator's trial. Where the author has requested further information from agencies, this has been provided where it is available. To examine the application of MAPPA in this case, the author has referred to the MAPPA guidance which applied at the time events took place.

4.0 Analysis of key decisions

4.1 The perpetrator's criminal history began with assaults, including a conviction for Section 18 wounding in his late teens for which he was sentenced to three years youth custody, taking vehicles without consent, several arsons, a Section 20 wounding for which he was sentenced to three years imprisonment in his mid-20s, firearms offences for which he was sentenced to 18 months imprisonment at the age of 30 and two counts of threats to kill for which he was sentenced to 30 months imprisonment in 1998 (age 32).

4.2 He began to be referred to mental health services by criminal justice services from 1996 onwards (age 29/30) and whilst serving a term of imprisonment for two counts of threats to kill in April 1999, was transferred from prison to Ravenswood House in Hampshire which is a medium secure unit providing assessment, care and treatment for adults with serious mental illness under Section 47 of the Mental Health Act. (Section 47 allows for the transfer of a person serving a prison sentence from prison to hospital where that person is assessed as having a mental disorder). When his prison sentence expired in June 1999, the perpetrator remained at Ravenswood House on a 'notional' Section 37 of the Mental Health Act. (Section 37 relates to a Hospital Order which may be imposed by a Court as an alternative to a prison sentence where the person is assessed as having a mental disorder. A 'notional' Section 37 means that the person is treated as though they are detained under a Section 37 Hospital Order).

4.3 The perpetrator was transferred to Broadmoor Hospital, one of three high security psychiatric hospitals in England and Wales, on 4th December 2002 after

stabbing a fellow patient near his eye with a table knife and later making plans to kill another patient.

4.4 On 17th March 2009, after spending over six years in Broadmoor Hospital, the perpetrator was transferred back to Ravenswood House. This transfer to a medium secure establishment was justified on the basis of the perpetrator's settled mental state over a protracted period and was initially for a trial period. On the same date the Hampshire MAPPA co-ordinator was advised of the transfer by Thames Valley Police, in whose area Broadmoor Hospital is situated (This review has received no information about how MAPPA arrangements were applied to the perpetrator prior to this date). The perpetrator's formal transfer to Ravenswood House took place on 1st June 2009.

4.5 The transfer of the perpetrator to a low secure ward in St Ann's Hospital in Poole was under discussion from early 2010 but the perpetrator was said to be adamant that he did not wish to return to Dorset because he feared reprisals from a drug dealer and expressed dissatisfaction with the treatment he had received in St. Ann's Hospital previously. After being advised that Dorset would be unwilling to fund an out of county placement following his transfer from Ravenswood House, the perpetrator agreed to consider St Ann's Hospital. A consultant clinical and forensic psychologist from the Dorset Forensic Team of the Dorset HealthCare University NHS Foundation Trust (hereinafter referred to in this report as 'the Trust'), which would be responsible for co-ordinating the perpetrator's care at St Ann's Hospital, began attending Ravenswood House Care Programme Approach (CPA) meetings in respect of the perpetrator from March 2010. The Trust has commented on this report and has advised that whilst a consultant clinical and forensic psychologist from the Dorset Forensic Team did begin attending the CPA meetings, the responsible clinician and the care co-ordinator for the Dorset Forensic Team would be responsible for co-ordinating the perpetrator's care once he transferred to St Ann's Hospital.

4.6 A forensic social worker from Ravenswood House submitted a MAPPA referral on 30th June 2010. On 6th July 2010 an initial MAPPA level setting meeting took place which was attended by the forensic social worker and a detective inspector from Hampshire Constabulary. At this meeting the perpetrator was identified as a Category 2 Offender in that he had been convicted of an offence specified under the Criminal Justice Act 2002 (in the perpetrator's case this was the two counts of threats to kill for which he had been convicted in 1998) and received a qualifying sentence or disposal for that offence (in the perpetrator's case he continued to be detained under the 'notional' Section 37 Hospital Order). It appears that it was decided the risk of harm he presented to the public was to be managed at Level 1, although this is not entirely clear from the documents from that time, many of which

were not fully completed. Following this meeting a MAPPA registration form was sent to the Hampshire MAPPA co-ordinator.

4.7 During August 2010 the perpetrator expressed a desire to kill a fellow patient and threatened to make a weapon with which to stab him. He also threatened to kill the patient by strangling him or pouring boiling water on him whilst he slept (MHHI report Paragraph 5.210). As a result, the perpetrator was transferred to an acute ward for a period and his escorted community leave was stopped until 18th October 2010, when it was said to have been reinstated (MHHI report Paragraph 5.214).

4.8 A MAPPA offender profile appears to have been completed on 1st November 2010, although the MHHI report states that it was completed a month earlier on 1st October (MHHI report Paragraph 8.55). This profile confirmed the perpetrator's status as a Category 2 Offender and stated the level at which he was to be managed as 'low'. It is assumed that this indicated that he was to be managed at Level 1. The overall risk he was assessed as presenting was stated to be 'low'. A police offender manager had now been appointed in respect of the perpetrator. It is assumed that the perpetrator was considered to be a 'low' risk on the basis of the limited risk he presented to the community at that time, rather than fellow patients, one of whom he had threatened to kill only three months earlier.

4.9 A MAPPA Level review meeting took place on 21st December 2010. MAPPA guidance (2009 version 3) stated that a Level 1 review must identify any new information relating to the case which has an effect upon the risk assessment and risk management plan, and that the latter plan should be reviewed and revised as necessary. The 2009 guidance went on to state that whether or not the case required a referral to MAPPA Level 2 or 3 should be recorded. The current MAPPA guidance (2019 version 4.5) states that the decision to manage at Level 1 should be reviewed when there is a change in circumstances, significant information is received from another agency or where there is an escalation of risks. At the December 2010 MAPPA Level review meeting, the perpetrator's level was increased to Level 2 on the grounds that he was about to start unescorted community leave which would initially be shadowed. His police offender manager was tasked with preparing an action plan. The Level 1 Review form was poorly completed. The sections of the form in which the nature of the risk should be set out and the identity of who may be at risk were left blank. The factors likely to increase the risk of serious harm were stated to be 'not taking medication, poor mechanisms to deal with problems and verbal threats' whilst factors likely to decrease the risk of serious harm were stated to be the 'opposite' of these. Whilst compliance with medication would decrease the risk of serious harm, it makes no sense to say that the opposite of 'poor mechanisms to deal with problems' would decrease risks, given that the

perpetrator was unlikely to be able to improve his problem solving mechanisms without a great deal of support. None of the boxes to indicate that a series of post-Level 1 review actions had been actioned were ticked.

4.10 The MHHI report states that the review form did not indicate whether or not the perpetrator remained on Level 1 (MHHI Paragraph 8.58). This is incorrect. The Level 1 review form and the consequent action plan, which were shared with this MAPPA SCR and the MHHI, clearly state that the perpetrator's Level was increased from 1 to 2 at this time.

4.11 On 23rd December 2010 the perpetrator's police offender manager prepared an action plan to address the risk of him absconding whilst on unescorted community leave which was anticipated to begin 'early in the New Year'. Specific actions in the event of the perpetrator absconding were included in the action plan which also noted that escorted family visits to his father and brother's address in Somerset would be continuing. It was stated that there was a care plan in place for these escorted family visits. The action plan anticipated that the perpetrator would be transferred to St Ann's Hospital in Poole over the following 6-9 months.

4.12 On 29th December 2010 the perpetrator was allowed shadowed leave (unescorted community leave with staff following or watching him covertly) (MHHI report Paragraph 5.217). During January 2011 unescorted leave was said to have been 'sometimes' shadowed (MHHI report Paragraph 5.218).

4.13 During Spring of 2011 the perpetrator repeatedly expressed the wish to be discharged into the community directly from Ravenswood House and avoid the St. Ann's Hospital pathway altogether. His unescorted leave was twice suspended for short periods. During May 2011 he asked his social worker to contact his son, who he had not seen for a decade and whose whereabouts he had no knowledge of.

4.14 On 23rd June 2011 a MAPPA meeting took place to discuss the perpetrator. He was now described as a Level 1 case. It is not known when he stopped being managed at Level 2 but the decision may have been taken at this meeting. At the meeting it was stated that the perpetrator now had unescorted community leave to the local area (3 visits weekly of 4 hours duration). He had visited St Ann's Hospital on two occasions to which it was hoped he would be transferred, although it was said that the perpetrator did not want to move back to the Bournemouth area 'as he knew too many people there'. He was also said to be attending a 'moving on' group

which was going 'OK'. A further MAPPA review meeting was planned for 22nd December 2011.

4.15 Before the next scheduled MAPPA meeting could take place, the perpetrator was transferred to St Ann's Hospital on 9th November 2011. The discharge summary stated that he was 'registered under MAPPA' and under 'current needs' was listed 'communication with MAPPA about the discharge'. The discharge summary assessed the perpetrator's risk of harm to others as 'low' although it was acknowledged that this could escalate quickly in 'a setting of adversity and stress'. It was further stated that the perpetrator was prone to acting impulsively, including with violence when he felt threatened or stressed. The longstanding hallucinations of the voice of 'Hans Blood' telling him to harm others was also referred to.

4.16 Hampshire MAPPA received a notification from Ravenswood House on 19th December 2011 which advised that the perpetrator had been transferred to St Ann's Hospital on 9th November 2011. Hampshire MAPPA records state that 'MAPPA file split, archived and retained in 1 OCU'. An interpretation of this record could be that the MAPPA file was split into two files, one of which was archived on the relevant Hampshire Constabulary operational command unit (OCU). If this interpretation is correct, it is worthy of note that there is no note made of the second MAPPA file in respect of the perpetrator being sent to Dorset. Dorset Police have advised this review that the perpetrator was never registered as a MAPPA nominal on their VISOR system (the central information system for up-to-date information about MAPPA Offenders, which the MAPPA 'responsible authority' agencies can access and update) and so it would appear that Hampshire MAPPA did not advise Dorset MAPPA of the transfer of the perpetrator or, if they did advise Dorset MAPPA, the perpetrator's MAPPA status was not recorded by Dorset. It should be noted that the completion of MAPPA documentation in respect of the perpetrator was very poor whilst he was a Hampshire MAPPA Offender. It is not known whether this may have been a contributory factor in the unsatisfactory communication between Hampshire and Dorset MAPPAs. Hampshire MAPPA has been given an opportunity to comment on this report. Their response does not provide any further clarification of what action they took in response to the notification of the transfer of the perpetrator from Ravenswood House to St Ann's Hospital. However, it is clear that the Trust was aware that the perpetrator was registered as a MAPPA offender.

4.17 The MHHI report states that the perpetrator was admitted to St Ann's Hospital in January 2012 (MHHI report Paragraph 5.241), which is incorrect. Elsewhere in the MHHI report, it correctly states that the perpetrator transferred to St Ann's Hospital in November 2011 (MHHI report Table 2) but the mistaken belief that the perpetrator did not transfer to St Ann's Hospital until January 2012 leads the authors of the

MHHI report to question why they had not been provided with any records of the scheduled 22nd December 2011 MAPPA meeting (MHHI report Paragraph 8.59). They were not provided with any records of this meeting because it didn't take place because the perpetrator was no longer at Ravenswood House.

4.18 It may have been sensible to bring forward the scheduled MAPPA meeting so that it was held prior to the perpetrator's transfer to St Ann's Hospital, although it is not known how much notice of the date of transfer Ravenswood House would have been given. However, the final Ravenswood House CPA meeting for the perpetrator took place on 21st September 2011 at which there was an opportunity to discuss all aspects of his impending transfer to St Ann's Hospital including any potential risks.

4.19 Once the perpetrator was transferred to St Ann's Hospital in November 2011, then the Trust, as the provider of the Dorset Forensic Team, had a 'duty to co-operate' with the MAPPA 'responsible authority' – Police, Probation and Prisons in each area are 'responsible authorities' for the purposes of MAPPA – in assessing and managing the risks which the perpetrator presented.

4.20 Where a MAPPA Offender is being managed at Level 1, as was the case with the perpetrator, the role of 'duty to co-operate' agencies is vital because Level 1 management consists only of ordinary agency management, involving the sharing of information but not requiring multi-agency meetings. Thus the Trust as the lead agency for the perpetrator had primary responsibility for managing the risks presented by the perpetrator. However, the MAPPA guidance (2009 version 3) anticipated that other agencies were likely to be involved in risk management stating that to assist in assessment, the lead agency should seek information from other agencies to which the offender is known. The current MAPPA guidance goes further than the 2009 guidance in stating that the lead agency must be able to satisfy themselves that they have taken all reasonable steps to gather information from other agencies, have responded appropriately to the offender's risk and that Level 1 management is appropriate.

4.21 By June of 2012 the Dorset Forensic Team began planning to discharge the perpetrator from St Ann's Hospital into supported housing in Bournemouth on a Community Treatment Order – which is an order made by a responsible clinician under Section 17A of the Mental Health Act to give a mental health patient supervised treatment in the community. Conditions are attached to support the patient's stability and prevent relapse. If these conditions are not followed, the patient can be recalled to hospital. Leven House in Bournemouth was identified as a suitable mental health support housing service.

4.22 However, the perpetrator's priority was to relocate to Cornwall to live near his son with whom he had been having almost daily telephone contact since January 2012. Staff noted that the perpetrator had a 'somewhat idealistic view' about the prospect of resuming his relationship with his son and his ex-partner (his son's mother). On 29th June 2012 the perpetrator visited his son, his ex-partner and her partner in Cornwall for the first time and was escorted by two members of the Dorset Forensic Team. The perpetrator visited his son again on 2nd August 2012 and began having overnight leave to Leven House.

4.23 On 5th September 2012 the perpetrator was discharged from St Ann's Hospital to Leven House on a Community Treatment Order.

4.24 Whilst managing the risks presented by the perpetrator was clearly a core responsibility of the Dorset Forensic Team, and one which the Team appears to have taken very seriously indeed, during the period from the perpetrator's transfer to St Ann's Hospital on 9th November 2011 until his transfer to Leven House on 5th September 2012, it is unclear how the Dorset Forensic Team fully discharged the MAPPA 'duty to co-operate' responsibilities placed upon the Trust. In May 2012 the Forensic Team requested the disclosure of the perpetrator's previous convictions from Dorset Police. It is unclear to what specific use the Forensic Team put this information. The Forensic Team acknowledged that they would need to initiate discussions with Cornwall (MHHI report Paragraph 5.245) but there is no indication that any information was shared with mental health services in Cornwall or any of the MAPPA responsible authorities there during this period. The Trust has advised this review that, in their view, there were no specific risks associated with the perpetrator's visits to Cornwall nor was there a plan to discharge the perpetrator to live in Cornwall at that point, therefore they feel that Cornwall MAPPA or Devon and Cornwall Police would not have added anything to the risk management plan that wasn't already considered under CPA.

4.25 The Dorset Forensic Team had reservations about discharging the perpetrator to Leven House (MHHI report Paragraph 5.258) but do not appear to have considered reviewing the MAPPA Level at which the perpetrator was managed at this time or notifying any of the MAPPA 'responsible authorities' that they were discharging the perpetrator from inpatient services. Whilst it is clear that the Dorset Forensic Team were aware that the perpetrator was registered as a MAPPA offender - as this is recorded in a succession of risks assessments of the perpetrator they carried out - there is no indication that his status as a MAPPA offender informed the manner in which they managed the risks he presented to the public during this

period. The Trust has advised this review that they are unclear how recognition of the perpetrator's MAPPA status would have enhanced the assessment of risks presented by the perpetrator. The independent author of this review finds it troubling that the Trust take this view. Contact with MAPPA 'responsible authorities' would have brought the benefits of involving agencies who had more experience of managing violent offenders and enabled the Forensic Team's approach to managing the risks presented by the perpetrator to be challenged constructively.

4.26 Following his discharge to Leven House, the perpetrator was initially provided with 24-hour support before moving to an annex in January 2013 to give him greater independence. The Dorset Forensic Team provided care co-ordination. The perpetrator continued to be highly motivated to move to live with, or near, his son in Cornwall and had overnight visits to his son, his ex-partner and her partner, who lived in an isolated village in Cornwall, in October and December 2012.

4.27 In late January or early February 2013 the Dorset Forensic Team made a referral to a consultant forensic psychiatrist in Cornwall. The initial view of forensic mental health services in Cornwall was that care co-ordination from their Forensic Team would not be appropriate as the perpetrator was on a Community Treatment Order rather than a restriction order. They also felt that it would not be possible to replicate the intensity of input the perpetrator was receiving in Dorset and that his mental state would need to be stable at the point of transfer. Additionally, they felt that the perpetrator would need to move at first into supported accommodation in Cornwall – which would present an out of area funding challenge for Bournemouth Borough Council which was responsible for the funding of his Section 117 Mental Health Act aftercare.

4.28 It is not known whether the perpetrator's MAPPA status was discussed with the Forensic Team in Cornwall during the initial discussions of his proposed transfer to Cornwall. One of the perpetrator's visits to his son in Cornwall was notified to the Forensic Team there because the latter team took the opportunity to carry out an assessment of him during that visit.

4.29 On 24th March 2013 the perpetrator disclosed that he had taken amphetamine to staff at Leven House who immediately evicted him, rendering him homeless, and he was recalled to St Ann's Hospital for a period of assessment and treatment. It was noted that there had been a change in the perpetrator's mental state in the weeks prior to his recall.

4.30 Following his recall to St Ann's Hospital, unescorted leave was suspended for a period in May 2013 after screening positive for amphetamines. Visits to his son and ex-partner in Cornwall later resumed. In June 2013, he was referred to the newly developed Pathfinder service – a community based service for forensic patients, diagnosed with a personality disorder, who were at risk of offending – who would support him when a further attempt to discharge him to the community under a CTO was made.

4.31 By the summer of 2013 the perpetrator had two voluntary jobs in the community and was continuing to make unescorted visits to his son in Cornwall. The offer of a housing placement in Bournemouth was withdrawn over concerns about the risks he presented in September 2013.

4.32 During October 2013 the perpetrator was accepted by Northover Court in Bournemouth, a mental health support housing service with 24-hour supported accommodation in which he was to share a two-bedroom flat. He began extended leave there later in the month and on 29th November 2013 he was discharged from St Ann's Hospital under a CTO. This discharge was preceded by a discharge planning meeting 3 days earlier in which it was noted that the perpetrator was at risk of emotional dysregulation if his (idealised) family relationships became difficult. The CTO was considered to be necessary due to the perpetrator's impulsivity, concrete thinking, limited insight, and vulnerability to stressors leading to risk to self and others. Relapse risk factors as non-compliance, non-engagement, social stress, substance misuse, and poor physical health were documented.

4.33 Once again there appeared to be no consideration of reviewing the MAPPA Level at which the perpetrator was managed at this time or notifying any of the MAPPA responsible authorities that they were discharging the perpetrator. There appeared to be an even stronger case for reviewing the perpetrator's MAPPA level at this point, given that the previous attempt to discharge him under a CTO had not succeeded.

4.34 Following his discharge to Northover Court on a CTO, the referral of the perpetrator to Cornwall was postponed until accommodation in that county had been identified and secured by the Dorset Forensic Team. The perpetrator continued to visit his son and ex-partner in Cornwall including a period of extended leave over Christmas and New Year. He tested positive for amphetamines in January 2014 and consideration was given to disclosing risk information about the perpetrator to a female resident of Northover Court with whom he had been spending a lot of time. The MAPPA guidance (2012 version 4) required all MAPPA offenders to be risk

assessed to identify anyone who may be at risk of serious harm to them. For Level 1 offenders it was not necessary to inform the MAPPA co-ordinator about disclosure decisions, but details of the decision making must have been recorded on the lead agency's case management system and must have been made available if required. The current MAPPA guidance on this aspect of disclosure is unchanged. The perpetrator's mental health history was shared with the female resident in May 2014. It is unclear whether this disclosure included the risk of harm he could present to others.

4.35 The perpetrator's CTO was renewed on 23rd May 2014 when it was noted that he remained vulnerable to poor decision making, at risk of disengagement and at risk of moving to Cornwall without proper planning. In late July 2014 the perpetrator was advised that his CTO would not be renewed in November 2014 if he remained stable, although it was acknowledged that should he disengage from his treatment plan and his lifestyle become more disorganised there would be an increased risk of a return to illicit substances and the consequent risks of violence and harm to himself.

4.36 The perpetrator was discharged from his CTO on 7th November 2014. He would continue to be supported by the Pathfinder team for a time before being transferred back to the Dorset Forensic Team's caseload. Thereafter, the plan was to transfer him to the community mental health team's (CMHT) caseload after around six months. The discharge from his CTO marked the first time that the perpetrator had been an informal patient for 16 years. This was also the point of the perpetrator's exit from MAPPA supervision. For Category 2 Offenders they exit MAPPA when a Community Treatment Order expires (MAPPA 2012 guidance version 4). At this point the responsible clinician from the lead agency should have informed the MAPPA co-ordinator that the perpetrator was no longer subject to MAPPA supervision. The current MAPPA guidance is more explicit about this requirement than the MAPPA guidance in force at the time (MAPPA 2012 version 4). However, there is no indication that this was done. The Trust accepts that the responsible clinician should have informed the MAPPA co-ordinator that the perpetrator was no longer on a Community Treatment Order, adding that responsible clinicians now undergo specific MAPPA training to heighten awareness of MAPPA procedures and it is planned that the process of notification and referral to MAPPA is to be audited regularly.

4.37 The discharge of the perpetrator from the CTO was also an opportunity for the Trust to engage the 'responsible authorities' in a discussion about the risks that the perpetrator presented to others and consider developing a contingency plan should he come to the attention of the authorities again. This was the first time the

perpetrator had been an informal patient for 16 years, he remained vulnerable to poor decision making, at risk of moving to Cornwall without proper planning and at risk of disengagement. Should the perpetrator have disengaged from his treatment plan and his lifestyle become more disorganised, it was recognised that there would be an increased risk of a return to illicit substances and the consequent risks of harm to himself and others.

4.38 The Trust was the 'duty to co-operate' lead agency for managing the risks that the perpetrator as a MAPPA Category 2 Offender presented to the public for 3 years from November 2011, when the perpetrator was transferred from Ravenswood House to St Ann's Hospital, until November 2014 when his CTO was discharged. Whilst it is clear from documentation that the Trust's Forensic Team was aware that the perpetrator was subject to MAPPA supervision, they do not appear to have discharged, or considered discharging, many of the responsibilities expected of the 'duty to co-operate' lead agency. This continuing omission was reinforced by the fact that Dorset MAPPA had no record of the perpetrator as a MAPPA Offender. In their contribution to this review the Trust asks whether the perpetrator committed any offences during this period. The perpetrator was clearly misusing controlled drugs during this period, admitting taking amphetamines in March 2013 and testing positive for amphetamines in May 2013 and January 2014. He was noted to make 'occasional' threats of violence to other patients, including a threat to break the arms of another patient who picked up his drink. He disclosed that he had kept and illegally driven a car for three months until 'he was caught'. He was also believed to have been involved in obtaining and supplying duty free tobacco for several months.

4.39 This does not mean that the risks that the perpetrator presented to public safety went unmanaged during this period that the Trust was the 'duty to cooperate' lead agency. MAPPA guidance recognises that interventions available under CPA will be the most appropriate way to manage the offender's risks (MAPPA 2012 guidance version 4). However, the guidance states that experience shows that the effective management of MAPPA Level 1 Offenders under CPA by the lead agency 'cannot be taken for granted' and that 'without appropriate planning and communication, the responsible authority might find itself suddenly dealing with a dangerous offender who has historically been dealt with by a health disposal but who for a variety of reasons is now considered unsuitable for such an approach' (MAPPA 2012 guidance version 4). Arguably, there were periods during which the Trust was the lead agency for the perpetrator as a MAPPA Category 1 Offender when such circumstances could have arisen, particularly during the two periods when the perpetrator was discharged into the community under a CTO. During the first of these CTO discharges (September 2012 until March 2013) the additional support from the Pathfinder team did not appear to be available. The Trust has advised this review that the perpetrator was subject to close monitoring by the Dorset Forensic Team

and any escalation and risk would have been noticed early. The Trust adds that if the perpetrator had exhibited criminal conduct or presented as an imminent risk of serious harm then active interagency management would have been considered.

4.40 The Trust MAPPA policy which was in being at the time Dorset Forensic Team was the lead agency for the perpetrator has been shared with this review. The policy sets out how the Trust would engage with the MAPPA process but focussed exclusively on the management of Level 3 cases and was silent on the role of 'duty to co-operate' agency responsibilities in respect of Level 1 and Level 2 cases.

4.41 Following the discharge of his CTO in November 2014, the perpetrator moved to Cornwall on 7th June 2015, at which point responsibility for his care and treatment transferred to Cornwall Partnership NHS Foundation Trust. There he was under the care of the forensic team for a brief period of transition before he was transferred to a community mental health team.

4.42 He stayed with his son in Cornwall but these arrangements quickly came under strain as Bournemouth Borough Council, which retained responsibility for his Section 117 aftercare was unwilling to fund accommodation in Cornwall as the perpetrator was considered to have made himself homeless and had not needed supported accommodation at the time he left Bournemouth. The perpetrator was sleeping on his son's sofa and feared that his presence would put his son's tenancy at risk due to accommodation sharing. By August 2015 the perpetrator had secured his own accommodation which was around 20 miles away from where his son lived. Later that year the perpetrator's other son, from whom he was estranged, died, reportedly by hanging.

4.43 By March 2016 the perpetrator appeared to be staying with his son once more and having difficulty coping. He had reported regular amphetamine and periodic opiate use to his GP and expressed the wish to end his life to the community mental health team. It appears that the home treatment team, the police and the ambulance service had some involvement with the perpetrator during that month.

4.44 In late March 2016 the perpetrator returned to Bournemouth where he was homeless. The Dorset Forensic Team accepted him back onto their caseload on an informal outpatient basis on 18th May 2016. The MHHI report noted that the perpetrator was accepted back onto the team's caseload without a multi-disciplinary review which the report felt was a missed opportunity to revise the historical information held and update the diagnostic formulation (MHHI report Paragraph

1.33). It was also a missed opportunity to re-assess the perpetrator's risk of harm to himself and others. Since his return to Bournemouth, the perpetrator had been spending time at Northover Court where he had been hiding in tenant's bedrooms. It was also thought that he had been staying with a community mental health team patient and by late May 2016 the perpetrator and a female Northover Court resident, who was described as vulnerable, were planning to move to a property together.

4.45 Difficulties were experienced in engaging with and supporting the perpetrator to access GP services and apply for housing whilst he was homeless. Two accommodation providers declined a referral because they considered the risks that the perpetrator presented to be too high.

4.46 On 4th June 2016 the perpetrator was arrested by the police for being drunk and disorderly and was taken to Hospital A&E as a result of concern about unspecified health issues. Assessments by Hospital mental health services and subsequently by the criminal justice liaison nurse when the perpetrator returned to police custody were not carried out because of concerns that this would reinforce what professionals at that time perceived to be 'accommodation seeking behaviours' by the perpetrator, which, it was decided, should be resisted unless there was a clear deterioration in his mental state. The perception that the perpetrator was being manipulative in order to access accommodation appears to have driven Dorset Forensic Team's lack of appreciation of the risk he presented to others until shortly before the murder of the victim. The MHHI report concluded that hospital admission should have been 'more properly or formally considered' on 4th June 2016, observing

That the perpetrator was not compliant with his medication, had presented to A&E complaining of feeling mentally unwell, was using illicit drugs and alcohol and was homeless, all of which were factors which indicated that he was becoming very unwell.

4.47 By early August 2016 the view that the perpetrator was displaying 'accommodation seeking behaviours' had been reversed with the Dorset Forensic Team noting that he had been sleeping rough, his physical state had deteriorated as had his mood and that they were unable to provide the healthcare he needed without him being housed.

4.48 On 14th August 2016 the perpetrator killed the victim with whom he may have been staying for a few weeks, unknown to the Dorset Forensic Team. The perpetrator and the victim had been inpatients at the same time at Ravenswood

House in 2011 and at St Ann's Hospital in 2013 but there is no indication that they formed any meaningful relationship during either of those periods.

4.49 As previously stated the perpetrator exited MAPPA when his CTO was discharged on 7th November 2014, which was twenty-one months before the perpetrator killed the victim. However, Dorset Forensic Team continued to incorrectly document that the perpetrator was under MAPPA supervision until shortly before the death of the victim, although this may have been information which was 'cut and pasted' from successive risk assessments.

4.50 Clearly the risks presented by the perpetrator to himself and others began escalating following his return to Dorset from Cornwall in March 2016. However, it would only have been possible to bring him back within MAPPA management had he been convicted or cautioned for an offence indicating that he was capable of causing serious harm and required multi-agency management at Level 2 or 3. Other than his arrest in June 2016 for an offence of being drunk and disorderly, the perpetrator did not come to the notice of the police following his return to Dorset.

4.51 However, there were opportunities for the Trust to have worked with the police to actively manage the risks presented by the perpetrator during the period following his return from Cornwall in late March 2016 and the death of the victim four and a half months later. His case was discussed at Forensic Team meetings on several occasions and two CPA meetings were held on 21st July and 10th August 2016. What was discussed at the first CPA meeting was not recorded in the perpetrator's contemporaneous records but at the second CPA meeting it was documented that his physical health and diet were poor, that he remained unhappy and low in mood and that he was only partially compliant with his medication. His risks were considered to be increasing, specifically his risk of suicide and harm to others which were considered to be 'significant'.

4.52 The Trust did not discuss the perpetrator's escalating risks with the police although on 9th August 2016 they requested the police disclose all his known previous convictions, modus operandi and alias names, adding that they would be grateful for any other information about his risk 'to other' which might support a full mental health assessment of the perpetrator from point of view of treatment and for the protection of others. On the same date a copy of his previous convictions, but not what the police described as the 'historic' intelligence they held, was shared with the Trust. In their contribution to this review Dorset Police have commented that, having reviewed this intelligence, it was information which would largely have been known

to the Trust. Dorset Police have acknowledged that their response to this disclosure request from the Trust was 'not sufficient'.

4.53 This request for information from the police is not included in the MHHI report and there is no reference to the mental health assessment referred to in the request to the police being conducted in the three working days before the murder of the victim.

4.54 The Trust has advised this review that they recognise the potential value of inviting the police to a professionals meeting to consider escalating risks. In the absence of a patient being eligible for MAPPA, they understand that such a meeting could now take place under the auspices of a MARM (multi-agency risk management) or Potentially Dangerous Persons Conference.

4.55 The MHHI report noted that the Dorset Forensic Team continued to rely upon the risk assessment they completed in January 2015 after the perpetrator returned to Dorset from Cornwall 14 months later by which time he had experienced a major change in his living arrangements, a bereavement, and a breakdown in his idealised relationship with his son. The MHHI report also notes that because the perpetrator registered as a temporary resident with his Dorset GP following his return from Cornwall, his full GP records were not transferred across and therefore did not inform care planning and risk assessment. The MHHI report also concluded that the lack of success in helping the perpetrator find accommodation exacerbated his mental health problems. There is the possibility that greater multi-agency involvement in addressing the perpetrator's needs and assessing and managing the risks he presented to himself and others following his return from Cornwall could have prevented the situation escalating.

4.56 There is no indication that Dorset Forensic Team considered making any disclosures about the risks that the perpetrator presented to others to any of the people he was known or believed to be staying with, or planning to stay with following his return to Dorset from Cornwall. The perpetrator was known to have stayed with a Christchurch community mental health team patient and for a time was planning to move to a property with a 'vulnerable' female resident of Northover Court.

4.57 Had the Trust fully discharged its MAPPA 'duty to co-operate' responsibilities when managing the risks the perpetrator presented to the public as a MAPPA Category 2 Offender between 2011 and 2014, this may have led to dialogue with the

MAPPA ‘responsible authorities’ and would have enabled the Dorset MAPPA to remedy the lack of recording of the perpetrator as a MAPPA nominal locally. Earlier dialogue between Dorset Forensic Team and Dorset Police when the perpetrator was registered with MAPPA could have helped prompt dialogue when the perpetrator returned to Dorset when no longer subject to MAPPA.

Family Engagement

4.58 A draft version of this report was shared with the father of the victim who commented that the report provided him with a clearer insight into how MAPPA should operate. He added that he wished to challenge the assertion that Dorset Forensic Team were unaware that the perpetrator had been staying with the victim (Paragraph 4.48). The victim’s father said he had a sincerely held belief that Dorset Forensic Team did know that the perpetrator was ‘sofa surfing’ in his son’s flat and chose to ‘go along’ with the situation despite everything they knew about the perpetrator. The MHHI report does not confirm the victim’s father’s belief, although the report states that a member of the Poole CMHT unknowingly encountered the perpetrator at the victim’s flat on 29th June 2016, and that it was established that the vulnerable female from Northover Court who the perpetrator had been planning to move in with, was staying at the victim’s flat by 9th August 2016.

5.0 Findings and Recommendations

5.1 The MAPPA documentation completed in respect of the perpetrator whilst he was a patient at Ravenswood House in Hampshire from 2009 until 2011 was generally poor, with the exception of the action plan created when the perpetrator’s Level was increased from 1 to 2. It is not possible to obtain assurance that key tasks were completed from reading these documents. This may or may not have contributed to the MAPPA notification not being sent or received when the perpetrator transferred from Hampshire to Dorset in 2011 (Paragraph 4.16).

Recommendation 1:

That Hampshire and Isle of Wight MAPPA Strategic Management Board audits the current quality of completion of MAPPA related documentation and seek assurance over the current notification of the transfer of MAPPA Offenders to other criminal justice areas.

Recommendation 2:

Since it is not known why the perpetrator was not recorded as a MAPPA nominal in Dorset, that Dorset MAPPA Strategic Board consider how to obtain assurance over the recording of notifications of the transfer-in of MAPPA Offenders from other criminal justice areas.

5.2 Dorset HealthCare University NHS Foundation Trust did not comply with many aspects of their MAPPA 'duty to co-operate' agency responsibilities. In particular they did not appear to consider reviewing the MAPPA Level at which the perpetrator was managed or notifying any of the MAPPA 'responsible authorities' when they first discharged the perpetrator to the community on a Community Treatment Order (Paragraph 4.25) or subsequently so discharged him (Paragraph 4.33). When they shared his mental health history with the female service user with whom he had entered into an intimate relationship in May 2014, it is unclear whether their disclosure included the risk of harm he could present to others (Paragraph 4.34). They did not apparently realise that once the perpetrator's Community Treatment Order was discharged in November 2014, he exited the MAPPA arrangements and did not notify the Dorset MAPPA co-ordinator (Paragraph 4.36). Nor did the Trust consider engaging the 'responsible authorities' in a discussion about the risk the perpetrator presented to others at time of the discharge of his CTO and exit from MAPPA, which could have led to contingency planning should he come to the attention of the authorities again or should his planned move to Cornwall break down (Paragraph 4.37).

5.3 The Trust has advised this review that consideration of MAPPA status is now a routine part of their CPA and Section 117 discharge planning meetings as well as occasions when potential risk of harm to others increases. They plan to audit the reliability of this process as part of their quality assurance. They also have a Task and Finish group working towards the implementation of the MAPPA national guidance.

Recommendation 3:

That Dorset MAPPA Strategic Management Board seeks assurance that Dorset Healthcare University NHS Foundation Trust currently complies with all of its MAPPA

'duty to co-operate' responsibilities, particularly where they are managing MAPPA Offenders at Level 1.

Recommendation 4:

The Board may also wish to disseminate the learning from this review to all agencies who are required to fulfil MAPPA 'duty to co-operate' responsibilities.

5.4 The Dorset Healthcare University NHS Foundation Trust MAPPA policy in being at the time of the events reviewed in this report was not fit for purpose as it focussed exclusively on Level 3 cases. It provided no guidance to the Trust's staff on how to manage MAPPA Level 1 cases.

5.5 The Trust has advised this review that a new Dorset HealthCare MAPPA policy has been written in partnership with the MAPPA co-ordinators. The Trust adds that they recognise the potential value of inviting the police to professionals' meetings to consider the merit of considering a multi-agency risk assessment and risk management plan. This is a welcome statement from the Trust as it is unclear whether the Trust did not involve the police because their staff were unaware of their MAPPA responsibilities, or whether they did not involve the police because they did not feel that other agencies could add anything to their assessment and management of the perpetrator. At the very least, a multi-agency approach can lead to constructive challenge of the perception of the lead agency which could have been invaluable following the perpetrator's return to Dorset from Cornwall and the escalation in the risks he presented to himself and others from that point onwards.

Recommendation 5:

That Dorset MAPPA Strategic Management Board seeks assurance that Dorset Healthcare University NHS Foundation Trust's current MAPPA policy is fit for purpose and adequately addresses all MAPPA 'duty to co-operate' responsibilities, and where necessary, has been revised to incorporate any learning from this MAPPA review.