OFFICIAL

SAFER CORNWALL

CORNWALL COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review 3

Overview Report into the

Death of Mr Mike Smith

Prepared by Mike Fowkes

Independent Chair and Overview Report Writer

CONTENT

1 Introduction

1.1 For the purpose of this Domestic Homicide Overview Report and in order to protect the identity[1] of those involved, the victim will be known as Mr Mike Smith, his son as Tony, daughter as Chloe and his former wife as Joyce. The perpetrator will be known as Mr Barnes[2] , his Aunt as Mrs East, his Uncle as Mr Newton and his **[redacted]** as Mr Kay.

1.2 This Domestic Homicide Review (DHR) follows the death of Mr Smith, reported on **[redacted]**. The Police were called to Mr Smith's home where Tony had visited to give Mr Smith his **[redacted]**. Mr Smith was found deceased **[redacted]**. A paramedic pronounced life extinct at 10.45pm. Whilst Mr Smith had been unlawfully killed, a post mortem examination conducted by a Home Office Pathologist on **[redacted]**, gave the medical cause of death as 'Unascertained'[3].

1.3 On **[redacted]**, Mr Barnes pleaded guilty to Mr Smith's murder and was sentenced to life imprisonment; with a minimum tariff of 15 years set by the Crown Court Trial Judge, who said it was a 'premeditated killing'. Drawing a comparison with a previous offence, involving the false imprisonment[4] of Mr Kay, committed between **[redacted]**, for which he was cautioned[5], Mr Barnes said 'I did what I did but this time he died'. On **[redacted]**, a Coroner's Inquest was held regarding Mr Smith's death. A verdict that Mr Smith had been unlawfully killed was recorded by Her Majesty's Coroner for Cornwall.

Purpose of Review

1.4 DHR's were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. They came into force on 13 April 2011, with due Home Office Guidance[6]. The Act requires a 'review of the circumstance in which the death of a person aged 16 years 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'.

An 'intimate personal relationship' includes between adults who are, or have been intimate partners or family members, regardless of gender or sexuality.

[1] The pseudonyms Mr Mike Smith, Tony, Chloe and Joyce were chosen by the victim's son and the other pseudonyms were chosen by the Independent Chair and Overview Report Writer.

[2] Mr Barnes's parents will be known as Mr and Mrs B. Barnes. They died in **[redacted]** respectively.

[3] Where a pathologist is unable to establish an exact cause of death.

[4] A Common Law offence which can only be tried at a Crown Court. Upon conviction the maximum punishment is a life sentence. This is where a victim is detained against their will (Blackstone's B.2.74).

[5] This is a formal alternative to a criminal prosecution, administered by the police, normally for low level offending.

[6] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

1.5 A member of the same household is defined in Section 5(4) of the Domestic Violence, Crime and Victims Act (2004) as:

(a) 'a person is to be regarded as a 'member' of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
(b) Where a victim lived in different households at different times, 'the same household as the victim' refers to the household in which the victim was living at the time of the act that caused the victim's death'.

1.6 In March 2013, the Government introduced a new Cross - Government definition of domestic violence and abuse and it is now defined as:

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

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

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

1.7 The Home Office Guidance for the conduct of DHR's states the purpose as being to:

a) '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.
b) 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.
c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working'.

The Guidance says the rationale for the review process is to 'ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence'

and to 'assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff'.[7]

Conduct of Review

1.8 Devon and Cornwall Police notified the circumstances of Mr Smith's death to The Safer Cornwall Partnership (SCP)[8], who commissioned a DHR. The DHR was held in compliance with the legislation and followed the Home Office Guidance. There were no other parallel reviews being held, such as an Adult Safeguarding Serious Case Review[9], or Mental Health Homicide Investigation[10].

1.9 A DHR Panel, comprised across a broad spectrum of both statutory and voluntary sector agencies, was convened to oversee this DHR. Representation was at a sufficient level of seniority within their respective organisations to commit to the delivery of resulting recommendations. The DHR Panel members had widespread knowledge and expertise in their specific areas of work. The Guidance requires that 'The Review Panel should appoint an independent Chair of the Panel, who is responsible for managing and coordinating the review process and for producing the final Overview Report, based on Individual Management Reviews (IMR's)[11] and any other evidence the Review Panel decides is relevant'.

1.10 An independent consultant Mr Mike Fowkes was appointed, as both Independent Chair and Overview Report Writer. He was a former police officer who retired, at the rank of Detective Chief Inspector. As a nationally accredited Senior Investigating Officer he was very experienced in leading murder investigations and reviewing live and historic major crime investigations. An essential objective of those reviews was to be independent, objective and to identify and report on areas of learning and good practice for the police locally and in some cases the Home Office. At the outset of the DHR he declared an interest that he would be reviewing his former police employers in Devon and Cornwall and that he only knew one member of the DHR Panel, none of whom like him, were directly concerned with Mr Smith, Mr Barnes or their families and were not the immediate line manager of any of the staff involved.

1.11 Given the professional background and information outlined, the SCP was satisfied the Independent Chair and Overview Report Writer met the skills and experience

[7] Pages 6-7: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

[8] Safer Cornwall is the chosen name for the statutory Community Safety Partnership which covers Cornwall. (The Safer Cornwall Partnership). It is a collective of public, private and voluntary sector organisations.

[9] Where an adult with needs for care and support was, or it was suspected was experiencing abuse, or neglect and the adult dies, or there is reasonable cause for concern about how person(s) involved in the adult's case acted.

[10] Where a homicide has been committed by a person who is, or who has been under the care of specialist mental health services in the six months prior to the event; where it is necessary to comply with the Human Rights Act 1998, or where it is deemed an independent investigation is warranted e.g. concern of systemic system failure.

[11] IMR's provide an accurate account of agency involvement, evaluation of their actions (with Mr Smith and Mr Barnes) etc.

criteria, outlined in the Home Office Guidance[12]. They were confident sufficient challenge; independence and objectivity were evident between the DHR panel chair and overview report writer; panel members and agencies involved, in terms of their roles in carrying out this DHR. The values and principles for this DHR (page 9, paragraph 1.15), reinforced this view. Everyone, including the SCP, DHR Panel members and Mr Smith's family, were confident and remain so now, with it completed that this DHR would be independent, objective, open and transparent.

1.12 In addition to the Independent Chair and Overview Report Writer, the other members of the DHR Panel and their professional responsibilities were:

- Detective Chief Inspector Public Protection Unit, Devon and Cornwall Police.
- Manager of Domestic Abuse Services and elected representative of Domestic Abuse and Sexual Violence Voluntary Sector Providers.
- Domestic Abuse and Sexual Violence Strategy Manager, Community Safety and Protection, Cornwall Council.
- Adult Safeguarding Lead Professional, Cornwall Partnership NHS Foundation Trust (CFT).
- Senior Probation Officer, National Probation Service (South West & Central).
- Safeguarding Adults Lead, NHS Kernow.
- Safeguarding Adults Co-ordinator, Cornwall Council.
- Assistant Director of Nursing Patient Experience, NHS England.
- Health Promotion Service Manager/Team Member, Health Promotion Service, Cornwall & Isles of Scilly ('Healthy Gay Cornwall' is one of its programmes).
- Senior Manager Professional Practice, Education, Health and Social Care, Cornwall Council.

1.13 The DHR Panel sought additional expertise from an independent LGBT domestic violence and abuse expert[13]. The LGBT expert's contribution has greatly enhanced this DHR. As an academic Professor, heading a leading faculty in Gender-based Violence, the LGBT expert is acknowledged as one of the main experts in the UK and Europe and a leading expert internationally. Part of the LGBT expert's work on domestic violence and abuse included carrying out a number of key studies into same sex and LGBT domestic violence and abuse. The LGBT expert has also written extensively on: domestic violence and abuse in same sex and LGBT relationships; policing and criminal justice approaches to domestic violence and abuse and on health sector involvement and responses. The LGBT expert was also awarded an OBE for services to the community in tackling domestic abuse. The LGBT expert's observations and recommendations are included from page 96, paragraph 14.1 onwards.

1.14 The DHR Panel met on a number of occasions, in order to agree specific Terms of Reference; decide which agencies were to be required to supply IMR's and

[12] Page 12, Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

[13] Herewith referred to in the Overview Report as the LGBT expert.

subsequently to examine the IMR's and chronologies. Additional meetings were held in order to agree the overview report and identify recommendations.

Terms of Reference for the Review

1.15 The intention of the Panel and its review was to reflect on significant and relevant events leading up to Mr Smith's death and analyse the actions of relevant agencies. It was also to identify whether Mr Smith's death was predictable or preventable and with the purpose of creating a joint strategic action plan, to address any gaps and improve policy and procedures in Cornwall and across the South West Peninsula. The DHR was underpinned by the following values and principles:

- Independent, unbiased and objective.
- Openness and transparency, acting in the Public Interest.
- Sensitivity.
- Thoroughness and meticulous.
- Challenging and deliver change.

1.16 The Chair of the Panel sought to instil an open and honest approach with a willingness to challenge robustly the actions, or lack of them, of the relevant organisations. This required a high level of organisational self-awareness and a critical, but supportive and respectful approach. The Chair said the DHR was not about apportioning blame, but it was an opportunity to learn lessons and improve services.

1.17 The scope of the DHR was carefully considered by the Panel and clear terms of reference drawn up which were proportionate to the nature of Mr Smith's death. The detailed terms of reference of the DHR, as agreed by the Panel, following consultation with members of the SCP and Mr Smith's family, were as follows:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish the facts that led to the events reported on **[redacted]** and what lessons are to be learned from the case regarding the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence and abuse.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses, including changes to policies procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims through improved intra and inter-agency working.
- Identify from both the circumstances of this case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

1.18 It remains unclear when Mr Smith first met Mr Barnes but it was believed to have been in approximately **[redacted]**.However, so as to be able to understand the events which led to the death of Mr Smith, the DHR also wished to fully consider the events of their lives from a much earlier period. This would help to identify any potential early warning signs and or opportunities for early intervention, on behalf of professionals and agencies. A decision was taken that **[redacted]** was a proportionate starting point, with agencies being asked to exercise their professional judgement and include any other information which pre-dated **[redacted]**.

- Mr Smith: **[redacted]** to **[redacted]** (Date death reported).
- Mr Barnes: **[redacted]** to **[redacted]** (Date of arrest for murder).

1.19 At the start of the DHR process the Panel agreed that an IMR should be conducted by agencies in accordance with the Home Office Guidance.[14] This determines that the aim of an IMR is to:

- 'Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working together to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies'.

1.20 In this specific DHR the following areas were addressed in the IMR's and examined by the DHR Panel:

- 'Mr Smith's contact with any specialist domestic abuse agencies or services[15]. The response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.
- Mr Smith's contact with any targeted services[16]. The response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.
- Mr Smith's contact with any universal services[17].The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process, the response of these services and to what extent was information shared in order to achieve a multi-agency safety plan.

[14] Page 18: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

[15] Domestic Violence and Abuse Services in Cornwall.

[16] For more acute and complex cases following individual referral and specialist assessment.

[17] Also known as 'Primary Care'. These are services that anyone can access from healthcare professionals, who act as the first point of consultation for all patients in the healthcare system e.g. GP's, Dentists, Opticians etc. (Common chronic illnesses including depression).

- Mr Barnes's contact with Mental Health Services[18].The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process.
- Mr Smith and Mr Barnes's contact with Devon and Cornwall Police. The review will address whether there were any warning signs that agencies could have identified, the agencies risk assessment and process.
- Whether there were any barriers experienced by Mr Smith, or his family/friends/colleagues, in reporting any abuse in Cornwall or elsewhere, including whether he knew how to report domestic abuse should he have wanted to.
- Whether Mr Smith had experienced abuse in **[redacted]** in Cornwall or elsewhere and whether this experience impacted on his likelihood of seeking support in the months before he died.
- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Mr Smith that were missed.
- Whether Mr Barnes had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mr Smith or Mr Barnes that were missed'.

1.21 IMR's were requested to be completed by the agencies listed here. The IMR authors had to confirm they had not been directly concerned with either Mr Smith or Mr Barnes, or their families and were not the immediate line manager of any staff involved. The findings from the IMR reports also had to be quality assured and endorsed by the senior manager within the agency who commissioned the IMR report. The senior manager would also be responsible for ensuring that any recommendations from their IMR and where appropriate the overview report, would be acted upon through an action plan:

- Devon and Cornwall Police.
- Adult Mental Health Services (AMHS) Organisation.
- NHS England.
- Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT).
- LGBT Organisation.
- Registered Social Landlord 1.
- Registered Social Landlord 2.

1.22 Requests were also made of the National Probation Service (South West & Central); Domestic Violence and Abuse Services in Cornwall; Cornwall Council Education, Health & Social Care and Healthy Gay Cornwall. None reported any contact with either Mr Smith or Mr Barnes, apart for minimal contact with Mr Smith for Social Care, which did not require an IMR to be completed. The contribution of all relevant agencies was maximised through the DHR and clearly noted, even where there was nothing relevant to add to the review process.

[18] Also known as 'Secondary Care'. These are healthcare services provided by medical specialists and other health professionals who do not have first contact with patients e.g. Hospital care, Adult Mental Health Services (Community Mental Health Team, Mental Health Nurses, Psychologists, Psychiatrists etc.).

1.23 The DHR Panel has given detailed consideration to and challenged robustly the IMR's submitted by individual agencies at two full and comprehensive day long DHR Panel meetings. Agencies produced varying standards of IMR's, of their full involvement with Mr Smith and Mr Barnes This was partly due to the fact this was still a relatively new process and agencies are still familiarising themselves with the level of detail required. Those documents have contributed significantly to this report.

Timescales for Review

1.24 The decision to undertake a DHR was taken by the Domestic Abuse and Sexual Violence Strategy Manager and endorsed by the Chair of the Safer Cornwall Community Safety Partnership (CSP), together with other partnership agencies. The Home Office Guidance[19] states that the overview report should be completed within a further six months of this decision, unless an alternative timescale is formally agreed with the relevant CSP. As soon as it emerges that the review cannot be completed within the timescale of six months, the Panel should notify the CSP to renegotiate the timescale for completion.

1.25 The Guidance goes on to state that, in cases where the alleged perpetrator is arrested and charged, the commissioning of the final overview report should be held temporarily until the conclusion of the criminal case, but agencies and interested parties should be notified of the requirement and be obliged to secure any records pertaining to the homicide against loss or interference. In those circumstances, the DHR Panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency, or agencies for action, secured for the subsequent overview report and forwarded to the police disclosure officer for the criminal proceedings. Any identified recommendations should be taken forward without delay. Following the criminal proceedings, the review should be concluded.

1.26 In this specific case there was a delay in the DHR. The criminal court case was concluded on **[redacted]** and the Inquest into Mr Smith's death took place on **[redacted]**. The police Senior Investigating Officer (SIO) advised any interviews with family members should not take place prior to the completion of the criminal proceedings. The Home Office Guidance[20] states that the quality and accuracy of DHR's is likely to be significantly enhanced by the involvement of family members and delaying this review enabled that to happen. There were capacity issues with four other DHR's in quick succession. The resources available did not allow for four in depth reviews to be conducted, in parallel with every-day business, without compromising either every-day business, or the quality of the DHR. The DHR was further delayed whilst identifying an independent LGBT domestic violence and abuse expert and then awaiting the LGBT expert's review of the Overview Report. As already stated, the contribution of the LGBT expert has greatly enhanced this DHR.

[19] Page 15: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

[20] Page 16: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

1.27 The Safer Cornwall Partnership (SCP) was updated regarding the progression of the DHR (as were Mr Smith's family) and an extension of the timescale for its completion was agreed. It is important to note lessons have been drawn out and acted upon quickly, without waiting to complete the DHR.

Involvement with Mr Smith's family and Mr Barnes

1.28 Home Office Guidance[21] states that the DHR Panel should carefully consider the potential benefits gained by including family, friends and colleagues from both the victim and perpetrator networks in the review process. This can help the DHR Panel to get a more complete view of the lives of the victim and perpetrator in order to see the homicide through the eyes of the victim and perpetrator and help them understand the decisions and choices the victim and perpetrator made.

1.29 The Independent Chair made early contact with the police SIO and Family Liaison Officer from Devon and Cornwall Police. Letters explaining the DHR process and offering the opportunity to contribute to the DHR and to receive its findings and recommendations were prepared. The letters also contained relevant leaflets that the Home Office has made available on its website and the draft terms of reference for the DHR, for their comment. Neither Mr Barnes nor his family, have so far responded to the letters which were sent to them. The police Family Liaison Officer spoke to Mr Smith's family and handed letters to Tony and Chloe. Whilst Chloe chose not to be involved in the DHR process, her brother Tony and their mother Joyce, agreed to a proposal from the Independent Chair to have an initial meeting. This was despite Tony believing they may not have anything to contribute to the DHR.

1.30 On **[redacted]**, Tony and Joyce met with the Independent Chair and Domestic Abuse and Sexual Violence Strategy Manager and the DHR process was explained to them. They were pleased with the outcome of the meeting; agreed to contribute further to the DHR and have continued to be engaged since. There has been a clear commitment by the Independent Chair and the Domestic Abuse and Sexual Violence Strategy Manager, to maintain contact with Mr Smith's family.

1.31 The draft terms of reference for the DHR were amended to take account of the following three specific areas Mr Smith's family requested further information on:

- 'Why did the Police not prosecute Mr Barnes the first time, even though **[redacted]**? Why did the police not take it further?
- Mr Barnes went into **[redacted]** how was he monitored by Mental Health/Social Services etc.? The Police told us he went to **[redacted]**. Why was he **[redacted]** How do you assess if someone is a risk back in the community. What community based support did he have.
- Did Mr Barnes's Doctor know his case history **[redacted]**.He was **[redacted]**. Was he getting counselling? How was the Doctor monitoring Mr Barnes? Was Mr Barnes supervised at all? He was staying at Mr Smith's home on an informal basis but still allowed to keep his flat in …….'

[21] Page 16: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

1.32 The Independent Chair met with Tony and Joyce to share the draft overview report and their comments are detailed at page 111, paragraph 15.39. The Independent Chair, together with the Domestic Abuse and Sexual Violence Strategy Manager, subsequently met with Tony to share the revised draft overview report and his comments are detailed at page 111, paragraph 15.40.

Equality and Diversity

1.33 All of the grounds for discrimination or nine protected characteristics[22], contained in the Equality Act 2010, were considered by both the IMR authors and the DHR Panel. Several were found to have relevance to this DHR. These were:

1.34 Age: Mr Smith was **[redacted]** years of age at the time of his death, some **[redacted]** years older than Mr Barnes.

1.35 Disability: Mr Smith's medical history documented his **[redacted]** dependency and **[redacted]**. He also had **[redacted]**. Mr Barnes's medical history documented his involvement with Mental Health Services and **[redacted]**. In Government Guidance[23], the Equality Act 2010 defines a disabled person as a person with a disability. A person has a 'disability … if he or she has a physical or mental impairment[24] and the impairment has a substantial[25] and long term adverse effect on his or her ability to carry out normal day to day activities'. With reference to the Equality Act 2010, both Mr Smith and Mr Barnes would have been classed as having a disability in relation to **[redacted]**. The question as to whether either or both Mr Smith and Mr Barnes were 'vulnerable adults'[26], was also subject to detailed consideration during this DHR. (A vulnerable adult is 'any person aged 18 years or over who is or may be in need of community care services by reason of mental, physical, or learning disability, age or illness AND is or may be unable to take care of him or herself or unable to protect him or herself against harm or exploitation').[27]

1.36 Sexual Orientation: From the mid **[redacted]** Mr Barnes's medical records documented he **[redacted]**. The police investigation **[redacted]**. Men who have sex with men (MSM), is a behaviour rather than identity. It encompasses gay, bisexual

[22] Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, sex, sexual orientation, religion or belief and race.

[23] Office for Disability Issues HM Government. Equality Act 2010. Guidance on matters to be taken into account determining questions relating to the definition of disability. (www.odi.gov.uk/equalityact).

[24] Page 11: Alcohol addiction is excluded, but a person may still be protected as a disabled person if he or she has an accompanying impairment, which meets the requirements of the definition e.g. a person who is addicted to alcohol may also have liver damage, or depression arising from the alcohol addiction.

[25] Page 15:One that is greater than the effect which would be produced by the sort of physical or mental conditions experienced by many people ,which have only 'minor' or 'trivial' effects.

[26] 'No Secrets': Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse 2000. (Now known as 'adults at risk', The Care Act 2015).

[27]This was the definition in place at the time. The DHR Panel recognise that the changes to 'adults at risk' are now defined within The Care Act 2015, which was introduced post completion of this DHR.

and transgender men and heterosexual men who sometimes have sex with men. Many men do not or cannot for various reasons self- identify in their sexual orientation.

1.37 Marital Status: Whilst he had been divorced since **[redacted]**, Mr Smith maintained good relations with Joyce, right up until the time of his death.

1.38 This was a homicide, involving a victim and perpetrator who were experiencing complex issues, including **[redacted]**. The DHR Panel comprised of professionals who were able to provide expert knowledge and advice of the key issues, including adult social care, LGBT, substance abuse, domestic violence and abuse, adult safeguarding, disability and the Mental Capacity Act 2005.

Confidentiality and Dissemination of Report

1.39 The content of the Overview Report and subsequent Executive Summary has been anonymised and redacted, in order to protect the identities of Mr Smith and Mr Barnes; relevant family members and others and in order to comply with the Data Protection Act 1998. The Overview Report brings together and draws overall conclusions from the information and analysis contained in the IMR's and reports, or information commissioned from the relevant agencies. All of the confidential information concerning Mr Barnes and other surviving members of Mr Smith's family have been disclosed, with the authority of each agency in the public interest[28].Individuals who have provided information have been informed that their material may be disclosed in the published Overview Report and Executive Summary. The Overview Report has also been shared with Mr Smith's family.

1.40 The Home Office Guidance[29] states 'The aim in publishing these reviews is to restore public confidence and improve transparency of the processes in place, across all agencies to protect victims'. The completed Overview Report and Executive Summary have been submitted for consideration by The Safer Cornwall Partnership (SCP) and Home Office DHR Quality Assurance Panel. Authority has now been given for the publication and dissemination of anonymised and redacted versions, on the SCP web page. The recommendations of the DHR will be acted upon by all agencies, in order that the lessons of the review are learnt at the earliest opportunity. It will be the responsibility of the SCP to monitor and deliver the Action Plan.

1.41 The DHR Panel would like to offer their sympathy to Mr Smith's family and to thank them and all those who have contributed to this DHR for their time, patience and cooperation.

[28] Caldicott Principles.

[29] Page 21: Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013).

2 Background and Chronology

2.1 This section has been brought together from the Agencies IMR's to give an overview summary. In a chronological order, it provides background information for the time periods concerning the following:

1. Mr Smith's life up until meeting Mr Barnes.
2. Mr Barnes's life up until meeting Mr Kay.
3. Mr Barnes's **[redacted]** with Mr Kay.
4. Mr Barnes's life after the false imprisonment of Mr Kay, up until meeting Mr Smith.
5. Mr Smith's **[redacted]** with Mr Barnes.

Mr Smith's life up until meeting Mr Barnes

2.2 Mr Smith was **[redacted]** years of age at the time of his death. He had been living in Cornwall for a number of years, having married Joyce in **[redacted]**; separated in **[redacted]** and divorced in **[redacted]**. They remained friends, with Mr Smith referring to Joyce as 'the light of his life'. In addition to Tony and Chloe, he had **[redacted]**. Whilst Mr Smith led an independent life, he was regarded as a sociable person, who was very close to his family. **[Redacted]**.

2.3 From the late **[redacted]** Mr Smith had a history of **[redacted]** dependency. He received help and support over many years from his General Practitioner (GP) Practice and the Adult Mental Health Services (AMHS) Organisation, who worked to meet his health needs.

2.4 From **[redacted]**, right up to the time of Mr Smith's death in **[redacted]**, his GP and the AMHS Organisation records detail **[redacted]** consultations for his **[redacted]**. This included offers of **[redacted]**; referrals to **[redacted]** and specialist placements at **[redacted]**.

2.5 Mr Smith made determined efforts to complete **[redacted]** courses with varying levels of success. He would seek help from his GP Practice and his medical condition would be reviewed, including an assessment by the AMHS Organisation. He would then be offered rehabilitation courses and counselling. When Mr Smith was not dependent **[redacted]** his health improved, but during periods when he was **[redacted]** dependent, this impacted on his overall health and at times made him [**redacted]**. Throughout this whole period he was consistently supported and encouraged by his GP Practice and received regular assessments from the AMHS Organisation.

2.6 Following his earlier divorce and having been assessed for 'general needs accommodation', Mr Smith lived in a one bedroomed, first floor flat[30], from **[redacted]** up until his death. **[Redacted]**. It is believed that Mr Smith first met Mr Barnes in **[redacted]** and then Mr Barnes became a paying lodger in Mr Smith's

[30]Registered Social Landlord 1: Independent, not for profit Housing Association and member of the Registered Social Landlord (RSL) Group in Cornwall. (Housing Associations provide low cost social housing for people with housing need).

home in **[redacted]**. He had given Mr Smith's address as his temporary address from **[redacted]**.

2.7 In August **[redacted]** Mr Smith met with a Community Advocate from the LGBT Organisation[31]. He said he**[redacted]**.

Mr Barnes's life up until meeting Mr Kay

2.8 Mr Barnes was **[redacted]** years of age at the time of Mr Smith's death. He had lived with his father and mother Mr and Mrs B. Barnes, until their deaths in **[redacted]** respectively. He was also the full time carer for his Uncle Mr Newton, until Mr Newton required residential care in **[redacted]**. The family had lived in the same home[32] in Cornwall since **[redacted]**. His Aunt Mrs East lived **[redacted]** and was supportive to him. He described himself as **[redacted]**.

2.9 Mr Barnes had his first contact with the secondary care AMHS Organisation in **[redacted]**. He felt **[redacted]**. There was then nearly a ten year gap, with no information available from his GP Practice, or the AMHS Organisations records. In January and February **[redacted]** Mr Barnes saw his GP four times after **[redacted]** and then between February **[redacted]** and February **[redacted]**, there were eight reported incidents of Mr Barnes **[redacted]**. This resulted in him being admitted as an in-patient at **[redacted]** and then his voluntary[33] admission to an AMHS Organisation Hospital **[redacted]**, for further assessment and treatment. These were for varying periods of time, with extended periods of home leave.

2.10 He was managed under the Care Programme Approach (CPA) .The CPA had been introduced in **[redacted]** to provide a framework for working with people with complex mental health needs and who required specialist Mental Health Services e.g. Community Mental Health Team (CMHT)[34]. The CPA enabled care to be delivered to meet identified health and social care needs. A care plan is coordinated by one person, but provided by others. The Care Coordinator is responsible for ensuring the care provided, with regular reviews of the care plan, as the need arises, to meet individual needs and as a minimum, at six monthly intervals.

2.11 In April **[redacted]** Mr Barnes disclosed being aggressive at times and kicking his **[redacted]** car. A note in his GP records said he accepted he may be **[redacted]**. In May **[redacted]** he was diagnosed with **[redacted]**. There was reference on a housing referral form to Mr Barnes having: 'unresolved anger leading to violence to

[31] An Organisation which supports Lesbian, Gay, Bisexual and Trans People and Communities in **[redacted]**.

[32] Registered Social Landlord 2: Not for profit charitable registered provider of social and affordable housing. (Also a member of the RSL Group in Cornwall).

[33] If someone agrees to be admitted to a psychiatric ward or unit, they are called a voluntary or an 'informal' patient. Where someone is admitted to hospital under Part 111 of the Mental Health Act 1983, they are called a 'formal' patient. The term 'sectioned' is also used to describe a compulsory admission to hospital.

[34] Community based assessment and treatment service for people suffering from mental health problems who are over the age of 18.The team include Mental Health Nurses, Psychologists and Psychiatrists.

property and people', 'assaults on property due to frustration' and 'assaults on Uncle (Mr Newton), which Mr Barnes denies'.

Mr Barnes's [redacted] with Mr Kay

2.12 Between February and June **[redacted]** Mr Barnes was voluntarily admitted to an AMHS Organisation Hospital. On discharge home his care was managed under the CPA. He was discharged from social care caseload as it was reported he would not engage and his needs would be best met by the CMHT. This decision was challenged by a Consultant Psychiatrist who believed social care was necessary. Throughout the remainder of **[redacted]** Mr Barnes was regarded as stable and doing well, with support and regular review by his GP and the Community Psychiatric Nurse[35].

2.13 It is believed it was during this time, or in **[redacted]** Mr Barnes first met Mr Kay. He said they **[redacted]**, but Mr Kay denied this. In November **[redacted]** Mr Barnes said whilst he had **[redacted]** at times, he did not want his **[redacted]** with Mr Kay to end. In February **[redacted]** Mr Barnes told his GP he felt **[redacted]** and at a CPA review in November **[redacted]** told his CPN he **[redacted]**. In June **[redacted]** Mr Barnes told his CPN that his Aunt Mrs East had accused him of 'pushing her' which Mr Barnes denied when questioned further by the CPN.

2.14 From July **[redacted]** through to January **[redacted]**, there were several periods of time when Mr Barnes was either **[redacted]** with Mr Kay, or Mr Kay had left and moved away. The effect on Mr Barnes's mood was documented in his medical notes. **[Redacted]**.

2.15 On **[redacted]** Mr Barnes was admitted to **[redacted]** following **[redacted]**. Mr Barnes had argued with Mr Kay and when seen by his CPN, Mr Barnes said he had 'hit' Mr Kay during the argument, but still **[redacted]**, despite always leaving Mr Barnes. The CPN noted that Mr Barnes was 'remorseful, more rational and a lot calmer, although that could all change when he next has contact with Mr Kay'. On **[redacted]** the CPN recorded that Mr Barnes *'*spoke of (laughingly) about how he had purchased gaffer tape and had planned to tape Mr Kay up and keep him there with him*'*. When the CPN asked him about this comment Mr Barnes 'laughed, stating he knew it was a ridiculous idea and clearly stated he would not really do such a thing'.

2.16 At about 4.30pm on **[redacted]**, Mr Kay, who was **[redacted]** years of age by now, had planned to leave Mr Barnes's home to visit **[redacted]**. Mr Barnes did not want him to leave and without warning, hit him **[redacted]**. Mr Barnes then picked up a large carving knife and forcibly restrained him against his will **[redacted]**. He initially **[redacted]** and then held him overnight, with the threat of **[redacted]**. At about 7.45am the next morning, Mr Kay escaped after Mr Barnes **[redacted]**, just prior to contacting the CMHT. A CPN and Paramedics went to Mr Barnes's home and Mr Barnes was firstly taken to **[redacted]** and then on **[redacted]**, he accepted

[35] Registered nurse with specialist training in mental health, providing counselling, offering support to those with long term mental health conditions and administering of medication.

voluntary admission to an AMHS Organisation Hospital. Due to his **[redacted]** and hospital admission, the police were unable to arrest or interview Mr Barnes regarding the false imprisonment of Mr Kay, at that time.

Mr Barnes's life after the false imprisonment of Mr Kay, up until meeting Mr Smith

2.17 A decision was taken that Mr Barnes would remain at the AMHS Organisation Hospital to provide support to him, but not as part of a further mental health assessment. On **[redacted]**, Mr Barnes was arrested and interviewed regarding the false imprisonment of Mr Kay. The following day he was discharged from the AMHS Organisation Hospital. His care was delivered under the CPA framework, with a care plan coordinated by his CPN. Later that month Mr Barnes reported to his CPN that he was being 'taunted' by **[redacted]** and was 'ventilating' **[redacted]** about Mr Kay.

2.18 On **[redacted]** Mr Barnes was assessed by a Consultant Psychiatrist. The police had requested a psychiatric report be prepared, which would assist in the decision making process for Mr Barnes, in relation to the false imprisonment of Mr Kay. The Consultant Psychiatrist said 'I do not think Mr Barnes is a danger to the public at large at all' and that the 'enormity of court proceedings are likely to result in Mr Barnes **[redacted]**. Following receipt of the psychiatric report and file of police evidence, a decision was taken by Devon and Cornwall Police, that Mr Barnes would be cautioned by the police for the offence of false imprisonment. He accepted his caution on **[redacted]**.

2.19 As of **[redacted]** Mr Barnes continued to be seen by his GP, Psychologist, CPN and Health Care Assistant. His mental health notes showed **[redacted]** was planned. He felt **[redacted]** would 'insult him if he goes out' and **[redacted]** continued to worry him. He was talking frequently of Mr Kay and appeared **[redacted]**. His **[redacted]** and a Counsellor in Psychology **[redacted]** that Mr Barnes was **[redacted]**. In June **[redacted]** Mr Barnes was given the offer to exchange to a smaller bungalow. He declined this and on **[redacted]** took over the legal tenancy of the property which his parents Mr and Mrs B. Barnes had previously been the legal tenants of, since **[redacted]**. An entry in the GP records of **[redacted]** recorded that Mr Barnes was stable; with no signs of anxiety and so following this review, no further appointments were made.

2.20 In November **[redacted]** Mrs East contacted Mr Barnes's CPN to express concern he had been victimised on Halloween night by people throwing eggs at his home and shouting abuse at him. Mr Barnes told his CPN it 'would not have helped if he had gone outside waving a carving knife'. In July **[redacted]** Mr Barnes alleged an unknown person had deliberately driven a car at him, only diverting at the last minute. In August **[redacted]** Mr Barnes was assessed and appeared to be 'coping' with the transition away from the AMHS Organisation. He was regarded as 'low' for risk of relapse of neglect, suicide and harm to others.

2.21 In January **[redacted]** Mr Barnes stopped seeing his Counsellor in Psychology **[redacted]** as he felt 'their work has finished'. His GP was advised by the Counsellor who said 'he has **[redacted]** in the past and I would be pleased to see him at any time if you think it appropriate'. On **[redacted]**, having maintained 'good progress,'

Mr Barnes was formally discharged from the secondary care AMHS Organisation by his CPN, who advised the GP to 'refer back if you have any concerns'. By May **[redacted]** Mr Barnes was referred by his GP for counselling, due to being **[redacted]**. This was followed up at the end of July **[redacted]**, with a further GP referral to the AMHS Organisation, for an expert review on the management of Mr Barnes's condition and medication.

2.22 On **[redacted]** Mr Barnes was given 'words of advice' by the police after a report of two men **[redacted]** in a public toilet. (He was later to be given further police 'words of advice' having been found **[redacted]** in public toilets with other men in **[redacted]**). On the last occasion Mr Barnes said he had travelled to another town as a result of threats of violence towards him in his home town.

2.23 On **[redacted]** Mr Barnes saw his CPN who reported Mr Barnes appeared 'better than he had ever seen him before' and on **[redacted]** Mr Barnes was seen by a Consultant Psychiatrist. He was assessed as **[redacted]** and was discharged from the secondary care AMHS Organisation. In October **[redacted]** Mr Barnes was referred by his GP for counselling and assessment by the secondary care AMHS Organisation, following concerns he **[redacted]**. He was not accepted for secondary care by the AMHS Organisation and was advised to see the Practice Counsellor and attend **[redacted[36]]**. Between January and May **[redacted]** Mr Barnes attended two counselling sessions before cancelling further appointments.

2.24 There was then no further contact with the secondary care AMHS Organisation for the next four years. On **[redacted]** Mr Barnes visited his GP and requested further involvement with the secondary care AMHS Organisation. On **[redacted]** Mr Barnes's case was discussed and screened out as he did not meet the criteria for assessment. In November **[redacted]** Mr Barnes's GP wrote to **[redacted[37]],** to request counselling for Mr Barnes as he was **[redacted]**. It is not clear if he received any counselling. Mr Barnes's only other contact with the secondary care AMHS Organisation was on **[redacted]**, shortly after his arrest and detention on suspicion of the murder of Mr Smith. This was for a mental health assessment where no mental health disorder was detected.

Mr Smith's [redacted] with Mr Barnes

2.25 It is unclear exactly when Mr Smith met Mr Barnes, or how often Mr Barnes stayed at Mr Smith's home. An entry in Mr Barnes's GP records showed he gave Mr Smith's address as his temporary address from **[redacted]**. It is believed he became a lodger at Mr Smith's invitation from **[redacted]**, with Mr Barnes paying Mr Smith £50 per week. Mr Barnes said he and Mr Smith were **[redacted]**. He described himself as **[redacted]**. In respect of Mr Smith it is believed he told his neighbours that Mr Barnes was his cousin.

[36] AMHS Organisation resource service in **[redacted]**, which worked with service users aged 18 to 65 years, who were recovering from mental health illness. Helps service users to lead independent lives.

[37] Independent agency delivering private and NHS counselling services, helping service users 16+ recover from common mental health problems e.g. depression.

2.26 In October **[redacted]** Mrs East confirmed to Registered Social Landlord 2 that Mr Barnes was still living in his own home after it was thought the property might have been 'abandoned'. She explained Mr Barnes suffered from **[redacted]** and avoided contact with people. On **[redacted]**, an anonymous telephone caller alleged a disturbance at Mr Smith's home. When the police attended, the flat was in darkness and there was no sign of any disturbance.

2.27 Throughout February to May **[redacted]** Mr Smith's GP recorded he had gone from being in a positive mood and ready for further hospital based **[redacted]**, to being **[redacted]** but **[redacted]**. Tony recalled how in February **[redacted]** his Father had **[redacted]**; was a completely different person and wanted to 'get rid of Mr Barnes, to kick him out'. Whilst Mr Barnes was away from Mr Smith's home during the month of April **[redacted]**, Mr Smith relapsed. Tony said he told his Father 'to go and apologise and get him (Mr Barnes) back', as it was clear to his family that he (Mr Smith) was not coping well on his own.

2.28 Mr Smith's family knew little about Mr Barnes, but believed him to be going through a divorce and someone who would regularly stay at Mr Smith's home. They said he appeared to 'moderate' Mr Smith's **[redacted]** and generally 'kept his home in order'. They had no concerns whatsoever about Mr Barnes and said 'it relieved their minds that someone was living there with Mr Smith' and that Mr Barnes had been 'nothing but a positive influence' on Mr Smith. On **[redacted]** at a tenancy visit, Mr Smith indicated he was living alone at the property. On **[redacted]** the police spoke to Mr Smith and his daughter Chloe in relation to a **[redacted]** dispute.

2.29 Between **[redacted]** and the date his death was reported, Mr Smith did not attend three planned GP medication review appointments. He had asked to commence **[redacted]** and had been due to start this on **[redacted]**.On that date it is believed Mr Smith had an argument with Mr Barnes because he would not help him with his **[redacted]** programme. Chloe saw her Father at his home and was told that he had 'kicked out' Mr Barnes following this dispute. By **[redacted]** Mr Barnes had returned at Mr Smith's request and the two of them were seen by Tony on **[redacted]** when he visited. On **[redacted]** two **[redacted]** carried out work at Mr Smith's home and by description both Mr Smith and Mr Barnes were present. On this same date it appears Mr Smith was involved in a verbal disagreement with **[redacted]**.

2.30 There is unconfirmed information that on **[redacted]** Mr Smith asked Mr Barnes to accompany him to a GP appointment in relation to his proposed **[redacted]** programme. After initially agreeing to support and accompany Mr Smith to the GP surgery it appears Mr Barnes felt unable to, which caused a disagreement between them, resulting in Mr Barnes being asked to leave. Subsequent to this Mr Smith contacted Mr Barnes and he returned to Mr Smith's home[38].

2.31 On **[redacted]** Chloe helped her Father to complete some financial papers. When she arrived to see him she was 'surprised' to see Mr Barnes back in her Father's home. Mr Smith had regularly complained to Chloe about Mr Barnes being in the flat

[38] This information is contained in the Devon and Cornwall Police IMR, but may in fact be referring to the 25 May 2012 disagreement. There is nothing in Mr Smith's GP notes to suggest he was due to see his GP on 1 June 2012.

together and sometimes wanting his own space and so as a result Mr Barnes would occasionally return to his own home. Chloe said that her Father told her 'ten to fifteen times' that he was going to ask Mr Barnes to leave for good.

2.32 On **[redacted]**, the day of Mr Barnes's birthday, a **[redacted]** visited Mr Smith at his home for a meal. Mr Barnes was also present. The **[redacted]** recalled that at some stage in late May **[redacted]**, there had been an argument between Mr Smith and Mr Barnes, resulting in Mr Barnes being asked to leave. Mr Smith later told the **[redacted]** that they had 'patched up' their differences and Mr Barnes had returned. Mr Smith cooked a meal for the three of them and the **[redacted]** then left at 7.30pm.

2.33 After **[redacted]** there were no other reported contacts, with either Mr Smith or Mr Barnes, until **[redacted]**, when Tony went to deliver a **[redacted]** to Mr Smith. He was unable to get a response at his home so left. Later that day he returned as he was concerned for the welfare of his Father. Together with a friend they were able to gain access to Mr Smith's home and found the body of Mr Smith **[redacted]**.

2.34 The Police were called at 7.40pm and saw Mr Smith's body on the bed **[redacted]**. A paramedic recognised life extinct **[redacted]**. A later post mortem was unable to provide a definitive cause of death, **[redacted]**.

2.35 A major police investigation commenced, with a priority to locate Mr Barnes. It appeared he left Mr Smith's home sometime after 12.15pm, on **[redacted]**. He was then eventually arrested at 9.30pm, on **[redacted]**, having spent **[redacted]** days travelling around the country using Mr Smith's identity and credit card. Prior to police interviews on **[redacted]**, Mr Barnes was subject to a mental health assessment. He was deemed mentally fit for interview and detention, with no mental health disorder detected. During this assessment Mr Barnes admitted killing Mr Smith and drew comparison with his previous offence of **[redacted]** when he said 'I did what I did but this time he died'. He told the assessing Doctor's that he had recently thought about 'hitting people and **[redacted]** people'.

2.36 Mr Barnes said living in his own home was 'very uncomfortable' and **[redacted]**. He said he found it very difficult to **[redacted]**, despite support from the Mental Health Team. He said he had been threatened **[redacted]** and ended up living in one room, with the curtains drawn, **[redacted]** himself away.

2.37 Mr Barnes stated he had met Mr Smith **[redacted]** years previously' on a bus. He said initially he would visit Mr Smith for the day, then for two days and later for a week at a time. He said he moved in just before Christmas **[redacted]** as a paying lodger. At the end of **[redacted]** Mr Barnes said he was due to help Mr Smith with his **[redacted]**, but it would mean having to go to the GP surgery with him on a daily basis. He was reportedly unhappy with his **[redacted]**, which he said resulted in him suffering from **[redacted]**. He said they argued and he left, but was called by Mr Smith on **[redacted]** and asked to come back which he did. He said that Mr Smith was **[redacted]** and was argumentative that week. He stated Mr Smith would ask him to leave and then apologise the next day.

2.38 Mr Barnes said on the morning of **[redacted]**, Mr Smith asked him to go out and get some sherry. Mr Barnes said his fear of going out was great and 'for some reason I lost control'. He said he **[redacted]** from the kitchen, followed Mr Smith into the **[redacted]** where he then **[redacted]** He said he did not want Mr Smith **[redacted]** so then decided to **[redacted]**. He said that Mr Smith had **[redacted]**, but he continued **[redacted]**.

2.39 Mr Barnes said they only ever had verbal arguments which were due to Mr Smith's **[redacted]** dependency. He said he had **[redacted]** He felt that should he **[redacted]**, then Mr Smith might ask him to leave his home, although he had never actually said this to him. **[Redacted]**.

2.40 On **[redacted]** Mr Barnes was charged with Mr Smith's murder and on **[redacted]**, he pleaded guilty to murder. He received a life sentence with a minimum tariff of 15 years. The Trial Judge said:

> 'You have a past. In **[redacted]** you were involved in a very serious incident, as I see it, of false imprisonment when you detained the victim on that occasion against his will and acted out a fantasy that you had of applying restraints to him and he was detained for some hours. The matter was eventually resolved by you being cautioned. You had been admitted in the aftermath of the incident to a local psychiatric hospital, having taken an overdose. I have seen and read an extract from a report that was prepared at that time. Following your release from that hospital, it appears as if you have either not required or you have avoided any psychiatric assessment or treatment. It is highly questionable whether it was in the public interest that the matter should have been resolved as it was at that time. And there is no doubt that the killing of Mr Smith evidenced once again that same fantasy when his body was found…It was a wicked act and Mr Smith, a much loved and missed man met his death in quite appalling circumstances… You had clearly been harbouring thoughts of killing Mr Smith for some days and killing him in exactly the way that you did. This was in no sense a domestic incident and could not properly be characterised as such[39]. It was not an act of killing but[40] was in any sense spontaneous. It had been in your mind… The starting point for the assessment of the minimum term is 15 years. That is to some extent aggravated by the fact that this was a premeditated killing.'

2.41 On **[redacted]**, a Coroner's Inquest was held into Mr Smith's death. Her Majesty's Coroner for Cornwall recorded the verdict and sentence of the Crown Court that Mr Smith had been unlawfully killed. She stated any lessons learned should be identified by the DHR process.

[39] This comment was raised by the Home Office DHR Quality Assurance Panel and it is the view of the DHR Panel that this was a domestic incident. (Please see recommendation at page 114, paragraph 16.24).

[40] The Court transcript says the word 'but', however it may be possible that the Judge said either 'that' or 'which'.

3 Analysis of Agencies IMR's

3.1 Relevant agencies have produced Individual Management Reviews (IMR's) in relation to this DHR and these form an important basis of this Overview Report. The objective of the IMR's is to provide an accurate account of agencies involvement with Mr Smith and Mr Barnes; evaluate their actions and identify improvements for the future. All IMR's have been challenged robustly and where appropriate, subject to review and revision since their initial submission.

3.2 The following sections of this overview report look critically and analytically at the responses of the agencies involved, to significant and relevant events, up to the date of Mr Smith's death, reported on **[redacted]**. Where appropriate, this includes comments upon the appropriateness of actions taken, or not taken and offers recommendations to ensure that lessons are learnt by relevant agencies. The analysis examines how and why events occurred; information shared; decisions made and actions taken, or not taken. It also contains consideration of whether different decisions, or actions, may have led to a different course of events[41]. The Chair and DHR Panel members note that these comments and recommendations are made with the benefit of hindsight and knowledge that there was information, which when drawn together, identified risk factors.

3.3 Care has been taken to avoid hindsight bias and outcome bias[42].

3.4 Hindsight bias 'is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident'.

3.5 Outcome bias is 'when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair'.[43]

3.6 It is acknowledged that hindsight is difficult to eliminate, but everything that is possible has been done to limit it. This analysis focusses on how things were perceived at the time; with the rationale for decisions, actions or inactions at the time; with thorough consideration of the context of individual decisions, actions or inactions. This has been achieved by reviewing the key factors, including those highlighted in the 'Suggested Contextual Factors for Domestic Homicide Review Analysis'[44], any or all of which might have had an impact on the decisions, actions or inactions at the time.

[41] Page 24: Home Office Domestic Homicide Review Toolkit 2012: 'Guide to Overview Report Writing'.

[42] Page 19: Home Office Domestic Homicide Review Toolkit 2012: 'Guide to Overview Report Writing'.

[43] Page 32: National Patient Safety Agency (February 2008) Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance.

[44] Page 21: Home Office Domestic Homicide Review Toolkit 2012: 'Guide to Overview Report Writing'.

3.7 By the very nature of the timeframe for this DHR; in particular, the period leading up to **[redacted]** and beyond, means it is important that the context of the time is considered. The policies, procedures and expected working practices of all the agencies, in the year **[redacted]** for example, will be different to what they are now. Knowledge, understanding, approach and response to domestic violence and abuse; LGBT specialism; multi-agency links and pathways; adult safeguarding etc. were not, for the majority of agencies, usual working practices, unlike they are today. There is a need to be proportionate and balanced, by applying the context of the time, of what were the expectations of agencies, at that particular time of their involvement. This approach will help to avoid hindsight bias and outcome bias.

3.8 Before detailing the analysis of the agencies IMR's, it is important to briefly set out background history in relation to domestic violence and abuse policy and also the socio-political context for individuals who may identify as LGBT and in particular, men who have sex with men(MSM).

3.9 Since the early 1990's there has been a variety of policy initiatives aimed at developing criminal justice approaches to domestic violence and abuse; in particular positive arrest, prosecution and conviction. The police had already been issued with guidance dealing with domestic violence and abuse incidents by the time of Mr Kay's false imprisonment in **[redacted]**. In May 2000, the Home Office issued the revised circular 19/2000[45]. This was aimed at the police, to ensure 'positive' policing, with the emphasis on arrest and evidence gathering. This was echoed again in the Association of Chief Police Officers (ACPO) guidance[46] of 2004 and then again in 2008[47]. This has recently been updated by the College of Policing 2015, with the 'Authorised Professional Practice on Domestic Abuse'. It should be noted that most policy and guidance has tended not to specify MSM.

3.10 While the guidance and associated action plans mostly focussed on the largest group affected by domestic violence and abuse, that is, women experiencing abuse from men, there has also been recognition that men can experience domestic violence and abuse and that it may feature in same sex or LGBT relationships. The Home Office definitions regarding domestic violence and abuse, have specifically included 'sexuality' since the mid - 2000's.

3.11 During the late 1990's there was a developing focus on multi-agency working in domestic violence and abuse cases and by 2000, the Home Office were actively encouraging criminal justice, domestic violence support services, public housing, social care and health services, to increase partnership working, in order to support and provide safety for victims[48]. This has been endorsed by successive governments

[45] The circular was designed to go with Multi-Agency Guidance for Addressing Domestic Violence (issued in March 2000 and which updated the previous Home Office Circular 60 of 1990).

[46] 'ACPO Guidance on Investigating Domestic Violence, 2004'.

[47] 'ACPO Guidance on Investigating Domestic Abuse, 2008'.

[48] Domestic Violence: Break the chain. Multi-agency guidance for addressing Domestic Violence. March 2000.

and also more recently by NICE.[49] Links between domestic violence and mental health impacts were already being identified in Department of Health guidance by the late 1990's. As an example, the National Service Framework for Mental Health[50] highlighted the 'association between abuse, including domestic violence, with mental illness and personality disorder'.

3.12 It was not until 1967 that the Sexual Offences Act made it legal for men aged 21 and above to have sex with other men (i.e. the 'age of consent'). It was lowered to 18, in 1994 and then to 16, in 2001.The 1980's saw a period of renewed public discrimination against LGBT individuals and homophobia: many individuals defining as LGBT grew up within discriminatory contexts. This may also have had profound impacts on the nature of relationships, as well as experiences of domestic violence and abuse[51]. **[Redacted]**. It is only since the mid - 2000's that we have seen a more welcoming approach. For example, since 2005, attacks on individuals because they are gay or thought to be gay, have been defined as 'hate crimes' and treated more seriously in law[52] .

[49] NICE: National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care. NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

[50] Guidance issued by the Department of Health, 1999.

[51] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

[52] Criminal Justice Act, 2005.

4 Devon and Cornwall Police

4.1 A summary is included of the police involvement with both Mr Smith and Mr Barnes. A key focus involves the false imprisonment incident of **[redacted]**.

Review of Involvement

4.2 Mr Smith had minimal contact with Devon and Cornwall Police. **[Redacted]**. Mr Smith was seen by the police concerning two reported disputes on **[redacted]** and **[redacted]**, involving a **[redacted]** and **[redacted]** respectively. On **[redacted]**, an anonymous telephone call was received by the police reporting a disturbance at Mr Smith's home. When the police visited the address they found his home in darkness and no sign of any disturbance.

4.3 Mr Barnes had no previous convictions, but received a police caution on **[redacted]** for an offence of false imprisonment. He was **[redacted]** years of age at the time and the victim Mr Kay, was **[redacted]** years of age. It is believed they had known each other for approximately 3 to 4 years and a few days prior to the incident; Mr Kay had **[redacted]** Mr Barnes's home. Although Mr Kay **[redacted]**, Mr Barnes said **[redacted]**.

4.4 At about 4.30pm on **[redacted]**, Mr Kay told Mr Barnes he was going out to **[redacted]** home and indicated he may stay at **[redacted]** address. Mr Barnes allegedly said 'You aint ……. going anywhere' and without warning, **[redacted]** hit Mr Kay; **[redacted]** and forcibly restrained him against his will overnight, using a knife, **[redacted]** masking tape, **[redacted]** ties and **[redacted]** cable. **[Redacted]**. Mr Kay said he made no attempt to escape as he was afraid **[redacted]**.

4.5 At about 7.45am the next morning, **[redacted]** Mr Kay was able to escape after Mr Barnes **[redacted]**, just prior to telephoning a Community Psychiatric Nurse (CPN) from the Community Mental Health Team. The CPN went to his home to see him. A relative of Mr Kay's had earlier called at Mr Barnes's home asking for him. Mr Barnes had managed to get the relative to leave without knowing Mr Kay was in the home, being held against his will. During the sixteen hours Mr Kay was falsely imprisoned Mr Barnes **[redacted]**. Mr Kay suffered **[redacted]**.

4.6 The police were initially unable to speak to Mr Barnes due to **[redacted]** and admission to **[redacted]** for treatment and then voluntary admission to an AMHS Organisation Hospital **[redacted]** on **[redacted]**. The Police asked the AMHS Hospital staff to advise them when Mr Barnes was ready for discharge. On **[redacted]** Mr Barnes was arrested, interviewed and then released on police bail, pending the completion of police inquiries and the submission of an advice file of evidence. In his police interview Mr Barnes said he **[redacted]** by Mr Kay and that Mr Kay had **[redacted]** their friendship. He said he had **[redacted]** for Mr Kay, but it appeared he was frustrated those **[redacted]** were not **[redacted]**.

4.7 Following a review of the evidence, including a psychiatric report on Mr Barnes, prepared by a Consultant Psychiatrist, a decision was made by a Police Support Staff Caseworker, of the police Criminal Justice Decision Making Unit, to caution Mr

Barnes for the offence of false imprisonment. He accepted a police caution on **[redacted]**.

Comment

4.8 The police investigation was led by a Detective Constable and a determined effort was made to obtain as much information as possible to assist the decision making process. This included requesting the psychiatric report on Mr Barnes. Although the Locum Consultant Psychiatrist at the AMHS Organisation Hospital assessed this as a 'domestic incident', rather than being indicative of Mr Barnes's poor mental state, this incident was not recorded as a domestic incident by the police.

4.9 Between **[redacted]** and **[redacted]**, Mr Barnes was given 'words of advice' by the police having allegedly been seen on four occasions **[redacted]** in public toilets **[redacted]**. These were on **[redacted]** and **[redacted]**.

Comment

4.10 The sporadic nature of the four incidents between **[redacted]** and **[redacted]** would have been unlikely to trigger any police activity in relation to Mr Barnes's behaviour as this may have been considered disproportionate. The police policy at that time advocated people being issued with a verbal warning; liaison with the local gay community and no other action, apart from in response to documented information, which supported the need for it. The guidance focussed on the location, rather than the individual and was followed in these instances.

4.11 During the last incident in October **[redacted]**, Mr Barnes told a Police Community Support Officer (PCSO), that he had travelled to another town, as he had been receiving threats of violence in his home town due to his **[redacted]**. This incident would have amounted to a Homophobic Hate Crime Incident[53]. An intelligence entry was submitted, documenting the contact with Mr Barnes, however, as the incident was not identified as a homophobic hate crime incident, no further action was taken. Further guidance at the time, from a police supervisor, could have been sought by the PCSO, as to the appropriate course of action.

4.12 There was no police intelligence held with regards to Mr Smith, or of any information to suggest he had been a victim of domestic violence or abuse with Mr Barnes, or anyone else. It was only during the police investigation into Mr Smith's death that one **[redacted]** disclosed that **[redacted]** knew of an argument in late **[redacted]**, but that they had 'patched up' their differences. Another **[redacted]** said there were tensions between Mr Smith and Mr Barnes at times and that on one unknown date; Mr Barnes had allegedly thrown a saucepan at Mr Smith, hitting him on the arm. Tony described how Mr Barnes had lived away from Mr Smith's home during **[redacted]** and how he suggested Mr Smith contact Mr Barnes, to apologise and ask him to return.

[53] Hate Crime; Delivering a Quality Service. Good Practice and Tactical Guidance 2005.

Comment

4.13 No details of these disclosures were known prior to the police investigation into the death of Mr Smith starting. Mr Smith's family had no concerns about Mr Barnes and were frequent visitors to their Father's home. They said they believed they would have known of any domestic violence or abuse towards Mr Smith and regarded Mr Barnes as a very quiet and withdrawn man.

4.14 There was no previous record of either Mr Smith, or Mr Barnes being identified as vulnerable adults, so adult safeguarding, information sharing, risk assessment and risk management procedures, under the police Domestic Abuse policies and working practices, were not invoked. The police IMR author said that 'under the current definition of vulnerable person Mr Barnes may have fallen within it', however this was not adopted by Devon and Cornwall Police at the time of the February **[redacted]** false imprisonment offence. As a result he would not have been identified on their Crime Information System[54] as a vulnerable adult per se.

Comment

4.15 The police Crime Information System holds no current intelligence relating to Mr Barnes's mental health condition. Given the significance of Mr Barnes's condition and the impact it was considered to have had on his behaviour, it would have been good practice to submit intelligence documenting this. The submission would also have included a 'mental health' marker which would have alerted police officers and police support staff to the potential issues of mental health, or illness.

4.16 Given the timescales, intelligence may have been submitted in **[redacted]** and subsequently weeded, in line with guidance on the management of police information[55]. The Police National Computer record relating to the caution on **[redacted]** was removed after five years and any markers, including mental health, would have been deleted with the record. It is not possible to say that the availability of this information would have changed, or influenced the outcome of future police interactions with Mr Barnes, or the sharing of information with other agencies.

4.17 Whilst this DHR does not include the police response and subsequent police investigation into the death of Mr Smith, it is important to record that Mr Smith's family acknowledged the work of the police investigation team and the National Homicide Service Caseworker[56]. Tony said 'Our family would like to thank all the police officers and their liaison officers involved in this case for the professional and sensitive way they have handled my Father's murder from start to finish. Also, a big thank you to Mr Hill[57] from Victim Support for his help and advice'. At the family

[54] Crime Information System: Police computerised system which recorded details of crimes, intelligence etc.

[55] MOPI: Management of Police Information (National Policing Improvement Agency (NPIA) Guidance on the Management of Police Information 2010).

[56] Dedicated Victim Support Homicide Caseworkers, who provide extra support for people bereaved by murder or manslaughter. This is a service independent of the police.

[57] This is a pseudonym.

meeting on **[redacted]**, when referring to Mr Smith's death, Tony said 'they couldn't see how it could have been prevented'.

Analysis of Involvement

4.18 For analytical purposes, the involvement of Devon and Cornwall Police with Mr Smith and Mr Barnes has been categorised as follows:

- False Imprisonment incident not identified as a Domestic Violence and Abuse Incident.
- Decision to caution Mr Barnes for the offence of False Imprisonment.
- Training, levels of awareness and access to specialist domestic violence and abuse services for Lesbian, Gay, Bisexual and Trans (LGBT) people and communities, in particular for older male victims.

<u>False Imprisonment incident not identified as a Domestic Violence and Abuse Incident.</u>

4.19 The offence of false imprisonment in **[redacted]** was not identified as a domestic incident. However, the police policy in place at that time defined a domestic incident as 'any incident...not just including violence… between people in **[redacted]**'. The **[redacted]** between Mr Barnes and Mr Kay was **[redacted]** and so within the definition of the police policy should have identified the false imprisonment (hitting, **[redacted]** etc.) as a domestic violence and abuse incident.

4.20 In **[redacted]**, there were no formal risk assessment procedures attached to the domestic violence and abuse working practices. Since that time and now, there have been significant changes to policy and legislation, including the Cross Government definition; the introduction of the Domestic Violence, Crime and Victims Act (2004) and the Association of Chief Police Officers (ACPO) Domestic Abuse Stalking Harassment and Honour Based Violence (DASH) risk assessments, introduced in February 2010. The police use the ACPO DASH risk assessment containing twenty seven questions/points. This involves police officers talking to victims to complete the checklist assessment.

4.21 The checklist helps to identify those victims who are at high risk of harm and whose cases should be referred to a Multi-Agency Risk Assessment Conference (MARAC)[58] in order to manage their risk. A high risk case is one where fourteen points or more out of twenty seven are scored on the risk assessment checklist, or where a case is escalated to it through the professional judgement of the police officer. 'High' risk means 'that there are very clear and identifiable indicators of further risk of 'serious harm'. The potential event could happen at any time and the impact would be serious.

4.22 The definition of 'serious harm' is a risk which is 'life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'. By bringing together all agencies at a MARAC, a risk

[58] A MARAC is a meeting where information about high risk domestic abuse cases is shared between local agencies.

focussed, multi-agency risk management plan can be drawn up to provide professional support to all those at risk and reduce the risk of harm. The introduction of DASH in February 2010 was supported by mandated risk assessment training for all front line Devon and Cornwall police officers and in 2011, generic risk training for safeguarding was also delivered to all front line police staff.

4.23 There have also been significant cultural organisational changes in Devon and Cornwall Police's response to domestic violence and abuse. This includes multi-agency raising awareness campaigns, targeting the prevalence of domestic violence and abuse in all communities, including minority groups. In 2006-2007, a national modular domestic abuse training programme was introduced to all police officers in Devon and Cornwall. Many police officers have also accessed multi-agency training.

4.24 In **[redacted]**, approximately **[redacted]** incidents of domestic violence and abuse were recorded by Devon and Cornwall Police. By **[redacted]**, over **[redacted]** were recorded. This increase could suggest improved confidence in reporting practices. All policy and working practices are now subject of an Equality Impact Assessment which scrutinises their suitability and accessibility for all members of the community.

4.25 Under current policies and procedures the **[redacted]** between Mr Barnes and Mr Kay would have been identified as **[redacted]** and the investigation would have been conducted in line with the domestic abuse policy and working practice. This would include the DASH risk assessment framework and positive action policy[59].The risk assessment framework provides a gateway to specialist services and links to the MARAC process for high risk cases, which on the evidence produced in the false imprisonment case of February **[redacted]**, would reach the threshold.

4.26 There was no previous police involvement with Mr Barnes to indicate a pattern of offending behaviour, or risk to others. The Criminal Justice and Courts Services Act 2000, which was enacted in 2001, introduced Multi-Agency Public Protection Arrangements (MAPPA), for the statutory management and identification of registered offenders; violent offenders and offenders who pose a risk of harm to the public.

4.27 There are three categories of MAPPA: Category 1- registered sexual offenders; Category 2 - violent offenders sentenced to imprisonment for 12 months or more; Category 3 - other dangerous offenders: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.

4.28 There are three levels of MAPPA management to ensure resources are focused upon the cases in most need: Level 1 involves ordinary management; Level 2 is where the active involvement of more than one agency is required to manage the offender; Level 3 is where senior management oversight is required These relate to

[59] The Human Rights Act 1998 (Articles 2, 3, 8), places positive obligations on police officers to take reasonable action, which is within their powers, to safeguard the rights of victims and children in domestic violence and abuse cases. For example making an arrest and prosecution where the evidence is available.

the 'critical few', those who pose the highest possible level of risk to the public. The same definition of 'serious harm' applies as for a MARAC.

4.29 Levels of risk range from Low (no current indicators); Medium (identifiable indicators of risk, potential to cause harm, but unlikely to do so unless a change in circumstances e.g. relationship breakdown); High (identifiable indicators, the event could happen at any time and the impact would be serious); Very High (imminent risk of serious harm, the potential event is more likely than not to happen imminently and the impact would be serious).

4.30 The false imprisonment offence of **[redacted]** the establishment of MAPPA, but **[redacted]**, under MAPPA Guidance, Mr Barnes could have been considered under Category 3 offenders, Level 2 and management and risk management plans been put in place. Had he been charged, convicted and sentenced to imprisonment he may have been considered under Category 2 offenders.

4.31 In **[redacted]**, considerations around risk focussed on the likelihood of Mr Barnes **[redacted]**, or suffering deterioration in his **[redacted]**, rather than the risk he posed to others. The management of this offence would now have followed a different course. It would have been classed as a domestic violence and abuse incident; invoking risk assessment and management procedures and a positive action policy under the MARAC and or MAPPA processes. The seriousness of the offence, together with the domestic violence and abuse nature of the incident, would mean that a decision to caution would be unlikely and a referral to the Crown Prosecution Service (CPS) for charging advice would be made.

<u>Decision to caution Mr Barnes for the offence of False Imprisonment.</u>

4.32 Following the police investigation, a file of evidence was submitted for advice on what police action should be considered against Mr Barnes. The police investigation considered there was some level of premeditation in the commission of the offence; including the purchase of the masking tape used **[redacted]** and the earlier disclosure from Mr Barnes to his CPN, stating he had thought about tying up Mr Kay.

4.33 The file was considered by a police support staff caseworker within the police Criminal Justice Decision Making Unit. The file was reviewed, but then not referred onwards to the CPS for advice. It was returned to the investigating officer for follow up action, with the following initial advice recorded:

> 'Bail file reviewed - the offences to be considered for Mr Barnes are - Unlawful imprisonment; common assault and criminal damage. Clearly if we are to believe the complainant Mr Kay, then the evidence is available to support all the proposed offences. However, there are several important matters to be taken into consideration, i.e.
>
> - Unlawful imprisonment is an indictable offence and therefore triable at Crown Court only.
> - There is no medical evidence on file as to whether Mr Barnes is **[redacted]**.

- It is likely that if we charge him then prior to trial we will receive a psychiatric report that a trial will seriously affect his wellbeing and future recovery!
- The OIC (Officer in Case) properly advises that if **[redacted]** of Mr Kay are likely to be brought out in open court, then **[redacted]**.
- Prosecution would have a detrimental effect on Mr Barnes.

The above issues require resolving prior to charging Mr Barnes. We require a full Psychiatric assessment on this man. Is Mr Kay prepared to attend court and give evidence? These are offences that in normal circumstances should lead to a prosecution and provided the police resolve the psychiatric matter and the willingness of Mr Kay to attend court then I believe that Mr Barnes should be charged as suggested'.

4.34 It appears the investigation was at that stage directed towards Mr Barnes being charged to a criminal court, through the criminal justice system. Following the provision of a psychiatric report on **[redacted]**, which followed an assessment of Mr Barnes, made by a Consultant Psychiatrist at an AMHS Organisations Hospital on **[redacted]**, the file was resubmitted with the outstanding actions updated. It was now at this stage the police support staff caseworker, having reconsidered all of the evidence, made the decision that Mr Barnes would be cautioned for the offence of false imprisonment.

4.35 The decision to caution was not made in isolation and it is clear the psychiatric report had a significant influence upon the decision making. The justification for the final decision included the following:

- Prosecution would have an adverse effect upon the wellbeing of Mr Barnes.
- The height differentiation between Mr Barnes and Mr Kay (this may have implied Mr Kay could have been able to escape had he wished).
- The likelihood that Mr Kay would **[redacted]** as a witness if **[redacted]** Mr Barnes became **[redacted]**.
- Absence of any previous convictions for Mr Barnes.

4.36 The Police IMR does not clearly state what Mr Kay's involvement was in the police investigation, but the information available suggests he was interviewed by the police and made a witness statement. The Police IMR does not contain any information as to whether Mr Kay was spoken to about the **[redacted]** as a witness, if **[redacted]** became **[redacted]**. It is therefore not possible to assess whether Mr Kay personally indicated his **[redacted]** to give evidence; or whether the police may have possibly assumed **[redacted]** would make Mr Kay **[redacted]** to give evidence; or would potentially **[redacted]** as a witness. Additionally, in one of the three questions asked by Mr Smith's family, they understood Mr Kay '… **[redacted]**…' There is no information available concerning this in any of the IMR's, but Tony said he had been told this by a police officer, who was investigating his Fathers homicide.

4.37 Following the caseworkers decision, Mr Barnes was seen on **[redacted]** and received a police caution for the offence of false imprisonment .The decision to issue a police caution should take into account the circumstances of the offence, Home Office Guidance and public interest factors for and against a prosecution. In addition,

the offence must be admitted by the alleged perpetrator. In general, police cautions may be considered as an appropriate disposal for first time or minor offences. It is very unusual to consider a caution for a serious indictable offence such as false imprisonment, which could only be tried at Crown Court.

4.38 Guidance at the time, in April **[redacted]**, was contained in 'Home Office Circular 18/1994 The Cautioning of Offenders'. The guidance for the use of cautions for serious offences said: 'Cautions have been given for crimes as serious as attempted murder and rape: this undermines the credibility of this disposal. Cautions should never be used for the most serious indictable only offences such as these, and only in exceptional circumstances (one example might be a child taking another's pocket money by force, which in law is robbery) for other indictable only offences, regardless of the age or previous record of the offender'.

4.39 The guidance advocated that 'Where there is any doubt about whether a prosecution should be brought, or a caution given in a particular case, it will often be useful to seek the opinion of the Crown Prosecution Service (CPS) at an early stage.' The decision to caution at the time was cognisant of public interest factors, but the use of a caution for such a serious offence was not in accordance with Home Office guidance at that time in April **[redacted]**. Given the complexities of the investigation and the seriousness of the offence, together with its domestic nature, the completed file of evidence should have been referred to the CPS.

4.40 The guidance now stipulates an indictable only offence must be referred to CPS for a charging decision. The Devon and Cornwall Police domestic violence and abuse policy now contains specific guidance in relation to the use of the caution in domestic abuse cases. This guidance reflects 'NPIA Practice Guidance on Investigating Domestic Abuse 2008'[60] which says: 'Cautions are rarely appropriate in domestic abuse cases. This is because cases coming to the attention of the police are not usually the first offence and the nature of such offences tends to constitute a breach of trust. For these reasons it is always preferable for domestic abuse defendants to be charged and prosecuted where the case meets the evidential prosecution test and public interest test'.

4.41 The Ministry of Justice document 'Simple Cautions for Adult Offenders' 14 November 2013 provides guidance for police officers and the CPS on dealing with criminal offences. The simple caution should not be confused with a conditional caution (caution with conditions). Simple cautions do not form part of an offender's criminal record. The guidance says at paragraph 14, 'Simple cautions should not be given for indictable only offences unless a senior police officer of at least the rank of Superintendent believes there are exceptional circumstances and the CPS agrees'.

4.42 For 'exceptional circumstances' the decision maker must conclude that the 'public interest does not require the immediate prosecution of the offender and that if the offender was prosecuted there would be reasons why the court would not impose a period of imprisonment, or high level of community order.'

[60] NPIA: National Policing Improvement Agency. (The NPIA is now called the College of Policing and in 2015, they issued further guidance: 'Authorised Professional Practice on Domestic Abuse').

The following public interest factors were cited:

- Extent of harm caused.
- Degree of intention, or the foreseeability of any resultant harm.
- Any significant aggravating or mitigating factors.
- Lack of any recent similar previous convictions or cautions.
- Any other factors relating to the offender, or commission of the offence, likely to have a significant impact on sentence.
- The overall justice of the case and whether the circumstances require it to be dealt with in open court.
- The range of sentences appropriate to the circumstances of the case.

4.43 With reference to domestic violence and abuse at paragraph 24, the guidance says 'Positive action is recommended … to ensure the safety and protection of victims and children while allowing the Criminal Justice System to hold the offender to account'. At paragraph 57, it says 'where the decision is to administer a simple caution for an indictable only offence the full reasons for that decision should be recorded'.

4.44 When considering cases there is a Code for Crown Prosecutors called 'The Full Code Test'.[61]It has two stages: the evidential stage, followed by the public interest stage. In the evidential stage there must be sufficient evidence to provide a realistic prospect of conviction, based on their objective assessment of the evidence. In the public interest stage Crown Prosecutors have to consider important matters such as:

- How serious is the offence committed. The more serious the offence, the more likely it is that a prosecution is required.
- What is the level of culpability of the suspect e.g. premeditated and or planned; previous criminal convictions; whether the offending was or likely to be continued, repeated or escalated.
- Prosecutors should also have regard when considering culpability as to 'whether the suspect is or was at the time of the offence suffering from any significant mental or physical ill health, as in some circumstances this may mean it is less likely that a prosecution is required. However, prosecutors will also need to consider how serious the offence was, whether it is likely to be repeated and the need to safeguard the public, or those providing care to such persons'.
- What are the circumstances of and the harm caused to the victim. 'The circumstances of the victim are highly relevant… prosecutors should take into account the views expressed by the victim about the impact that the offence has had… And if a prosecution is likely to have an adverse effect on the victim's physical or mental health, always bearing in mind the seriousness of the offence. If there is evidence that prosecution is likely to have an adverse impact on the victim's health it may make a prosecution less likely…However, the CPS does not act for victims or their families in the same way as solicitors act for clients and prosecutors must form an overall view of the public interest'.
- What is the impact on the community?

[61] CPS website Code for Crown Prosecutors: The Full Code Test.

- Is prosecution a proportionate response?

4.45 The 'Prosecution of Domestic Violence cases Guidance', issued by the Director of Public Prosecutions (DPP) 14 May 2014, at paragraph 64 says: 'The police should consider cautions carefully in domestic violence cases. This is because such cases involve a breach of trust and are unlikely to be the first offence'. At paragraph 65 it says 'Prosecutors should note Guidance on Simple Cautions for Adult Offenders recommends 'positive action' is taken, to ensure the safety and protection of victims and children, whilst allowing the offender to be held to account'.

4.46 At paragraph 66 it says 'If the evidential stage of the Full Code Test is satisfied, it will rarely be appropriate to deal with a domestic violence case by way of a simple caution'. At paragraph 67 it says 'As stated clearly in the DPP's Guidance on Conditional Cautions, domestic violence cases must not be considered for conditional cautioning'[62].

4.47 A formal charge, conviction and possible prison sentence, rather than a police caution, would now be the potential outcome of the false imprisonment and domestic violence and abuse crimes committed by Mr Barnes against Mr Kay. In 2013 the CPS produced Legal Guidance[63] on relevant sentencing guidelines for offences of Kidnapping and False Imprisonment. For offences at the bottom end of the scale, a person found guilty, could be expected to receive a prison sentence of between 12 to 18 months[64]. This would be dependent on aggravating factors such as:

- Degree of planning or premeditation.
- Vulnerability of victim.
- Duration of loss of liberty.
- Using, brandishing, threatening with or possession of weapons.
- Unpleasant circumstances of detention, such as degradation.
- Threats intended to discourage victim from reporting offence.

Mitigating features would be an absence of the above features.

4.48 Since 18 April 2014, Devon and Cornwall Police have introduced Sexual Offences and Domestic Abuse Investigation Teams (SODAIT) across the policing area. This structure contains **[redacted]** police officers and police staff, with all areas of the force having specialist domestic abuse investigators and domestic abuse investigation teams. There will be dedicated domestic violence Detective Sergeants, who will have an increased awareness of the complexities of domestic violence and abuse cases. This should ensure consistency and improvements in decision making processes, particularly around the submission of evidential prosecution files for charging decisions.

[62] Conditional Cautioning: A caution given in respect of an offence which has specified conditions attached to it. (Conditional Cautioning-Code of Practice & associated annexes, Criminal Justice Act 2004, Sections 22-27).

[63] www.cps.gov.uk CPS Legal Guidance S to U.

[64] R v Spence and Thomas (1983)5 Cr.App. R (S.)413; R V Saker (2012)1 Cr.App. R (S.)16.

4.49 There is no indication the police false imprisonment investigation of **[redacted]** was overseen by a police supervisor. The investigating officer, a Detective Constable at the time, had no recollection of the decision making processes, or whether there was any supervisory direction. She stated that it was not uncommon at that time to manage investigations with minimal supervision.

4.50 Since **[redacted]** there has been considerable efforts and progress to improve standards of police investigations and supervision, including the introduction of the PIP (Professionalising Investigation Programme) accreditation programme. In response to serious crimes, a Detective Sergeant, or an experienced investigator, must develop a bespoke investigation and victim management plan. In addition, there is now specific guidance for the responsibilities of supervisors, including that they must conduct regular and meaningful workload reviews with staff at least every two weeks. There is also a presumption that investigations will be directed towards a prosecution outcome and that indictable only offences must be referred to CPS for a charging decision.

4.51 In summary, the police evidential file of the false imprisonment incident should have been referred to and considered by the CPS. Guidance at that time and also now, both indicate this should take place.

4.52 Her Majesty's Inspector of Constabulary's (HMIC) report into 'Devon and Cornwall Police's approach to tackling Domestic Abuse' 2014, highlighted that: 'limited use of restorative justice and cautioning is used for domestic abuse cases where using these would meet the needs of the victim. The Head of Public Protection[65] dip-samples cases and examines trend information to ensure these outcomes are properly applied and supervised. There are clear guidelines for officers and good scrutiny at each level'.

4.53 The DHR Panel recommends Devon and Cornwall Police carry out an audit, over a predetermined period of time, to establish if prosecution advice files, containing allegations of indictable only offences are being referred to the CPS for a charging decision. **(Recommendation at page 112, paragraph 16.1).**

Training, levels of awareness and access to specialist domestic violence and abuse services for Lesbian, Gay, Bisexual and Trans (LGBT) people and communities, in particular for older male victims.

4.54 In relation to the **[redacted]** false imprisonment and domestic violence and abuse crimes committed by Mr Barnes against Mr Kay, there is no indication either person was offered any support by Devon and Cornwall Police, in terms of accessing specialist domestic violence and abuse services. The incident was not identified as a domestic violence and abuse incident and consequently no onward referral was made to specialist domestic violence and abuse services. It should however be noted that in **[redacted]**, it was not the policy and practice of Devon and Cornwall Police, to directly refer perpetrators of domestic abuse to support services.

[65] Detective Superintendent Devon and Cornwall Police.

4.55 There have now been significant changes and improvements in both societal and organisational beliefs and understanding around domestic violence and abuse. The diversity of support services has expanded to reflect this and national and local specialist support services exist, to help meet the needs of men and LGBT people and communities experiencing domestic violence and abuse. These include: Men's Advice Line; The Intercom Trust; Broken Rainbow Cornwall, REACH[66] (Risk Evaluation and Co-ordination Hub), supporting the LGBT community; Mankind and Male Advice helpline, supporting male victims of domestic abuse and NORDA[67] House Project (Refuge and outreach support for male victims).Self-referral perpetrator programmes are available within Devon and Cornwall and details of all these services are offered to victims as part of the DASH process.

4.56 There remain concerns that incidents involving older people, or male on male, are necessarily recognised as domestic violence and abuse. There are 22 million people in the UK aged 50 years and above. This is one third of the population. There are now more people aged over 60 years than there are aged less than 18 years.[68] In Cornwall 37% of the population of 532,000 people are aged 50 years and over and 18% aged 65 to 84 years old[69]. Incidents involving victims aged over 65 years account for 3% of all incidents reported to the police. (There were just fewer than 200 reported incidents in the 12 month period to 30 September 2010).[70]

4.57 Significant statistics in relation to domestic violence and abuse include the following:

- In the Crime Survey England and Wales, respondent's equivalent to two million people reported experience of one or more behaviours that may be deemed domestic violence and abuse, of which 7.3% (1.2 million) of victims were women and 5% (700,000) of victims were men[71]. (1 in 4 women and 1 in 6 men will experience domestic violence and abuse in their lives). However, this data relates almost exclusively to heterosexual and not MSM, or other LGBT experiences.
- We have no nationally representative data on MSM on domestic violence and abuse. The Government estimates that between 5-7% of the UK population are LGBT. Between 25-33% of LGBT people experience domestic abuse. The prevalence of domestic abuse in lesbian and gay relationships is the same as for abuse of women by men in heterosexual couples. Fewer than 10% of LGBT victims report domestic violence and abuse to the police. The reasons why it is under reported include because victims do not want to reveal their

[66] Twelves Company: Providing help and support to all victims of domestic violence and abuse in Cornwall.

[67] Formerly called Esteem Men Cornwall.

[68] CADA briefing.

[69] 2011 Cornwall Census.

[70] Action for a Safer Cornwall (Cornwall and Isles of Scilly Domestic Abuse and Sexual Violence Strategy 2011-2015-'The Right Response').

[71] Office for National Statistics Bulletin February 2013.

sexual orientation, or nature of their relationship, and/or are concerned about the attitudes and responses by agencies if they do so.[72]

- A systematic review and meta-analysis found that domestic violence and abuse in MSM relationships is significantly associated with an increased risk of HIV, depressive symptoms, substance abuse and unprotected anal sex.[73]
- Nationally, 96% of referrals to a MARAC are for women,[74] but this is not surprising as women are by far the largest group at high risk of domestic violence and abuse.
- Of 779 cases presented to MARAC's in Cornwall in 2013, only one was recorded as LGBT[75]. This is perhaps not surprising given the large rate of referral to MARAC from the police, as few LGBT individuals report to the police. Currently 92% of cases going to the Cornwall MARAC are referred from Devon and Cornwall Police and 8% are referred from other agencies. The national average is 30%.
- In Devon and Cornwall policing area[76] from May 2013 - April 2014, there were 5,740 reported female victims of domestic abuse, of which 133 were aged 60 and over (2.3%).In the same time period there were 1,155 male victims of domestic abuse, of which 57 were aged 60 and over (4.9%).This was a 10.8% and 5.6% increase respectively, on the previous year. In the age group 40-59 years there were 1,342 female victims (23%) and 399 male victims (34.5%) for the year May 2013 - April 2014.There is no data however, regarding the proportion of male victims who are MSM.

4.58 In 2014 HMIC published their findings and recommendations[77] on the 43 Home Office funded police forces, in relation to the effectiveness of the police approach to domestic violence and abuse. Recommendation 2 said 'By September 2014, every police force …should establish and publish an action plan[78] that specifies in detail what steps it will take to improve its approach to domestic abuse…'This DHR Panel welcomes the fact that Devon and Cornwall Police have an Action Plan which incorporated **[redacted]** actions and demonstrates its commitment to addressing domestic abuse.

4.59 The HMIC report of 2014 into 'Devon and Cornwall Police's approach to tackling Domestic Abuse', specifically identified the force did not yet provide a consistent service in all cases of domestic violence and abuse. Training received by police call

[72] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

[73] Buller, Devries, Howard et al, 2014: Associations between Intimate Partner Violence and Health among Men who have sex with Men: A systematic Review and Meta-analysis.

[74] HMIC Overall Report 2014, page 30 'Everyone's business: Improving the police response to domestic abuse'.

[75] Safer Cornwall Partnership.

[76] Devon and Cornwall Police Performance and Analysis Department. There were data limitations due to the quality of the data available.

[77] HMIC Overall Report 2014:'Everyone's business: Improving the police response to domestic abuse'.

[78] The action plan should take account of the College of Policing 2015 'Authorised Professional Practice on Domestic Abuse'.

handlers in relation to domestic abuse was found to be inconsistent, with a concern that they may fail to recognise incidents of domestic abuse. Application of the 'vulnerable' category of incident response was based entirely upon the call handler's judgement.

4.60 Of the ten recommendations made in the HMIC report concerning Devon and Cornwall Police, five were of particular relevance to this DHR:

1. 'The force should analyse training needs and develop a training plan for all staff involved with domestic abuse from first report to resolution'.
2. 'The force should publish a single definition for 'repeat' and 'vulnerable' victims, with supporting guidance for staff'.
4. 'The force should set and promote minimum standards for supervision of domestic abuse incidents, from initial report in the control room to initial attendance and subsequent investigation'.
6. 'The force should review the SODAIT pilot structure as soon as possible and ensure a corporate , well led way of working ,which delivers consistent service to victims of domestic abuse'.
10. 'The force should ensure that corporate learning is disseminated throughout the organisation in order that all staff are aware of any changes and why these changes have been made'. (In Devon and Cornwall Police corporate learning is maintained and embedded following recommendations from DHR's and Serious Case Reviews through the Protecting Vulnerable People Board and then the Force Learning Lessons Board).

4.61 In light of the current domestic violence and abuse statistics and recommendations contained in the HMIC report of 2014; together with a further HMIC report 'Police effectiveness 2015 (Vulnerability)'[79], which commented on progress and areas for improvement since 2014, the DHR Panel believes this is an opportune time for Devon and Cornwall Police to progress all of these issues raised. All members of the police SODAIT, together with call takers, call handlers and control room staff are to receive LGBT and male victims of domestic violence and abuse training. This is to form part of domestic violence and abuse training given to police officers during initial training. **(Recommendation at page 112, paragraph 16.2).**

4.62 As evidenced by the current statistics, the police IMR author said despite universal improvement in service provision for victims and an increasing acceptance that domestic violence and abuse impacts on the lives of both male and female victims, there still exists significant barriers for male victims of domestic violence and abuse, irrespective of their sexuality, in both heterosexual and same sex relationships. In addition, older men living in abusive relationships, may feel particularly isolated, unwilling to disclose their sexuality, access services or disclose abuse. As such, it is believed a more coordinated gender specific approach is needed, to openly encourage male victims to report domestic violence and abuse and access services.

4.63 During **[redacted]**, the LGBT Organisation embarked on a **[redacted]** survey **[redacted]**. This was in relation to the key issues affecting people, with a view to

[79] PEEL: Police effectiveness 2015 (Vulnerability). An inspection of Devon and Cornwall Police by HMIC.

helping influence services in **[redacted]**. This is an opportune time for the Cornwall Council Domestic Abuse and Sexual Violence Strategic Group, to review the findings of this survey. **(Recommendation at page 114, paragraph 16.18).**

4.64 To try and encourage victims to report domestic violence and abuse and access services, the DHR Panel believes it is important to scope specialist LGBT services, to offer the two day ACPO DASH Awareness/Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training, which should have appropriate reference to domestic violence and abuse within the LGBT community, including older people and also to scope any LGBT services that are willing to provide LGBT awareness training to non LGBT specialist agencies. This will help staff to identify, risk assess and refer where appropriate high risk cases of domestic abuse**. (Recommendations at page 113, paragraphs 16.11 - 16.12).**

4.65 In reviewing the sentencing comments of the Trial Judge concerning Mr Smith's murder, at page 23, paragraph 2.40, ('…This was in no sense a domestic incident and could not properly be characterised as such…'), the DHR Panel believes that this could be considered as a potential action for the Home Office Violent Crime Unit, to raise with the Judicial College[80]. The Home Office DHR Quality Assurance Panel raised this comment for consideration and taking all of the information into account it is the view of the DHR Panel that this was a domestic incident. **(Recommendation at page 114, paragraph 16.24).** When asked about this Tony said 'I can see that technically, according to the law, this was a domestic incident, but as a family we were **[redacted]** until the police told us. We believed he (Mr Barnes) was an occasional lodger, **[redacted]**'.

Effective Practice/Learning

4.66 Effective Practice:

- The review did not highlight any specific instances of good practice.

4.67 Learning:

- The need for investigations into serious crimes to be carried out to the required standards, with appropriate supervision and criminal justice disposal.
- A need for domestic violence and abuse awareness training for staff, particularly in relation to specialist groups e.g. LGBT and older male victims.

Recommendations[81]

4.68 Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences, are being referred to the Crown Prosecution Service for a charging decision.

[80] The Judicial College is responsible for the training of all 36,000 judicial office holders in England and Wales and tribunals around the UK. (Came into being 1 April 2011.Formerly known as the Judicial Studies Board).

[81] Please see additional comments from the LGBT expert at: page 96, paragraph 14.2; page 113, at paragraph 16.13 and page 114, at paragraph 16.25.

4.69 Devon and Cornwall Police to take account of recommendations 1, 2, 4, 6 and 10 of the HMIC 2014 report on 'Devon and Cornwall Police's approach to tackling Domestic Abuse'; to review the SODAIT Training Plan to establish whether team members, as part of their continued professional development, can receive additional training in respect of increased understanding of 'specialist' groups e.g. LGBT and older male victims; and establish whether domestic violence and abuse incidents involving members of LGBT communities and particularly older male victims, could be introduced into the Police Training Programme, for all police officers and police staff from call handlers to responders.

5 Adult Mental Health Services (AMHS) Organisation - Mr Smith

5.1 The AMHS Organisation helped to provide services to Mr Smith for his **[redacted]** from **[redacted]** up to **[redacted]**. During this period of time the AMHS Organisation did not have specialist **[redacted]** services within its Adult Mental Health Services. Up until **[redacted**[82]**]** a person requiring community input for **[redacted]** would have been helped by **[redacted**[83]**]**. If a person had a dual diagnosis, or needed primary rehabilitation in **[redacted]** an AMHS Organisation in-patient unit, then they would be referred to the AMHS Organisation Community Mental Health Team (CMHT), to access the treatment, intervention or mental health input.

5.2 It was then and still is now, in Cornwall and elsewhere, accepted practice that Adult Social Care[84] would only become involved with a community care assessment of needs[85] if drugs and alcohol, or mental health issues were no longer prevalent for a service user and it was apparent an assessment was needed, even if not requested by the service user. The reason for this is because Drug and Alcohol and Mental Health Services are regarded as best equipped to examine the service user's history and to coordinate the most appropriate treatment and support services.

Review of Involvement

5.3 The AMHS Organisations first contact with Mr Smith was in **[redacted]**. This followed a GP referral, which recorded Mr Smith's history of **[redacted]** dependency from **[redacted]**, his **[redacted]** marriage separation and **[redacted]**. He was offered and declined admission to **[redacted]**, expressing instead an interest in private clinics, but **[redacted]** there were none in Cornwall. In **[redacted]** Mr Smith accepted admission to **[redacted]** for in-patient **[redacted]**, but **[redacted]** after four days.

5.4 On **[redacted]** Mr Smith's GP made a referral to the AMHS Organisation Community Mental Health Team (CMHT), requesting his inclusion into a residential **[redacted]** rehabilitation programme. On **[redacted]** a GP referral was made to the CMHT Consultant Psychiatrist asking for Mr Smith to be assessed so that funding could be obtained for this programme. This was promptly done and Mr Smith admitted to **[redacted**[86]**]**, but on **[redacted]**, after one day.

---

[82] In **[redacted]** the AMHS Organisation developed a specialist service for **[redacted]**, who prioritised clients at high risk of hospital admission.

[83] In **[redacted]** became **[redacted]** and in **[redacted]** they became **[redacted]**.

[84] Also known as Adult Care, Health and Wellbeing. Part of Cornwall Council and provides help for older people, adults with learning and physical disabilities, mental health problems, drug or alcohol problems etc.

[85] Local Authorities have a duty to assess a person who may be in need of community care services and meet the 'Eligibility Criteria 2010' (previously known as 'Fair Access to Care Services 2003' and prior to that 'The National Health Service and Community Care Act 1990').The eligibility criteria identifies the risks to independence which threaten a person's ability to manage in the community. Only those assessed as 'critical' and 'substantial' would receive services. Those classed as 'moderate' and 'low' would not receive services, but would be signposted to relevant agencies. (Community Care and Law (2011).Fifth Edition by Luke Clements and Pauline Thompson).

[86] **[Redacted]** residential rehabilitation unit, for clients with **[redacted]**.

Comment

5.5 In patient **[redacted]** (primary rehabilitation) was provided by the AMHS Organisation in **[redacted]** their **[redacted]** in - patient units. Community **[redacted]** services and case management were provided by the Local Authority (**[redacted]**). This included sourcing residential rehabilitation (secondary rehabilitation) and out of area placements if needed. This required collaborative working and good communication to work well, but was a complicated process, with differing elements of the pathway coordinated and provided by different services and agencies.

5.6 On **[redacted]** the AMHS Organisation received a GP referral requesting support following Mr Smith's admission to **[redacted]**. The CMHT responded promptly and offered Mr Smith regular intervention. On **[redacted]** Mr Smith's GP requested in-patient **[redacted]**, prior to out of county residential rehabilitation. There is no record available to indicate if this took place. On **[redacted]** Mr Smith was referred to the CMHT Consultant Psychiatrist by **[redacted]**. They referred Mr Smith for admission for **[redacted]**, prior to residential rehabilitation. Previous attempts **[redacted]** in the community had been **[redacted]**. On **[redacted]** Mr Smith was admitted to **[redacted]**, but **[redacted]** four days into his rehabilitation programme. This was the last contact the AMHS Organisation had with Mr Smith, until he became a client of the AMHS Organisation, eight years later, in **[redacted]**, with his referral to **[redacted]**.

Comment

5.7 The admission documentation provided comprehensive assessment of needs, including the risk assessment sections and a good care plan was in place which addressed Mr Smith's identified needs.

Analysis of Involvement

5.8 For analytical purposes, the involvement of the AMHS Organisation with Mr Smith has been categorised as follows:

- Assessments; decision making; action taken and services provided to Mr Smith. Were concerns and risks identified and acted upon?
- Historic gaps in compliance with policy, procedures and training needs relevant to this DHR.

Assessments; decision making; action taken and services provided to Mr Smith. Were concerns and risks identified and acted upon?

5.9 In respect of the **[redacted]** GP referral and assessments, Mr Smith was seen promptly and received a good service which accommodated his needs. Several options were listed in the letter back to the GP after Mr Smith expressed an interest in a private clinic. This communication showed that Mr Smith was engaged with the clinician and was working collaboratively to deal **[redacted]** and its link to his **[redacted]** use. Mr Smith was offered all assistance to enable him to make informed decisions about his care and treatment which he declined at that stage, wanting to pursue a private route. Appropriate services were readily offered and enquiries made

regarding alternative service providers. Mr Smith's assessments identified he did not have a history of **[redacted]** issues and his **[redacted]** was viewed as existing co morbidly alongside **[redacted]**.

5.10 Following Mr Smith taking discharge during his in-patient **[redacted]** at **[redacted]** in **[redacted]**, there was evidence, both of the medical and nursing staff, discussing the risk of **[redacted]** and relevant professionals being informed, but nothing was documented in the clinical record as to the decisions taken. Staff showed good knowledge and awareness of the procedures regarding concerns about safety of users and escalating behaviour. In relation to his GP referral and assessment for rehabilitation at **[redacted]** between July and December **[redacted]**, there was good collaborative working, information sharing and decision making across agencies, but the process took five months to be achieved.

5.11 In response to the GP request for Mr Smith's in-patient **[redacted]** and admission to an out of county rehabilitation unit in **[redacted]**, clinical staff worked with Mr Smith to maximise his opportunity to **[redacted]** successfully. The plan recognised Mr Smith's **[redacted]** in completing a **[redacted]** programme and organised flexible admission for **[redacted]** to immediately precede residential rehabilitation. The AMHS Organisation were consistently responsive in following up their actions, making decisions regarding treatment, when to access it and responded positively to the GP, or **[redacted]** requests to see Mr Smith to enable primary or secondary rehabilitation. Information was shared across agencies and enabled the AMHS Organisation to make decisions relevant to Mr Smith's needs in a professional and helpful way. It also helped community services, provided by other agencies, to respond to his needs. The AMHS Organisation provided timely out-patient appointments were offered and in-patient admission for **[redacted]** when requested, or as a follow up.

5.12 Professionals involved with Mr Smith's care (GP, the AMHS Organisation, **[redacted]**, Health Authority and Out of County Rehabilitation Units) were sensitive to his needs and wishes and provided a comprehensive and holistic assessment of need on each occasion he was referred, or admitted. The risks to Mr Smith were predominantly **[redacted]** related which affected his **[redacted]** at times. The **[redacted]** risks were managed by continued assessment, treatment and follow up as was acceptable practice then and also now. There were no indications of adult safeguarding, or domestic violence and abuse concerns.

<u>Historic gaps in compliance with policy, procedures and training needs relevant to this DHR.</u>

5.13 Between **[redacted]** and **[redacted]** (the period Mr Smith was in receipt of Adult Mental Health Services); the AMHS Organisation had child protection policies, but did not have policies, formal procedures or training for Adult Safeguarding.[87] **[Redacted]** to **[redacted]** and the publication of 'No Secrets' DH (2000), Adult Safeguarding and Adult Protection was not part of the service provision and was not

[87] In **[redacted]** the AMHS Organisation developed policy and procedures for clinical risk assessment and management and in **[redacted]** the AMHS Organisation developed policies and procedures for Adult Safeguarding.

embedded in best practice guidelines as it is now, with clear policies, e-learning and face to face training in place.

5.14 Prior to **[redacted]**, risk assessment was used in clinical assessment, although practice was variable across the various teams. Formal policies for risk assessment and management of domestic violence and abuse concerns and escalating behaviours were in place, but these policies are now much more robust. Training on risk assessment was limited and did not have the focus it has today in Mental Health Services.

5.15 Following the publication of Health Service Guidelines by the NHS Management Executive[88] there was a requirement for all mental health provider units to establish Supervision Registers. The aim of the register was to identify those people, with a severe mental illness, who may be at significant risk to themselves, or others and ensure they receive appropriate and effective care in the community. In this specific case the AMHS Organisation had been compliant with the directive from **[redacted]**, with a risk register and robust assessment structures in place for identified high-risk individuals. The AMHS Organisation clinicians complete a core assessment at the beginning of episodes of care with clients, with assessments made on information concerning:

- Risk of deliberate self-harm.
- Past violent episodes.
- Risk of suicide, violence, self-neglect, relapse, victimisation, exploitation, wandering, absconding.
- Feelings, including anger.

5.16 In relation to Mr Smith none of the risks were identified in his two core assessments. His risk was assessed as 'Low' and so would not have met the criterion for the Risk Register.

5.17 For the remaining mental health service population like Mr Smith, who were not identified as high risk-individuals, risk assessment and management was variable from service to service. No formal policy and procedures were in place until **[redacted]**[89], for risk assessment and management of domestic violence and abuse concerns and escalating behaviours. In **[redacted]** the AMHS Organisation introduced the **[redacted]**. This brought about a stand-alone risk assessment document which promoted a more thorough risk assessment and contingency plan about risk management. This was superseded in **[redacted]** when risk assessment, history and management became fully documented on **[redacted]**. This is timely and accurate to all members of staff within the AMHS Organisation.

[88] HSG (94)51: Guidance issued on 10 February 1994.The working practices of these registers across the UK were inconsistent and from **[redacted]** there was an accepted process to close the AMHS Organisations Risk Register down, with ongoing management of risk and risk assessments of service users centred on a robust Care Programme Approach process.

[89] Clinical risk assessment and risk management for specialist mental health services **[redacted]**. (In place since **[redacted]** and currently under review).

5.18 The AMHS Organisation now have relevant policies and procedures developed and up to date for adult safeguarding; clinical risk assessment and risk management for specialist Mental Health Services; guide to risk management etc. These previous gaps in policy and procedure no longer exist in the AMHS Organisation and are firmly embedded into practice. Additionally, there are no identified gaps in multi-agency policies and procedures.

5.19 A separate review of another DHR, action planned that the AMHS Organisation review their Adult Safeguarding and Child Protection policies and procedures relating to Domestic Violence and Abuse. This was in relation to considering whether or not the current policy needed updating, or whether a separate stand-alone policy regarding Domestic Violence and Abuse, Children and Adults was required.

5.20 The DHR Panel considered this, but supported a wider recommendation that there should be consideration of a review of the South West Child Protection Procedures[90], in relation to domestic violence and abuse and a review of the Cornwall and Isles of Scilly Multi-Agency Adult Safeguarding Policy. In coming to this view there was discussion between DHR Panel members as to whether Child Protection fell within the remit of this DHR, but it was felt that it would be a good practice recommendation, based on fringe learning. The DHR Panel believes the SCP should support the Local Safeguarding Children's and Adults Board's to consider and complete this review. **(Recommendation at page 113, paragraph 16.15).**

5.21 Additionally, the DHR Panel considered there should be a multi-agency practitioner's guide/flow chart developed on how to respond to potential cases of domestic abuse and sexual violence. This should ensure all staff have the right information and are clear about their roles and responsibilities. **(Recommendation at page 114, paragraph 16.16).**

5.22 During the period **[redacted]** to **[redacted]**, the AMHS Organisation training, unlike now, did not include Adult Safeguarding; Domestic Violence and Abuse, or Clinical Risk Assessment and Management training. Knowledge and awareness about domestic violence, abuse and its impact on risk remains a training need. The AMHS Organisation had previously been prioritising and targeting relevant staff to complete their Adult Safeguarding and Risk Training. This training is now mandatory for all **[redacted]** identified priority AMHS Organisation staff. Ensuring compliance remains an ongoing process.

5.23 Safeguarding Training:

- Domestic Abuse (essential e-learning).
- Adult Safeguarding Level 1(essential e-learning).
- Adult Safeguarding Level 2 Human Rights (face to face).
- Adult Safeguarding (face to face).

[90] Provides all agencies in the South West of England with core multi-agency child protection guidelines.

5.24 Risk Training:

- Clinical risk assessment and management (essential e-learning).
- Clinical risk awareness (essential e-learning).
- **[Redacted[91]]** (face to face).
- **[Redacted[92]]** (face to face).

5.25 Currently the new AMHS Organisation staff induction includes ½ day domestic abuse and violence awareness, linked to the Adult Safeguarding Training. The AMHS Organisation have agreed **[redacted]** identified priority staff will receive the two day ACPO DASH awareness/risk assessment training, as commissioned by Safer Cornwall Partnership (SCP) between 2014 and 2016. The AMHS Organisation are also reviewing which staff and teams need priority training for 'Routine Enquiry into Domestic Violence and Abuse' in appropriate Mental Health Services. This will ensure staff are able to identify, risk assess and refer where appropriate high risk cases of domestic abuse. A large number of the AMHS Organisations staff have already completed the SCP commissioned two day training. **(Recommendation at page 112, paragraph 16.4 and Recommendation at page 113, paragraph 16.11).**

Effective Practice/Learning

5.26 Effective Practice:

- Out patients assessments of Mr Smith were mostly conducted by one clinician, an Associate Specialist. This ensured consistency and the ability to establish a rapport with a known worker. The NICE[93] guidance supports this approach, advising that in working with people who **[redacted]**, workers must 'build a trusting relationship and work in a supportive, empathic and non-judgmental manner'. The Associate Specialist was not a specialist in **[redacted]** work, but did record **[redacted]** patterns, triggers and habits, in addition to the usual assessment information.
- The AMHS Organisation was consistently responsive and offered flexibility to Mr Smith's treatment options, recognising the **[redacted]** and decisions linked to his **[redacted]**. It worked effectively as a single agency and across agencies to promote Mr Smith's welfare. They responded promptly to all requests to assess Mr Smith and undertook thorough assessments on each occasion. Risks were identified and managed effectively, with appropriate treatment and interventions offered and provided.

Recommendations

5.27 Please see the AMHS Organisation recommendations for Mr Barnes from page 65, paragraphs 6.79 and 6.80.

[91] **[Redacted]**: Risk Assessment Tool.

[92] **[Redacted]**: Skills based training, on core communication skills in suicide risk assessment and management.

[93] NICE (CG115 Alcohol Dependence and Harmful Alcohol use- February 2011).

6 Adult Mental Health Services (AMHS) Organisation - Mr Barnes

6.1 The AMHS Organisation were involved with Mr Barnes during the period from **[redacted]** to **[redacted]**, with further brief referrals in **[redacted]** and **[redacted]**.

Review of Involvement

6.2 Mr Barnes was first known to the AMHS Organisation on **[redacted]** following a GP referral. It was reported he **[redacted]**. A Consultant Psychiatrist recorded: 'he felt **[redacted]** for years; avoids **[redacted]**; very self-conscious of **[redacted]**; father died in **[redacted]** and mother **[redacted]** (Mr and Mrs B. Barnes), with him now caring for **[redacted]** and physically ill Uncle (Mr Newton) in family home having given up his employment; probably **[redacted]** now thinking more constructively re future'. The LGBT expert commented that Mr Barnes's **[redacted]** and **[redacted]** may have been compounded by his **[redacted]**.

6.3 There was then a ten year gap until **[redacted]**, which followed another GP referral to an AMHS Organisation Consultant Psychiatrist. He was **[redacted]** 'caring for his **[redacted]** ill Uncle (Mr Newton) and developed the idea that he was **[redacted]**, very self-conscious with **[redacted]**, his **[redacted]** as making provocative amounts **[redacted]** to annoy him'. Mr Barnes said he had tried to leave his home, had taken **[redacted]** and wanted his '**[redacted]**'.

6.4 This was the first of four **[redacted]** in one month which led to his first admission to an AMHS Organisation Hospital on **[redacted]**. He was seen and assessed on two occasions prior to the admission and was diagnosed with **[redacted]**. A year long voluntary admission to the AMHS Organisation Hospital followed, for ongoing assessment and treatment. This led to extended periods of supported leave home from **[redacted]** and Mr Barnes was discharged from the AMHS Organisation Hospital on **[redacted]**.

Comment

6.5 The AMHS Organisation Hospital records showed significant professional input, support and interventions to support his transition home after a long admission. There was a comprehensive CPA discharge package in place.

6.6 By **[redacted]** Mr Barnes was 'increasingly **[redacted]**, describing aggressive outbursts to the extent he kicked a **[redacted]** car'. On **[redacted]** he was re admitted to the AMHS Organisation Hospital for four days following **[redacted]** and diagnosed with **[redacted]**. Other admissions to **[redacted]** and an AMHS Organisation Hospital followed for Mr Barnes after further incidents of **[redacted]**:

- **[redacted]**.
- **[redacted]** to **[redacted]**.
- **[redacted]** to **[redacted]**.
- **[redacted]** to **[redacted]**.

Comment

6.7 A supported housing referral made reference to Mr Barnes having 'unresolved anger leading to violence to property and people' and the admission risk paperwork notes 'assaults on property due to frustration?; assaults on Uncle (Mr Newton) which Mr Barnes denies'. The clinical record assessment showed that risks to others had been identified, but there was no evidence available of the assessment of these risks, or plans to manage or minimise them, or consideration of minimising the risks to his Uncle Mr Newton. Following his return home on **[redacted]**, he was also discharged from social work caseload because he 'will not take up anything offered or planned'. A Consultant Psychiatrist expressed **[redacted]** 'horror' and 'frustration' at this decision, believing social care was necessary. The Social Care team were 'adamant' his needs were bests met by the Community Mental Health Team (CMHT) within the AMHS Organisation.

6.8 By **[redacted]** Mr Barnes's CPN recorded that he (Mr Barnes) was 'enormously improved, functioning better than he has done for years'. Throughout this period of community care, through to the end of **[redacted]**, records show Mr Barnes talking frequently to all of his mental health workers, including his GP, of his involvement with Mr Kay, who it was recorded, was **[redacted]**. It was documented that Mr Barnes was often **[redacted]** with his **[redacted]** regarding his **[redacted]** with Mr Kay and **[redacted]**. He said he preferred this **[redacted]** (with Mr Kay) to no **[redacted]**, albeit it did cause him to have **[redacted]**. He said he **[redacted]**.

Comment

6.9 There was good compliance with the CPA, with his CPN coordinating and reviewing Mr Barnes's care on a regular basis during this period.

6.10 In **[redacted]** Mr Barnes's GP requested a psychological assessment and this began in **[redacted]**, with regular sessions provided from then onwards. These focussed on his **[redacted]**. On **[redacted]** Mr Barnes was seen by a Staff Psychologist at the request of his GP, who was concerned about Mr Barnes's **[redacted]**. He was assessed as **[redacted]**. His CPA was discontinued on **[redacted]** by his CPN, but Mr Barnes was still receiving six monthly psychology support and monthly CPN input, which included discussions on relationships and safe sexual practices.

Comment

6.11 The CPN requested the GP refer Mr Barnes to the Psychologist rather than directly which created a delay in the process and additional work for the GP.

6.12 On **[redacted]**, at a home visit, Mr Barnes told his CPN that his Aunt, Mrs East, had accused him of pushing her. When questioned about this Mr Barnes denied it.

Comment

6.13 This information was not followed up, with the CPN explaining Mr Barnes was always open and honest and had denied it ever happened.

6.14 At a psychology session on **[redacted]**, Mr Barnes explained the pattern of behaviour he had got into: 'Mr Kay turns up; Mr Barnes agrees to anything to spend time with him, including Mr Kay **[redacted]**; Mr Barnes goes along with it even helps, stands around, pays for taxis; Mr Barnes **[redacted]** his family (Uncle Mr Newton and Aunt Mrs East);Mr Kay leaves; Mr Barnes gets angry because he **[redacted]**; Mr Barnes **[redacted]**, feels he **[redacted]**'.

6.15 On **[redacted]** Mr Barnes was seen by his CPN following **[redacted]** the previous day. This **[redacted]** centred on his **[redacted]** by Mr Kay. A **[redacted]** of Mr Barnes contacted the CPN, explaining Mr Barnes had been involved in an argument with Mr Kay, which resulted in Mr Barnes getting a one way train ticket to **[redacted]**. It appears **[redacted]** asked for Mr Barnes to be '**[redacted]**'. The CPN contacted Mr Barnes and arranged for his safe transfer back to Cornwall.

6.16 Mr Barnes was assessed by the CPN and disclosed **[redacted]** for Mr Kay. He chose to remain with him, despite 'feeling angry and frustrated at **[redacted]**'. He said he wanted to **[redacted]** with Mr Kay, but he 'always leaves'. He said he felt financially and emotionally **[redacted]**. He 'vented feelings of **[redacted]**'. The CPN noted Mr Barnes was 'remorseful, more rational and a lot calmer, although that could all change when he next has contact with Mr Kay'.

6.17 On **[redacted]** the CPN wrote a letter to the Consultant Psychiatrist describing the recent events and now sharing additional information, that Mr Barnes had in fact 'hit' Mr Kay, prior to boarding his train to **[redacted]**. This information was not available to the Staff Psychiatrist who assessed Mr Barnes on **[redacted]**. A copy of the CPN's letter was also sent to Mr Barnes's GP. On **[redacted]** the CPN recorded in Mr Barnes's internal mental health records that Mr Barnes 'spoke of (laughingly) about how he had purchased gaffer tape and had planned to tape Mr Kay up and keep him there with him'. When the CPN asked him about this comment Mr Barnes 'laughed, stating he knew it was a ridiculous idea and clearly stated he would not really do such a thing'.

6.18 At about 7.45am on **[redacted]**, the on duty CMHT worker (CPN) received a telephone call from Mr Barnes. He explained he had bound and threatened Mr Kay with a knife. He was upset and wanted help to release Mr Kay. The duty CPN agreed to attend Mr Barnes's home following assurances he had 'no desire to hurt **[redacted]** or Mr Kay'. On **[redacted]** arrival **[redacted]** found that Mr Kay was not there, having managed to 'escape'. Mr Barnes told the CPN he **[redacted]** for money. He said Mr Kay was **[redacted]** and had been planning to go out the day before, to see **[redacted]** and he had been unable to reassure Mr Barnes of his return the same night. Mr Barnes said he picked up a **[redacted]** hit Mr Kay with it. He told the CPN he then threatened Mr Kay with a carving knife and forced him upstairs, where he then restrained Mr Kay with electrical cable, ties and masking tape **[redacted]**. Mr Kay was held with the **[redacted]**.

6.19 Mr Barnes told the CPN he had been impulsive, had taken **[redacted]** and needed help. He appeared **[redacted]** and so paramedics were called to take him firstly to **[redacted]** and subsequently to an AMHS Organisation Hospital. The police were

contacted, but they were unable to arrest or interview Mr Barnes at that stage, regarding the false imprisonment of Mr Kay.

Comment

6.20 The CMHT CPN attended Mr Barnes's home, in the knowledge he had falsely imprisoned someone against their will, without first contacting the Emergency Services. The CPN stated **[redacted]** did not consider the risks to **[redacted]** due to **[redacted]** prior knowledge of Mr Barnes. It was Mr Barnes's Aunt Mrs East, who called the police, not the CPN.

6.21 Mr Barnes was voluntarily admitted to an AMHS Organisation Hospital from **[redacted]** until **[redacted]**, when he was discharged following his police interview. A core assessment was completed and he was assessed as 'low' risk for suicide and violence. The care plan on admission to the AMHS Organisation Hospital was for assessment, with a view to 'support Mr Barnes with regards the recent incident and promote mental health state, until feeling able to return to the community'. Following a request from Devon and Cornwall Police for a psychiatric report to be prepared on Mr Barnes, he was assessed on **[redacted]**, by an AMHS Organisation Consultant Psychiatrist. On **[redacted]** the psychiatric report was provided back to the police. The following summary of the report has been taken directly from the AMHS Organisations IMR document:

> '**[Redacted]** person who suffers **[redacted]**, many attempts at **[redacted]**. For many years he has lived with an Uncle (Mr Newton) until a month prior to these events. This compounded Mr Barnes's **[redacted]**, who is a **[redacted]**'. It went on to say that Mental Health Services aware for 3 years of **[redacted]** with Mr Kay, description of **[redacted]** and ongoing discussions with Mr Barnes regarding this, who is aware of **[redacted]**, but **[redacted]** to do anything about it **[redacted]** was he for any form of **[redacted]**'. Difficulties in the **[redacted]** have been escalating (examples given of recent **[redacted]** and admission and impulsively getting on a train to **[redacted]**). Mr Kay had been **[redacted]** Mr Barnes for the week and as money started running out said **[redacted]**. Mr Barnes describes 'something snapping*',* hitting Mr Kay **[redacted]**.
>
> The Consultant Psychiatrist noted: 'this was extremely brave bearing in mind that Mr Kay is approx. 6 foot and Mr Barnes is 5 foot'. Mr Barnes ordered Mr Kay upstairs at knifepoint, tied Mr Kay up **[redacted]**. The 'imprisonment' ended with Mr Barnes **[redacted]** and going to phone his CPN. Mr Barnes is 'coming to recognise that Mr Kay actually let him do it, as obviously he could have very easily overpowered him at the outstart*'.*
>
> The Consultant Psychiatrist added 'I do not think that Mr Barnes is a danger to the public at large at all. These events are a culmination of 4 years of **[redacted]**'; there was 'considerable deprivation in parting with his money'. The Consultant Psychiatrist said: 'The enormity of court proceedings are likely to result in Mr Barnes **[redacted]**, he is being offered close support by CPN' and 'I have offered him sanctuary at **[redacted]** Hospital.' The Consultant

Psychiatrist asked 'If charges are brought against him could the Community Mental Health Team be informed so we can take preventative action from preventing a tragedy'.

6.22 Post discharge, on **[redacted]**, Mr Barnes received regular home visits and input from his CPN and a Community Care Assistant. A Health Care Assistant[94] was also involved with Mr Barnes from **[redacted]**.He received psychology appointments two to three times per week and attended **[redacted]**. He continued to raise issues about **[redacted]** who were making him angry and also 'ventilated' feelings about Mr Kay. He was offered, but declined the chance to exchange his home for a smaller property.

Comment

6.23 Mr Barnes's care plan was evaluated regularly and provided a comprehensive package of support and intervention. Post discharge, it does not appear that Mr Barnes's GP received a discharge letter from the Locum Consultant Psychiatrist at the AMHS Organisation Hospital. The GP also did not receive a copy of the psychiatric report prepared for the police, but would only have done so with Mr Barnes's consent. It is unknown if this was ever discussed with him, as it may have been beneficial for the GP to have read it.

6.24 During **[redacted]** and **[redacted]** Mr Barnes was regularly seen by his CPN, Psychologist and Health Care Assistant. He was concerned about **[redacted]** 'insults' and noise and spoke frequently of Mr Kay. On **[redacted]** Mr Barnes's Counsellor in Psychology expressed concerns that he was **[redacted]**.On **[redacted]** Mr Barnes told his CPN that he had 'thrown a **[redacted]**', by breaking crockery after discovering **[redacted]** had visited Mr Kay.

Comment

6.25 The information from the CPN on **[redacted]**, did not reach a Staff Psychiatrist in time for a clinic review on **[redacted]** and so Mr Barnes was assessed as improving, with no anxiety and increased self- esteem. It appears this was because the letter was typed on **[redacted]**. Following the assessment, no further appointments were planned, but the Staff Psychiatrist was prepared to see Mr Barnes again if the need arose.

6.26 On **[redacted]** Mr Barnes was seen by his CPN who said he was still preoccupied with Mr Kay and recorded 'No violence towards self or others expressed'. On **[redacted]** Mr Barnes's CPN wrote to his GP to inform him that Mr Barnes believed he had been victimised by **[redacted]** on Halloween Night, who had thrown eggs at his home and called him a **[redacted]**.The CPN also said in the letter that Mr Barnes had told him that it 'would not have helped if he had gone outside waving a carving knife'. On **[redacted]** Mr Barnes told his CPN an unknown person had driven a car at him, only diverting at the last minute. He was advised to contact the police.

[94] Work in hospital or community settings under the guidance of a qualified healthcare professional. Assist clients with e.g. overall comfort, monitoring client's health conditions etc.

Comment

6.27 The information about the carving knife, although disclosed in the GP letter, was not recorded in the clinical records, either in the progress notes, or a risk assessment and so was not shared with other workers involved. Although adult safeguarding was not embedded into working practice at that time, there was no evidence of consideration of safeguarding alert, for example, contact with the police, or potential risks to Mr Barnes, in view of the two incidents on Halloween night and the car being driven at him.

6.28 At a psychiatric assessment on **[redacted]**, Mr Barnes appeared to be 'coping well with the transition away from Mental Health Services'. As of **[redacted]**, Mr Barnes was assessed by the CPN as 'Low' for risk of relapse of neglect, suicide and harm to others. On **[redacted]**, the Counsellor in Psychology advised Mr Barnes's GP that Mr Barnes had been discharged as Mr Barnes felt he no longer needed to see the Psychologist. The Counsellor noted Mr Barnes had in the past **[redacted]** and the GP should re- refer if he thought it appropriate. On **[redacted]**, having 'maintained good progress', Mr Barnes was formally discharged by his CPN from the secondary care AMHS Organisation. The CPN offered re referral if the GP had any concerns.

6.29 On **[redacted]** Mr Barnes was assessed by his regular CPN. This followed a GP request for an expert psychiatric view on his management. The CPN recorded Mr Barnes appeared **[redacted]** and had been seeking **[redacted]** through advertisements. The CPN said 'despite receiving counselling and input he continues to **[redacted]**. Mr Barnes advised he had been verbally cautioned the previous week after police had received a report of **[redacted]** in the local public convenience'. The CPN said 'I found him to be better than I have ever seen him and found most of his problems to be of a social or relationship nature'. Whilst there was no planned follow up from the CMHT, Mr Barnes was seen on **[redacted]** by a Consultant Psychiatrist. He was assessed as **[redacted]** '. They discussed Mr Kay and Mr Barnes reported he had no ongoing **[redacted]** Mr Kay. He was then discharged from the AMHS Organisation.

Comment

6.30 The CPN assessment was carried out by a previous known worker who was aware of the difficulties and risks. The later assessment by the Consultant Psychiatrist was comprehensive and was the first clinician who talked about Mr Kay as the victim.

6.31 On **[redacted]** Mr Barnes was assessed by a CPN at the request of his GP. This followed a recent **[redacted]** which reinforced Mr Barnes's **[redacted]**, although he said he was **[redacted]**. The assessment identified Mr Barnes 'has a **[redacted]** not towards carers'. He was assessed as **[redacted]**. He was not accepted by the secondary care AMHS Organisation and was signposted to see the Practice Counsellor and attend **[redacted]**. The CPN said although Mr Barnes was discharged from **[redacted]** care he could contact him directly if required.

Comment

6.32 Mr Barnes was assessed by a known worker which gave consistency to Mr Barnes and his GP. There had been consideration as to who might be at risk from Mr Barnes, but there was no information available to detail and support how this assessment and conclusion was reached.

6.33 From **[redacted]** up until **[redacted]**, there was no reported contact between Mr Barnes and the AMHS Organisation, apart from two brief occasions in **[redacted]** and **[redacted]**. Mr Barnes's GP referred him for counselling in **[redacted]** but once the appointment was made Mr Barnes declined to attend. In **[redacted]** the GP requested counselling for Mr Barnes through **[redacted]**. He attended two sessions before cancelling further ones.

6.34 On **[redacted]** a GP referral was made after Mr Barnes requested further involvement with the secondary care AMHS Organisation. He was '[**redacted]**, does not like staying at home **[redacted]** so does not go out'. It was unknown if he was **[redacted]**. On **[redacted]** Mr Barnes's case was discussed in a Multi-Disciplinary Team[95] (MDT) meeting. A subsequent letter to his GP identified the presenting information in the referral did not meet the CMHT criteria for assessment; there were no changes to his presentation and so no role for the CMHT. It noted referrals to **[redacted]** had been beneficial in the past and also signposting to **[redacted]**. The minutes of the MDT meeting were not located for this DHR so it is not clear who was part of the decision making process.

6.35 Mr Barnes had no further contact with the AMHS Organisation from **[redacted]**, until **[redacted]**, following his arrest on suspicion of the murder of Mr Smith. He was deemed mentally fit for interview and detention, with no mental health disorder detected.

Comment

6.36 Between **[redacted]** and **[redacted]**, (nearly ten years), apart from the brief contact in **[redacted]**, Mr Barnes had one recorded contact with the AMHS Organisation, on **[redacted]**, which involved a paper review.

Analysis of Involvement

6.37 For analytical purposes, the involvement of secondary care Adult Mental Health Services (the AMHS Organisation) with Mr Barnes has been categorised as follows:

- Were concerns and risks identified and acted upon?
- Assessments; decision making; action taken and services provided to Mr Barnes.

[95] CMHT's are widely regarded as the model for all Multi-Disciplinary Teams. Social Workers and Community Psychiatric Nurses are the mainstay of CMHT's. Other professionals include Occupational Therapists, Psychiatrists and Psychologists.

- Historic gaps in compliance with policy, procedures and training needs relevant to this DHR.

Were concerns and risks identified and acted upon?

6.38 Mr Barnes's clinical records document incidents of:

- Kicking **[redacted]** car.
- Requests to put **[redacted]**.
- Allegations of pushing Mrs East and assault on Mr Newton. (Both denied).
- Hitting Mr Kay.
- Purchase of gaffer tape and comment *'*planned to tape Mr Kay up and keep him there with him'.

6.39 Within most core assessments the risk of **[redacted]** was identified for Mr Barnes and although violence was assessed as a 'No', it details in this section including the following: 'assaults on property due to frustration? Assaults on Uncle which Mr Barnes denies*'.* The allegations of harm to his Aunt, Mrs East and his Uncle, Mr Newton, were not considered as potentially domestic violence and abuse concerns. The AMHS Organisation staff accepted what Mr Barnes said. He denied the allegations and the AMHS Organisation staff did not question him, believing him to be open and honest.

6.40 These views may have obscured the AMHS Organisation staff to consider Mr Barnes's potential risks to others. They were not followed up with family members, or viewed as either safeguarding or risk concerns. Prior to **[redacted]** the AMHS Organisation staff may not have identified these allegations as adult safeguarding issues, as would now be the case, with clear policies, e-learning and face to face training in place. The risk indicators were present and could have been considered.

6.41 A lack of recognition was also found regarding Mr Barnes's escalating behaviour prior to the false imprisonment of Mr Kay on **[redacted]** to **[redacted]**, with aggressive and risk incidents viewed in isolation and rationalised due to Mr Barnes's own alleged **[redacted]** with Mr Kay. Following the false imprisonment, thorough assessment of risk was not evidenced and a care plan regarding risks to others was not in place.

6.42 With regards to 'hitting' Mr Kay, the CPN assessed Mr Barnes immediately upon his return from **[redacted]**, but the 'hitting' comment was only documented in a GP letter. Mr Barnes was described as 'remorseful, more rational and a lot calmer, although that could all change when he next has contact with Mr Kay'. This indicates a recognition that Mr Barnes may behave aggressively if the right triggers were present. However, there was no care plan or risk management plan, or discussion in his clinical records.

6.43 In relation to Mr Barnes telling his CPN he had purchased 'gaffer tape' and had 'laughingly' planned to tape Mr Kay up and keep him, this does not appear to have been shared with anyone, including the Multi-Disciplinary Team. The information was

not updated on a risk assessment for easy identification; especially the potential risk to Mr Kay and no risk management strategy was in place.

6.44 The false imprisonment incident of **[redacted]** and **[redacted]** was fully documented by the CMHT duty worker, but the subsequent psychiatric report; notification of Serious Untoward Incident (SUI)[96]; SUI managerial report and clinical records, all reframed the incident to show Mr Barnes as the victim, rather than the perpetrator. The IMR author believes it is possible this mind-set minimised, or obscured the AMHS Organisations professional's view of future risk from Mr Barnes to others.

6.45 Mr Barnes was not identified as a high risk service user[97] in relation to the AMHS Organisations Supervision Risk Register[98] and was therefore not placed onto it. He was assessed as 'Low' for violence and suicide after the false imprisonment incident of **[redacted]**. In **[redacted]** to **[redacted]** there was no evidence available of discussion and reflection, through a multi-disciplinary or multi-agency risk meeting, or forensic mental health assessment, following the false imprisonment incident and prior to discharge, or consideration of any domestic violence and abuse strategy.

6.46 If this had taken place this may have introduced alternative pathways for Mr Barnes i.e. forensic mental health assessment; recognised documented risk assessment available if re-referred and better long term management. As it is the case now, specialist assessment and advice was available within the AMHS Organisation in **[redacted]**, through the Forensic Mental Health Team[99] running clinics and offering assessment, but there was a lack of awareness of this resource by the AMHS Organisations staff. This course of action would have been expected and best practice following the false imprisonment incident involving Mr Kay.

6.47 There is no evidence available that a risk strategy and planning meeting took place, prior to discharge from the AMHS Organisations Hospital and so ongoing, or future risks to others, were not evidently considered. There was no 'risk to others' care plan in place following this incident, yet progress notes evidenced Mr Barnes's **[redacted]**, an ongoing theme in his CPN and psychology interventions.

6.48 Professionals were constantly discussing the benefits of Mr Barnes **[redacted]** with Mr Kay and finding alternative healthy relationships and social networks. There does not appear to be discussions between professionals exploring options, or a

[96] In March 2010 the National Patient Safety Agency published the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (SIRI). SIRI replaced 'Serious Untoward Incident'(SUI) .The framework details how all organisations providing NHS funded care should report, investigate and monitor serious incidents e.g. unexpected death, serious harm, allegations of abuse of patients, staff, visitors, members of the public etc.

[97] A person with a severe mental illness who may be a significant risk to themselves, or others and ensure that they receive appropriate and effective care in the community.

[98] It was recognised across the UK that the use of Risk Registers was inconsistent. From **[redacted]** there was an accepted process to close the AMHS Organisations Risk Register down and ongoing risk and risk management centred on robust CPA processes.

[99] Provides treatment for people over the age of 16 years old with mental illness, who come into contact with the police or courts.

contingency plan with Mr Barnes, in readiness for a change, or a care plan, to outline what support and process was available to Mr Barnes, should he have wanted to **[redacted]** with Mr Kay.

6.49 Given the escalation of aggressive behaviour towards Mr Kay prior to the incident, reflecting and reviewing all of the information held, the clinical team may have understood Mr Barnes differently. This was not as someone who 'snaps', but someone who given the right triggers and circumstances can become more unreasonable, calculated and dangerous towards others. A level of premeditation was also shown. The clinical team viewed this incident in isolation, without pooling of all the other historical known risk information together and did not consider the risk assessment towards others and how to minimise risks and safeguard them.

6.50 Realistically, risk assessment, management and risk strategy in **[redacted]** would not have had the profile it has now, where the AMHS Organisation staff are supported to prioritise risk, with appropriate training; paperwork; assessment tools and the time to discuss and manage risk. The AMHS Organisation staff now have an increased awareness about risk. They recognise the necessity to document and share information and discuss it to minimise risk. They have training in assessing risk and formulating risk management and care plans. Face to Face clinical risk assessment and management training began in **[redacted]**, alongside the development of policy and procedure.

6.51 Since **[redacted]** the AMHS Organisation has provided **[redacted]** training for all clinical staff and all risk information is held on **[redacted]**, accessible to all staff. A risk assessment tool **[redacted]**, is used to undertake in depth risk assessments, which is available to staff. The AMHS Organisations staff also participate in Multi Agency Public Protection Arrangements (MAPPA).

6.52 At the time the IMR was completed the IMR author identified that across Cornwall different teams worked differently with regards to discussion and management of risk. For example, different Consultants on the same ward did not all use risk management/strategy meetings to discuss, share and own decisions regarding risk. This could have potentially caused confusion to staff, as different service users will have their risk needs met and planned by different processes. Since this DHR process began, changes have been implemented to risk assessment processes which have addressed this issue**.**

<u>Assessments; decision making; action taken and services provided to Mr Barnes.</u>

Response to Mr Barnes's call to the CMHT duty worker on **[redacted]**.

6.53 The CMHT duty worker attended Mr Barnes's home, alone, in the knowledge he had falsely imprisoned someone with a knife. **[Redacted]** did not call the Emergency Services first. This action, despite him giving **[redacted]** reassurances he had no desire to hurt anyone, reflects the AMHS Organisations mind-set of Mr Barnes in terms of risk and lack of risk awareness and safety to others (Mr Kay). The decision to attend was made in isolation, by a lone duty weekend worker, albeit **[redacted]** said **[redacted]** knew Mr Barnes, having worked with him before. **[Redacted]** said it

was 'custom and practice' at that time to deal with situations as they arose and described risk as not having the profile it does today. **[Redacted]** said 'at no time did I feel under threat'. The AMHS Organisation did not have a lone working policy in place at that time, but do so now, as well as policies and procedures, training and working knowledge of working with risk.

6.54 The Immediate Notification of Serious Untoward Incident (SUI) process was commenced by the CMHT duty worker, who recognised the incident as serious and assumed this would lead to assessment and consideration of Mr Barnes's actions and risk. The process was further completed by the team manager, but following information gathering, a recommendation was made that there was a 'MDT review of care package and risk assessment on discharge' and the SUI process was ended.

6.55 This report was copied into the next tier of management, but did not detail all known information and risks regarding this incident, as detailed in the clinical records and it minimized the risk to Mr Kay and others. It failed to recognise the gravity of the incident and therefore the incident was not escalated further, for a full investigation and assessment. On discharge there was no documentary evidence to suggest a more thorough risk assessment took place.

6.56 The AMHS Organisation now has a Serious Incident (SI) policy which followed the introduction of the SUI and national Serious Incident Requiring Investigation (SIRI) policy. This provides detailed clear and robust systems for processing an SI form, with the decision to grade and process, or not, being made by a group of identified professionals, not a sole team leader, as in this case. This process is also now electronic and allows wider dissemination of serious incidents.

Assessment and discharge planning during the **[redacted]** admission.

6.57 A core nursing assessment and risk assessment were completed on admission to the AMHS Organisation Hospital. The risk assessment scored Mr Barnes as 'Low' for suicide and violence and notes the **[redacted]** was a direct result of the incident. Mr Barnes was now 'claiming no **[redacted]**'. It said the aim of the care plan was 'to support Mr Barnes with regards to the recent incident and promote his mental state, until he feels able to return to the community'.

6.58 There were no details of any past violent incidents, or the current incident being viewed as high risk, although the care plan states 'Mr Barnes's current problems result from a **[redacted]**, who was being **[redacted]** Mr Barnes and so Mr Barnes hit him and tied him up at knife point, **[redacted]** and keeping him hostage overnight and then **[redacted]** the next day…Action relating to risk… inform CID[100] if leave or discharge is taken'.

6.59 The assessment and management of his risk to others is not acknowledged in the core assessment or care plan and important information is lost e.g. hitting Mr Kay; information on the gaffer tape and the escalation of his aggressive behaviour. The only action regarding risk was to inform the police if Mr Barnes left or discharged

[100] CID: Criminal Investigation Department of Devon and Cornwall Police.

himself. Whilst the risk assessment noted details of the incident with Mr Kay, subsequent assessments and scoring appears to relate to **[redacted]** only.

6.60 The false imprisonment incident was seen as a 'domestic' incident and not linked to poor mental state by a Locum Consultant Psychiatrist. There was nothing in the clinical records to suggest what a 'domestic' incident meant, or that the clinical team believed the circumstances to be part of **[redacted]**. The records do not offer any further detail as to the depth of the assessment that took place, or of any multi-disciplinary discussions regarding Mr Barnes's risks. In fact the plan had been to discharge Mr Barnes the day after his admission on **[redacted]**. This indicates the incident was not viewed as a serious event, which placed Mr Kay at risk of harm, or indicated Mr Barnes's potential risks to others.

6.61 It does not appear that a discharge letter was sent from the AMHS Organisation Hospital to Mr Barnes's GP concerning the events of **[redacted]** and **[redacted]** and his admission to the AMHS Organisation Hospital. This may have been due to the fact that he was seen by a Locum Consultant Psychiatrist. If such an omission were to happen now this would be seen as a significant failing.

6.62 The procedure now is that, if a person is admitted to hospital after a significant event, such as harm to another person, the GP Practice would be notified of the admission. At the time of the admission the AMHS Organisation would request up to date information from the GP Practice on the patients last five GP attendances. On discharge from hospital a discharge summary letter, with the reasons for the admission treatment and plan of care following discharge, would be sent to the GP Practice. If the patient was in the community and not admitted to hospital, the GP Practice would be told when the AMHS Organisation reviewed his or her case e.g. if arrested and bailed by the police. The GP Practice would receive a review letter regarding a summary of the incident, any change to medication etc.

6.63 In terms of discharge planning, the AMHS Organisation now ensures that when a patient comes out of hospital there is a discharge plan. They would be seen within seven days of discharge and then contact will be as required by the care plan. If a person is discharged from hospital, back to the care of the CMHT, they will be cared for under the Care Programme Approach (CPA) policy and their care will be either under:

- CPA, when there is an identified mental health need to assess, plan, review and coordinate the range of treatment, care and support needs for people who have complex characteristics.
- No CPA, which is the system used to describe the provision of Mental Health Services, to those with more straightforward needs, receiving services from the AMHS Organisation. No CPA applies where following assessment relating to mental health needs, it is identified that the service user has needs which are not complex and can be met by one discipline; lower risk; contact with only one agency, or no problems with access to other agencies.

6.64 A package of care under the CPA is planned prior to discharge. The patient would be referred to the Home Treatment Team[101] or CMHT and a Care Coordinator allocated if the patient did not already have one. Support to patients can be varied with varying levels of contact based on need. The monitoring of patients risk is a core activity of the CPA process, undertaken as a minimum every six months. The risk assessment is commenced and recorded at first contact with the service and updated at CPA, or other care review processes; when there is a change in presentation; on entry or exit to other areas of service, or prior to discharge from services provided by the AMHS Organisation.

6.65 The completion of risk assessments are under taken with the use of clinical judgement, that has been informed through consideration of factors known to be relevant to the risk in question, for example: face to face interview; history; situation the person is in. The relevant core risks presented on the **[redacted]** risk assessment screens are: Harm to Self; Harm from Others; Harm to Others; Accidents; Other Risk Behaviours. The timely sharing of risk information to other involved agencies is readily available through the **[redacted]**. The current AMHS Organisation risk management policy is being reviewed and there is a drive to undertake a different type of risk assessment which relates to self-harm. A number of different skills have been introduced to the process.

6.66 In cases where there are no ongoing mental health needs requiring secondary care Mental Health Services, the patients are referred to their GP to coordinate their primary care.

6.67 When Mr Barnes was discharged on **[redacted]**, following his police interview, he was given three to four days of medication to reduce the **[redacted]**, but there was no consideration of risks to others, including a risk assessment relating to Mr Kay; the general public; friends; family or mental health workers, with the knowledge of his violence towards others, given the right circumstances and triggers. The risks regarding Mr Barnes were not adequately assessed, discussed or managed during this admission and in particular in regards to discharge planning and the management of Mr Barnes's risks in the community. The AMHS Organisations IMR author said 'This is poor practice and shows naiveté around risk'.

6.68 Following the request from Devon and Cornwall Police, a psychiatric report was prepared by a Consultant Psychiatrist relating to the false imprisonment of Mr Kay. One of the comments within the psychiatric report may appear to infer the Consultant Psychiatrist believed Mr Kay was compliant and allowed Mr Barnes to imprison him. This view may have led to **[redacted]** opinion that Mr Barnes was not a danger to the public at large. The psychiatric report would have had a significant influence on the police decision to subsequently caution Mr Barnes for the false imprisonment incident.

[101] The teams have Doctors, Nurses, Social Workers, Occupational Therapists etc. and help people who have been discharged from hospital, as they make their transition back into the community. Helps to avoid admission to a mental health in-patient ward, by supporting people who may be in acute mental health crisis in their homes.

6.69 As already stated, Mr Barnes was seen as the victim, rather than the perpetrator. The CPA for his needs was detailed. However, with him being seen as the victim, this potentially obscured the AMHS Organisation professional's view of his future risk to others. All of the risk information was known and should have been brought together for discussion and consideration through a multi-disciplinary, multi-agency risk meeting, or forensic mental health team meeting. This may have provided enhanced long term management of Mr Barnes and more effectively minimised and managed risks towards others.

6.70 With training, policy and procedures in risk and its management; Adult Safeguarding and Child Protection, the AMHS Organisation members of staff are now more aware of identifying abuse and risk and how to manage and work collaboratively across agencies.

Discharges from the AMHS Organisation: CPN and Psychology **[redacted]**.

6.71 Mr Barnes's risk assessment at **[redacted]** for relapse of neglect, suicide and harm to others was classed as 'Low'. There was no documented evidence of the basis and discussion regarding this assessment decision. The IMR author was unable to establish if Mr Barnes's risk to others was considered prior to discharge. When Mr Barnes was formally discharged from the secondary care AMHS Organisation on **[redacted]**, the letter to the GP did not include any risk information, or guidance. Considering the risks to others, it would be expected that the GP letter would clearly identity the triggers and early warning signs which might prompt re-referral, providing both the GP and subsequent professionals involved, with clear information and guidance relating to risk. There was also no evidence identified that a risk assessment had been completed in relation to the CPA being discontinued.

6.72 Now, when an AMHS Organisation service user is discharged from CPA following their CPA/Review, this review must be recorded electronically. The service user is discharged from CPA or Care Process when:

- The service user no longer requires specialist Mental Health Services and is discharged to the care of his/her GP.
- All service user outcomes are met.
- The service user leaves the area and is discharged to the care of services in the new area.
- The service user has capacity and declines further intervention from specialist mental health services and is not a risk of harming themselves, or others, or at risk of exploitation.
- Clinicians have developed a discharge from service care plan, which gives details of how the service user can access the services again, should they need them in the future.

Re-referral to CMHT in **[redacted]**.

6.73 Mr Barnes was re referred by his GP to the AMHS Organisation (CMHT) on **[redacted]**, after Mr Barnes requested further involvement. On **[redacted]**, the referral was discussed in a Multi-Disciplinary Team (MDT) meeting and screened

out, without a face to face assessment. The referral information did not meet the **[redacted]** CMHT criteria for assessment. The IMR author discovered an agreed criterion was not used to determine who would be offered an assessment and that different CMHT's across Cornwall used different thresholds for assessment. Given Mr Barnes's history; presenting referral information; lack of contact for a number of years and no recent mental health assessment, an assessment by CMHT would have been good practice.

6.74 The current Cornwall wide CMHT policy on eligibility criteria for who will be offered assessment says 'it is good practice that there is a person to person discussion with the referrer and preferably that the referred individual is seen for a screening assessment, even if it appears from the written referral that these criteria are not met'. Now, an assessment would have been offered to Mr Barnes, but it is highly likely that Mr Barnes would not have met the threshold for the secondary care AMHS Organisation and would have been dealt with by primary care professionals. He may have been referred to **[redacted]** (counselling/psychological therapies), who help clients to recover from more common mental health problems such as depression.

6.75 In **[redacted]**, Mr Barnes's clinical record (**[redacted]**) was available to help with referral decision making. The risk history was available to inform the MDT decision regarding offering an assessment or not. Those **[redacted]** were requested by the Team Manager on **[redacted]**, following the GP referral. Since the inception of **[redacted]** in **[redacted]**, historical risk information, held in **[redacted]** for service users, who are not registered on **[redacted]**, is scanned into **[redacted]**. This means that any new referral, of a known (pre **[redacted]**) patient, has to be viewed on **[redacted]**, to ensure relevant information is not missed. Realistically, this is not a robust system for assisting clinicians to easily and timely find risk information. A process will be need to be agreed, which will ensure information held on the **[redacted]**, is reviewed for relevant information about risk and used in the current **[redacted]** risk assessment**. (Recommendation at page 112, paragraph 16.3).**

Historic gaps in compliance with policy, procedures and training needs relevant to this DHR.

6.76 Whilst Mr Smith and Mr Barnes's dates of involvement with the AMHS Organisation were different; this has not affected the analysis, which is the same for both of them. The analysis for this section is detailed on pages 45-48, at paragraphs 5.13-5.25 of this Overview Report and so is not repeated again here.

Effective Practice/Learning

6.77 Effective Practice:

- Mr Barnes's assessments, admissions, sessions with his CPN and Psychologist created a comprehensive and holistic understanding of his needs, which notably professionals sought to meet. He was seen regularly by Medical, Nursing and Psychology staff from the AMHS Organisation who were responsive to his needs. Assessments were conducted by known workers. This ensured consistency and the ability to establish a good rapport. Mr Barnes was fully engaged in services over many years, with full involvement

in his frequent visits, interventions, care planning and evaluation. The initial diagnosis was one of **[redacted]** for which he was in regular assessment, prescription and advice, monitored by frequent contact with the CPN and **[redacted]**.

- The CPN's coordinated his care plan and evaluated it regularly under the Care Programme Approach (CPA). The CPA was inclusive of all the AMHS Organisation professionals involved, GP and Social Services. It offered regular opportunity for agencies to share information and discuss concerns. Information sharing between the GP and the AMHS Organisation was frequent and informative.
- Sensitivity was shown by the AMHS Organisations staff towards Mr Barnes with regards to his needs. A referral for **[redacted]**; referral to Social Services to arrange day care for his Uncle, Mr Newton and an offer to help with a home transfer **[redacted]**, were just a few examples. It was believed from his first hospital admission that Mr Barnes was **[redacted]**. He was described as wanting a 'meaningful relationship, but found it difficult to go out or socialise due to his self-consciousness **[redacted]**.This had led to him using networks associated with casual sex in order to meet his own intimacy needs, which led to ruminating thoughts of **[redacted]**'.The CPN's involved in Mr Barnes's care worked with him on an ongoing basis, to research and make contact with established **[redacted]** social networks, to encourage and support more safe and meaningful relationships.
- Sensitivity was also shown to Mr Barnes's family each time they expressed concerns about **[redacted]** and if admission was necessary. Consideration was given for his Uncle, Mr Newton's needs, as Mr Barnes acted as his carer. This was despite the fact that Mr Barnes chose not to involve his family in his care from the AMHS Organisation. This care provided to Mr Barnes was good practice at the time and would be considered good practice now.

6.78 Learning:

- Mr Barnes's risk following the **[redacted]** false imprisonment offence was minimised and the mind-set may have influenced how the AMHS Organisation worked with him. In **[redacted]**, his re-referral was screened out. His risk history was available, but did not reflect him as a perpetrator of violent offences. If he had been offered an assessment by the CMHT, there would have been an opportunity to gain a more recent mental state assessment and a potential opportunity for a Care Coordinator to review his clinical records and arrive at a different decision regarding his risk. The professional focus was of Mr Barnes's risk to himself **[redacted]**. Risk to others was not recognised, assessed or managed, as it would be now. Staff had described a culture of care being delivered, without the emphasis on assessing risk, as they would do so now.
- There were two allegations noted in Mr Barnes's clinical records (pushing his Aunt, Mrs East and assaulting his Uncle, Mr Newton) and one account of him hitting Mr Kay, prior to the **[redacted]** train incident. There is no documented evidence, or information gathered, to suggest that these allegations were followed up by the AMHS Organisation, or other agencies. These were

potentially missed opportunities to assess the safety of others from Mr Barnes and assess if Mr Barnes was a perpetrator of domestic violence and abuse.

- There was limited exploration of the potential protection and adult safeguarding concerns e.g. alleged intimidation and harassment of Mr Barnes from **[redacted]** and the unknown person driving a car at him. Adult Safeguarding is now embedded into the current AMHS Organisations practice and would recognise the potential adult safeguarding issues and trigger the adult safeguarding processes.
- The AMHS Organisation offered Mr Barnes 'sanctuary' by way of admission to an AMHS Organisation Hospital following the false imprisonment incident of **[redacted]**. This was despite the incident being assessed as 'not linked' to his mental health. The admission and subsequent psychiatric report from the Consultant Psychiatrist offset his risk and would have been a significant consideration in the decision making process for the police on whether to prosecute Mr Barnes. A consequence of the criminal justice route not being taken was that Mr Barnes's behaviour could not be further monitored and assessed.
- Future training should involve specialist LGBT domestic violence and abuse agencies/trainers and include an awareness update on domestic violence and abuse in MSM relationships.

Recommendations[102]

6.79 AMHS Organisation to consider how pertinent risk information held in **[redacted]** for service users who are not on **[redacted]**, is easily available to clinical staff, if the service user is re-referred to Adult Mental Health Services.

6.80 AMHS Organisation to ensure staff complete the two day ACPO DASH Awareness/Risk Assessment training, as commissioned by Safer Cornwall Partnership between 2014 and 2016, followed by a structured roll out of 'Routine Enquiry into Domestic Violence and Abuse' in appropriate Mental Health Services, to ensure staff are able to identify, risk assess and refer where appropriate high risk cases of domestic violence and abuse.

[102] Please see additional comments from the LGBT expert at: page 101, paragraphs 14.19-14.20 and page 113, paragraphs 16.10-16.13.

7 NHS England - Mr Smith

7.1 From **[redacted]** onwards Mr Smith normally saw the same General Practitioner (GP), who according to Tony was sent a Christmas card each year by Mr Smith, as a sign of his appreciation. There was no indication in the GP records Mr Smith discussed **[redacted]**, or any domestic violence and abuse history with his GP Practice.

Review of Involvement

7.2 From the **[redacted]** the GP records highlighted Mr Smith's **[redacted]** dependency. The General Practice had raised a **[redacted]** to alert other GP's of the **[redacted]** affecting Mr Smith's health and wellbeing. Between **[redacted]** and **[redacted]** Mr Smith had a number of GP consultations, the majority of which were for his **[redacted]**. The **[redacted]** were given as the reasons for **[redacted]**. He was given advice on how to **[redacted]** and referred to the AMHS Organisation for **[redacted]** assessment.

7.3 The GP Practice sought relevant funding for **[redacted]** programmes and actively encouraged Mr Smith to attend the AMHS Organisation assessments and complete **[redacted]** courses in hospital, prior to attending out of county residential rehabilitation courses. On one occasion, in **[redacted]**, Mr Smith's GP was advised he had discharged himself from a **[redacted]** programme. The GP twice tried to make direct contact him and then also by letter, to offer support, counselling and encouragement. This involvement had a positive effect on Mr Smith, who returned to complete the programme on **[redacted]**.

7.4 On **[redacted]** Mr Smith was referred by his GP to the AMHS Organisation **[redacted]**. Whilst waiting to see the Consultant Psychiatrist Mr Smith completed a hospital **[redacted]**.This was reported in **[redacted]** as going 'well', but by **[redacted]**, Mr Smith told his GP he **[redacted]**, to help him to **[redacted]**. On **[redacted]** Mr Smith's GP was advised by letter that Mr Smith had been assessed by a Consultant Psychiatrist (**[redacted]**), who then discharged him back to primary care with support from **[redacted]**. Mr Smith was offered appointments with the **[redacted]** Team Clinic and on **[redacted]**, Mr Smith was discharged from **[redacted]**, having **[redacted]** for four months. His GP received regular update letters from the **[redacted]** Specialist Nurse concerning Mr Smith's condition throughout this period.

7.5 Mr Smith had fewer GP consultations from **[redacted]** through to **[redacted]**. During both this timeframe and the earlier one (**[redacted]**), there were times when Mr Smith was **[redacted]** dependent. There were also periods of up to twelve months at a time when he remained **[redacted]**. The GP records in **[redacted]** reported Mr Smith telling his GP he had been **[redacted]**. On **[redacted]**, Mr Smith's GP noted he was currently **[redacted]** dependent, but wanted to **[redacted]** and so was referred for **[redacted]**. On **[redacted]** Mr Smith's GP recorded Mr Smith was in a 'positive mood' and ready for **[redacted]**, but by **[redacted]**, Mr Smith was '**[redacted]**. On **[redacted]** the GP notes recorded Mr Smith was attending an **[redacted]** appointment, following his discharge from a hospital **[redacted]** and was keen to go to a local day care programme. On **[redacted]** Mr Smith's GP notes

indicated he had attended the **[redacted]** appointment, but remained **[redacted]**. On **[redacted]** his GP notes recorded Mr Smith attended the day care programme for a few days, liked the people, but was **[redacted]**.

7.6 Between **[redacted]** and the date his death was reported, Mr Smith did not attend three GP appointments to review his medication. It was recorded he said that 'his cousin (Mr Barnes) had been called away regarding a bereavement and therefore couldn't attend Surgery with him'. The appointments had been planned to enable Mr Smith to commence a **[redacted]**, which he had been due to start on **[redacted]**.

Comment

7.7 Within the Devon and Cornwall Police IMR there was information to suggest that Mr Smith was due to attend a GP appointment on **[redacted]**, regarding his proposed **[redacted]** programme, but did not do so, following a disagreement with Mr Barnes. There is nothing within this NHS England IMR to indicate Mr Smith had an appointment with his GP on **[redacted]**.

Analysis of Involvement

7.8 Please see analysis of involvement for Mr Barnes from page 72, paragraph 8.28 onwards.

Effective Practice/Learning

7.9 Please see effective practice/learning for Mr Barnes from page 78, paragraph 8.55 onwards.

Recommendations

7.10 Please see recommendations for Mr Barnes at page 78, paragraph 8.57 onwards.

8 NHS England - Mr Barnes

8.1 Mr Barnes was registered with the same GP Practice from birth, with the exception of a short spell in another Practice during the **[redacted]**, up until the date of his arrest on **[redacted]**. From **[redacted]** onwards, he rarely visited his GP Practice, except for repeat prescriptions. Consultations were normally with the same GP, who said **[redacted]** tried to undertake the majority of them to ensure consistency.

Review of Involvement

8.2 An AMHS Organisation Consultant Psychiatrist wrote to Mr Barnes's GP in **[redacted]** following an assessment, which recorded Mr Barnes as **[redacted]** and caring full time for his **[redacted]** physically ill Uncle Mr Newton.

Comment

8.3 There is nothing in the GP records, to indicate what instigated the referral to the Consultant Psychiatrist, although the AMHS Organisation IMR for Mr Barnes says it was a GP referral.

8.4 There is then no information in the GP records for the next ten years, until **[redacted]** and **[redacted]**, when Mr Barnes had four GP consultations. He was feeling **[redacted]** and had problems with **[redacted]**, so he avoided being **[redacted]**.The GP wrote a referral to an AMHS Organisation Consultant Psychiatrist after Mr Barnes had **[redacted]**.The Consultant Psychiatrist said Mr Barnes appeared rational.

Comment

8.5 It was recorded the GP was going to write to the Housing Association, requesting **[redacted]**, but there is no record available to confirm if this took place.

8.6 The GP notes detail how Mr Barnes was an in-patient following an **[redacted]** between **[redacted]** and **[redacted]**. Mr Barnes reported **[redacted]**. He was offered psychological interventions by a **[redacted]**. The GP notes of **[redacted]** stated he would arrange to see Mr Barnes 'next week'.

8.7 On **[redacted]** the GP Practice received a letter to say Mr Barnes had been seen by a Locum Consultant Psychiatrist, who said **[redacted]**. On **[redacted]**, the GP Practice were advised by a **[redacted]**, that Mr Barnes had **[redacted]**, before being admitted to an AMHS Organisation Hospital, after presenting himself to the police. On **[redacted]** a GP letter to a Consultant Psychiatrist recorded Mr Barnes said he had **[redacted]** '.

8.8 In **[redacted]** and **[redacted]** the GP Practice were advised Mr Barnes had been subject to further admissions to **[redacted]** and an AMHS Organisation Hospital, following **[redacted]**, before he was sent home on extended leave in **[redacted]**. On **[redacted]** Mr Barnes was seen at his GP Practice following his discharge from **[redacted]**, having **[redacted]** the day before. His notes recorded **[redacted]**. Two case conferences were held to discuss options for his **[redacted]**. Following his

discharge from the AMHS Organisation Hospital Mr Barnes was seen by his GP, who then planned to have consultations with him every two weeks. In **[redacted]** Mr Barnes told his GP he may be **[redacted]**.

8.9 On **[redacted]** a GP referral letter was sent to a Staff Psychologist asking for a review, as the GP **[redacted]** about Mr Barnes's long term future. He said **[redacted]**. This letter followed two further **[redacted]** and admissions to **[redacted]**. During **[redacted]** and **[redacted]** the GP Practice was advised by way of AMHS Organisation letters, of further **[redacted]** episodes involving Mr Barnes. These required hospital admission and then transfer to an AMHS Organisation Hospital for admissions on **[redacted]**; from **[redacted]** to **[redacted]**; **[redacted]** to **[redacted]** and then **[redacted]** up to **[redacted]**, when he was discharged on extended leave, with support from his CPN. The letters indicated Mr Barnes was being reviewed three monthly; was doing well on his medication and being managed under the Care Programme Approach (CPA).

8.10 During the second part of **[redacted]** the GP notes for Mr Barnes referred to letters between the CPN and an AMHS Organisation Consultant Psychiatrist. This indicated Mr Barnes was '[**redacted]** but he wants it to continue'. This would appear to be Mr Kay. On **[redacted]** the GP referred Mr Barnes for help with **[redacted]**, as Mr Barnes **[redacted]**. When the GP was advised the waiting list to see a Clinical Psychologist was 6 to 9 months, he asked for an earlier consultation, in view of Mr Barnes's current assessment.

8.11 On **[redacted]**, in response to a note from the Psychology team regarding Mr Barnes's current condition, the GP disagreed and wrote 'I would categorise Mr Barnes as **[redacted]** and may **[redacted]**. **[Redacted]** requested Mr Barnes stay on the waiting list and was assessed on **[redacted]**, by a Counsellor in Psychology. **[Redacted]** reported him as **[redacted]**.

8.12 On **[redacted]** the GP wrote to a Staff Psychologist requesting Mr Barnes's outpatients review be brought forward as he was '**[redacted]** and in contact again with previous male friend'. At his review on **[redacted]** Mr Barnes was reported as 'fairly well, but **[redacted]**'. For the rest of **[redacted]** Mr Barnes appeared well and was **[redacted]**.

8.13 On **[redacted]** the GP Practice were advised of Mr Barnes's admission to **[redacted]** following **[redacted]**. On **[redacted]** the GP Practice were copied into a letter from a CPN to an AMHS Organisation Consultant Psychiatrist. This noted a review of Mr Barnes due to: 'referral from **[redacted]**, contact from Mr Barnes's **[redacted]** to report Mr Barnes had hit Mr Kay and caught train to **[redacted]** (sat); contact from **[redacted]** (sun) concerned re Mr Barnes's behaviour …Uncle (Mr Newton) in hospital **[redacted]**…' It was noted by the CPN that Mr Barnes '…felt **[redacted]** for issues previous weekend; now **[redacted]** same male again (this male **[redacted]** from Mr Barnes); mixed feelings **[redacted]**, but more rationale and calmer'. In a letter to the GP, dated **[redacted]**, from a Staff Psychologist, it was reported that Mr Barnes was **[redacted]**.

Comment

8.14 Whilst the CPN had written that Mr Barnes had 'hit' Mr Kay, in the letter to the AMHS Organisation Consultant, this information was not recorded in the clinical records. It said an 'argument' in the records.

8.15 On **[redacted]**, the GP Practice was informed, by way of an **[redacted]** attendance note, of Mr Barnes's admission and transfer to an AMHS Organisation Hospital following **[redacted]**. The next entry in the GP notes was on **[redacted]**, with the GP being copied into a letter from the Consultant Psychiatrist to the CPN. The Consultant Psychiatrist was asked to review Mr Barnes due to **[redacted]** involving Mr Barnes's **[redacted]**, making him stay out of his home'.

Comment

8.16 There is no information in the GP notes to indicate any discharge note from the AMHS Organisation Hospital was sent or received; or a copy of the psychiatric report prepared for the police. It is however likely the psychiatric report would only have been sent with Mr Barnes's consent.

8.17 On **[redacted]** the GP Practice were copied into a letter from the Counsellor in Psychology to a Staff Psychologist, who **[redacted]** that Mr Barnes was **[redacted]**. On **[redacted]** the GP Practice were advised Mr Barnes had been seen at an out-patients review; that whilst **[redacted]** continuing to **[redacted]**, he was getting weekly support from community care and monthly support from his CPN. His next review was carried out on **[redacted]**, when the GP Practice was advised by a Staff Psychiatrist, that Mr Barnes had 'increased self-esteem and confidence and no longer **[redacted]**'.

8.18 On **[redacted]** the GP Practice were copied into a letter from the CPN indicating Mr Barnes was being **[redacted]** (although Mr Barnes did not retaliate), by **[redacted]** calling him **[redacted]** '- eggs thrown at house'.

8.19 On **[redacted]** the GP Practice were advised of Mr Barnes's referral to an AMHS Organisation Consultant Psychiatrist, for an annual review, because the Counsellor in Psychology's contract was finishing. On **[redacted]** Mr Barnes's GP referred him to the AMHS Organisation and he was seen by a Locum Staff Grade Psychiatrist, who assessed Mr Barnes as **[redacted]**. In **[redacted]** the GP Practice were advised by letter that Mr Barnes had been discharged by the Counsellor in Psychology and the CPN, but if the GP had any concerns **[redacted]** could re- refer Mr Barnes again.

8.20 On **[redacted]** the GP referred Mr Barnes to a Clinical Psychologist for counselling as he was **[redacted]**. On **[redacted]**, a GP letter was sent to a CPN, asking for an expert review of Mr Barnes's condition and medication. On **[redacted]**, the GP was advised a CPN had completed a home assessment of Mr Barnes, who felt he had improved, despite stating he was **[redacted]**; wanted friends; **[redacted]**; knowingly puts himself in danger and had been cautioned for **[redacted]** in public place'. On

[redacted] the GP was given a pro forma for **[redacted**[103]**]**, but Mr Barnes declined this therapy.

8.21 On **[redacted]** the GP Practice was advised by way of letter from a Consultant Psychiatrist that a review had been completed with Mr Barnes on **[redacted]** and Mr Barnes had been discharged from the AMHS Organisation. The letter said he was 'doing well but **[redacted]** not now'. It was also recorded Mr Barnes told the Consultant Psychiatrist 'he had previously held **[redacted]** hostage for one night in flat. Felt remorse for this so then **[redacted]** and had police caution'. On the same date (**[redacted]**), the GP referred Mr Barnes for counselling. **[Redacted]** was later informed Mr Barnes had been diagnosed as **[redacted]**.

Comment

8.22 This was the first entry in the GP notes for Mr Barnes concerning the false imprisonment incident of **[redacted]** to **[redacted]**.It is unclear whether this was first time Mr Barnes's GP Practice would have known the details of this incident.

8.23 On **[redacted]** the GP was advised by the CPN that Mr Barnes was being discharged from **[redacted]** care, but could contact **[redacted]** directly if required. Mr Barnes was reported as **[redacted]** and 'wants to go to **[redacted]**'. On **[redacted]** Mr Barnes's GP wrote a referral letter to the Clinical Psychologist, requesting more counselling, but once the appointment was made Mr Barnes declined to attend. Following a request by the GP for **[redacted]** on **[redacted]**, Mr Barnes attended one session and then did not attend again. When the GP asked for further sessions Mr Barnes attended one additional one before cancelling further appointments.

8.24 The IMR then indicated from this time moving forwards, the medical records were **[redacted]**. Medication reviews are listed in the electronic records, but there is no other correspondence from this point, until **[redacted]**. The reason for this is not clear. The GP Practice reported there were no other letters. It is likely that some may exist, but if this is the case they could not be traced by the IMR author.

8.25 On **[redacted]** a CPN letter was received by Mr Barnes's GP. This followed a GP referral of **[redacted]**, for consideration of the AMHS Organisation being offered to Mr Barnes. The referral was discussed, but declined as there were no changes in Mr Barnes's presentation. On **[redacted]** the GP wrote to **[redacted]** to request counselling as Mr Barnes was **[redacted]** and having **[redacted]**'. There is no information available as to whether or not this counselling was provided. Between **[redacted]** and **[redacted]**, there were no consultations or contact with his GP Practice, except for Mr Barnes requesting repeat medication.

Comment

8.26 The GP records show Mr Barnes provided Mr Smith's home as a temporary address from **[redacted]**.

[103] Therapy Service: Delivers both private and NHS counselling /psychological therapy services across **[redacted]**.

8.27 On **[redacted]** the GP Practice were advised by way of a letter from a Consultant Psychiatrist, that Mr Barnes had been arrested on suspicion of murder and a mental health assessment had shown no evidence of mental health disorder.

Analysis of Involvement

8.28 For analytical purposes, the involvement of the GP Practices with Mr Smith and Mr Barnes has been categorised as follows:

- Training Needs (Domestic Violence and Abuse, Mental Capacity Act and Safeguarding).
- Risk management and risk assessment e.g. GP knowledge of the **[redacted]** false imprisonment incident.
- Management of complex cases.
- Information Sharing.

Training Needs (Domestic Violence and Abuse, Mental Capacity Act and Safeguarding).

8.29 The GP records demonstrate the clinicians involved indicated at all times their patience, empathy and tenacity in addressing the very complex and enduring needs of both Mr Smith and Mr Barnes. NHS England recognises GP's work mainly within the Medical Model[104] of Practice. Mr Smith and Mr Barnes appear to have received good care within the scope of that model. Now, a more holistic[105] social model of care is considered. Modern training is focussed on the concepts within the multi-agency and social model and a broader understanding of their interactions and impact, when reviewing the clinical needs of patients.

8.30 The care and support provided by both GP Practices and in particular the two main GP's was evident. There was a consistent approach between primary care and the secondary care AMHS Organisation, but neither GP Practice appeared to consider outside the medical model of care. With today's knowledge of the desired result of taking a joint medico-social[106] approach to the holistic management of patients, those different approaches may now be considered. The IMR author said during an interview with Mr Barnes's GP, **[redacted]** suggested that approaches for earlier intervention and joint thinking were now more embedded.

8.31 There is no record that either Mr Smith or Mr Barnes was ever asked about domestic violence and abuse by their GP's. As in all primary care consultations, a general enquiry would routinely be made about the effect of a patient's problems on their home, work and social life. General Practice may be the first formal agency where the victim presents in many cases of domestic violence and abuse. GP's may have an opportunity to help victims through early identification and sign posting to specialist support services.

[104] Set procedures by which all GP's are trained e.g. complaint, history, examination, tests, diagnosis and treatment.

[105] The interaction between the physical, mental and social aspects of a person's health.

[106] Medico-social: Taking into account both medical and social aspects.

8.32 Current best practice guidance[107] to GP's covers issues such as:

- Awareness of and engagement with local domestic abuse services.
- Recognising the signs of domestic abuse.
- Enquiring routinely and sensitively about domestic abuse.
- Training for Practice staff.
- Procedures following the disclosure of domestic abuse by Patients.
- Information sharing and multi- agency working.

8.33 The NHS England IMR author questioned whether at times either Mr Smith or Mr Barnes had the full mental capacity to make informed decisions, or choices, about the type of care and level of engagement that would be beneficial to them. The DHR Panel discussed this and drawing on their varied knowledge and expertise agreed that whilst both men had complex needs, neither lacked the full mental capacity to make decisions or choices for themselves.

8.34 NHS England has been carrying out a review of the training needs of GP's, which will indicate where support and skills enhancement could be achieved through specific training. A programme to address any identified needs could then be clearly defined. Training in domestic violence and abuse and the Mental Capacity Act 2005[108], should be areas for consideration.

8.35 South West Peninsula Postgraduate Medical Education is part of Health Education South West and is under the direction of the Postgraduate Dean. Amongst many things it is responsible for organising, accrediting and reviewing educational and training activities for GP's across Devon and Cornwall[109]. This training has to be in accordance with the General Medical Council report 'Tomorrow's Doctors-Outcomes and Standards for Undergraduate Medical Education 2009'. The aim is to promote the delivery of high quality patient care by having Doctors who are skilled in all aspects of patient care and well equipped to develop their knowledge and skills .The ultimate goal is that all Doctor's completing their training in the South West Peninsula are fit to practise.[110]

8.36 The DHR Panel understands the curriculum is being reviewed; a training audit[111] being completed and the Medical Director NHS England[112] is in contact with the Postgraduate Dean. The DHR Panel have made a request for the Medical Director to

[107] Responding to domestic abuse: Guidance for general practices produced by Royal College of General Practitioners, the Identification & Referral to Improve Safety programme and CAADA national charity (Co-ordinated Action Against Domestic Abuse).

[108] Mental Capacity Act 2005: Designed to protect clients who are unable to make decisions for themselves, or lack the mental capacity to do so.

[109] University of Exeter Medical School and University of Plymouth University Peninsula Schools of Medicine and Dentistry (Formed from the Peninsula Medical School).

[110] http://www.peninsuladeanery.nhs.uk

[111] Training a medical workforce of the future: 'The shape of training'.

[112] South Region (Devon, Cornwall and the Isles of Scilly).

act as a champion, for the proposal that South West Peninsula Postgraduate Medical Education, consider reviewing their training curriculum, in relation to domestic violence and abuse and the Mental Capacity Act 2005. **(Recommendation at page 112, paragraph 16.6).**

8.37 The Domestic Abuse And Sexual Violence Strategy Manager, Community Safety and Protection for Cornwall Council, has also indicated there may be an opportunity for joint training, with the provision of the two day ACPO DASH Awareness/Risk Assessment training, as commissioned by Safer Cornwall Partnership between 2014 and 2016. This will help staff to identify, risk assess and refer (where appropriate) high risk cases of domestic violence and abuse. **(Recommendations at page 113, paragraph 16.11).**

Risk management and risk assessment e.g. GP's knowledge of the **[redacted]** false imprisonment incident.

8.38 The AMHS Organisation IMR for Mr Barnes says 'Following the incident involving Mr Barnes in **[redacted]** the GP was made aware of the incident, antecedents to the incident, admission and subsequent police caution in **[redacted]**.The GP was the only other agency involved in Mr Barnes's care at that time and so the appropriate agencies were informed'. The evidence which led to this was as follows: A copy of a fax was sent to the GP Practice on **[redacted]**, informing them of the hospital admission and on **[redacted]**, a telephone call was made and message left at the GP Practice, informing them of Mr Barnes's discharge. There is however, no way now of knowing if the message left contained any specific details of the false imprisonment incident.

8.39 The AMHS Organisation IMR also noted that on **[redacted]** Mr Barnes wrote a letter to the Consultant Psychiatrist 'thanking …for support having been cautioned by police… **[redacted]** now police interview over'. Whilst in general the two way communication between the GP Practice and the AMHS Organisation had been good and frequent, there was no specific information recorded in the notes concerning the false imprisonment incident.

8.40 In Mr Barnes's GP notes all that was detailed was an **[redacted]** note to say Mr Barnes had **[redacted]**. The next entry in the GP notes was dated **[redacted]**.Given its importance, it is of significant note there was no documentation or GP note, relating specifically to the false imprisonment incident, until a letter with brief details, was received on **[redacted]**.This was from a Consultant Psychiatrist to the GP Practice which said 'Mr Barnes had admitted holding a **[redacted]** hostage overnight and receiving a police caution'.

8.41 It is unclear exactly how much information was known by the GP and **[redacted]** Practice colleagues at the time in **[redacted]** to **[redacted]**.It appears a letter or discharge summary may, not have been sent by the Locum Consultant Psychiatrist following Mr Barnes's discharge from the AMHS Organisation Hospital on **[redacted]**. It also appears the Consultant Psychiatrist may not have sent a copy of **[redacted]** psychiatric report to Mr Barnes's GP, following an assessment of him, on behalf of the police, on **[redacted]**.This however would not be unusual, as the

Consultant would have needed Mr Barnes's consent to send that report to the GP Practice.

8.42 In order to try and establish exactly what Mr Barnes's GP Practice did know about the false imprisonment incident, the NHS England IMR author was asked to clarify this with Mr Barnes's main GP. **[Redacted]** said that **[redacted]** did not remember whether **[redacted]** was aware at the time or not, but did not recall seeing a psychiatric report for the police. **[Redacted]** said **[redacted]** was 'sure there wasn't one'. **[Redacted]** said it appeared 'a whole chunk of notes were missing from Mr Barnes's records and although those notes relate to different years, it is quite possible that documentation from the AMHS Organisation may have been misfiled and may be with those'.

8.43 The NHS England IMR author said the 'GP did know his case history; **[redacted]** regularly saw Mr Barnes; proactively supported him; made referrals to CPN's etc., who provided support in line with the medical model. This was the level of supervision required, as none other was deemed necessary'. In summary, there is no clear information identifying whether the GP or GP Practice were made aware of the details of the false imprisonment incident at the time of Mr Barnes's hospital admission, or shortly afterwards.

8.44 All GP professionals supporting Mr Smith and Mr Barnes were trained in their specific profession, which would have included some elements in relation to risk recognition and management. It was however not clear if they had received recent training to support assessment of risk, in the context of the specific needs of Mr Smith and Mr Barnes. Both Practices did have up to date Safeguarding policies and one of the Practices had a risk assessment policy.

8.45 In relation to risks, information was followed up in line with normal clinical practice and there was written evidence that indicated direct conversations with other professionals had also taken place. However, no formal regular risk assessments were recorded in either Mr Smith's or Mr Barnes's medical records; although at certain points, the records did indicate that the risks to them had been considered and at that point, they were referred to the appropriate services. It is not explicitly clear whether all the risks for either Mr Smith or Mr Barnes, were adequately identified.

8.46 Clinical interventions and actions appeared partially effective in terms of addressing the immediate presenting symptoms of both Mr Smith and Mr Barnes. There appears to be a gap in some of the information within the records of Mr Barnes, so it is difficult to assess whether or not risks were more fully considered. The IMR author said the GP notes and comments from the GP at interview suggested Mr Barnes's risk was de-escalating, rather than escalating, albeit his last face to face consultation was on **[redacted]**

8.47 It would seem advisable to ensure there is a routine approach to risk assessment for individuals, with the **[redacted]** presented by Mr Smith and Mr Barnes and that in their best interests, those risk assessments are undertaken; recorded and routinely shared with other relevant professionals across agencies. One area which could be

subject to further consideration, regarding risk assessments, revolves around the fact that currently GP's do not get access to potentially important information concerning MARAC cases. Recommendation 2 of the NICE Guidance,[113] says that health and social care practitioners should be part of this process.

Management of complex cases.

8.48 The medical histories of both Mr Smith and Mr Barnes were long standing and complex, as evidenced by the GP, AMHS Organisation and DAAT records. Decisions appear to have been based on prioritisation of the presenting symptoms, which would be entirely appropriate with good clinical care. However, there may have been opportunities, when a more proactive horizon scanning, jointly with other professionals and agencies, may have proved helpful. The sheer complexity of both the medical histories meant the interrelationship between presentation; symptoms; general health and wellbeing of each individual, was very difficult, with both making individual choices about the treatment they would accept and their engagement with professionals.

8.49 The clinical notes for Mr Smith and Mr Barnes indicate the GP's were in receipt of the relevant information to be able to make informed decisions. They also indicated that relevant information was shared with other professionals as and where appropriate and generally in a timely manner, in accordance within the context of the Medical Model of Practice. Information and consultations with other professionals were followed up by the GP's involved. Current practice now, within medical practices, is no longer purely based on a medical model, but a more socio-holistic approach which would support enhanced communication and interaction between professionals, when supporting similar clients. The DHR Panel believed that due to the complexities presented by both Mr Smith and Mr Barnes, these were cases which might have benefitted from a multi-agency approach, with clear pathways of care that would promote the optimum opportunities for them, as individuals, to receive the best and most appropriate co-ordinated care, from a range of professionals working together. In respect of Mr Smith and Mr Barnes, it was not possible to determine whether relevant stakeholders were aware of all the issues and whether a multi-agency strategy was evident. There was evidence that multi-agency conversations had taken place, but no record of multi-agency meetings (minutes). In this respect, the quality of case notes and practice may be enhanced through the use of regular audit.

8.50 There were a range of services accessed by both Mr Smith and Mr Barnes, but it is not apparent that there was a clear pathway of care that clearly outlined the appropriate route for either of them. It was apparent the GP's were spending a great deal of time seeking out the appropriate referral route and the thresholds for some services were not always apparent. Referrals were followed up by the GP's, but there was no evidence, audit, or quality assurance, of either the impact of treatment, or their individual long term outcomes. It is possible a more holistic joint approach, focussed on the individuals proposed outcomes, may have resulted in different

[113] NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

approaches being adopted. Recommendation 1 of the NICE Guidance[114] emphasises the need for local Commissioners of domestic violence and abuse services to identify and develop referral pathways to meet the health and social care needs of all those affected by domestic violence and abuse.

8.51 It is likely other GP Practices will have patients who present with complex issues, such as those associated with the 'Toxic Trio'[115]. There are currently no mechanisms for GP's, for example, to discuss complex needs, if a patient is not considered to be a vulnerable adult; or someone who resides in a property where no children are present, or who do not fall under the MAPPA or MARAC process. It was the view of the DHR Panel that multi-agency guidance should be developed for GP's on working with complex cases, including frequent service users, who present with the 'Toxic Trio'. This would help to address some of the issues raised around a more socio-holistic approach; clearer pathways; earlier engagement of services and coordination of overall care. **(Recommendation at page 114, paragraph 16.17).**

8.52 Mr Smith and Mr Barnes were offered appropriate treatments, some of which they declined to engage in. Waiting times for engagement with therapy services was not always timely, unless regarded as an emergency. Waiting times for assessment have now improved, with for example, AMHS Organisation clients being assessed within 28 days and for urgent cases, within 5 days.

Information Sharing.

8.53 It is important that, learning from Domestic Homicide Reviews, is routinely shared with Local Safeguarding Children's Boards and Local Safeguarding Adults Boards, to facilitate an early approach to alter the cyclical nature of some of these events. The DHR Panel believes that this is a national issue and needs to be considered by the Home Office Violent Crime Unit. **(Recommendation at page 114, paragraph 16.22).**

8.54 The importance of DHR's also needs to be re-emphasised in terms of all Health partners engaging and sharing information, for the purpose of DHR's, in a timely manner, to avoid delays. Initially the NHS England IMR author was unable to access the GP records in this DHR. It was only resolved following discussion between NHS England and the GMC Legal Department. The delays in achieving consent for an independent review to be undertaken at the GP Practices for this DHR would indicate there is still some confusion regarding what information should be shared. This DHR Panel believes this should be considered by the Home Office Violent Crime Unit and the Medical Director of the General Medical Council, as it may be a national issue. **(Recommendation at page 114, paragraph 16.23).**

[114] NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

[115] Domestic Violence, Substance Misuse and Mental ill health.

Effective Practice/Learning

8.55 Effective Practice:

- Both of the GP Practices showed consistent respect for both Mr Smith and Mr Barnes and were determined in their efforts to achieve improvement in their lives, even when it seemed this would be difficult.
- There was a great deal of evidence that both GP Practices fully considered the nine protected characteristics of the Equality Act 2010.
- Mr Barnes's GP said he presented as 'vulnerable' and was offered regular appointments and consultations. (The GP's view was Mr Barnes was more likely to be a victim rather than the other way round).

8.56 Learning:

- Having consistency in terms of the same GP's dealing with their patients could be seen as good practice, but it could also be said that this would mean other GP's did not have the opportunity to assess and provide another view.
- Review the training needs of GP's and complete relevant training if required e.g. Domestic Violence and Abuse, Mental Capacity Act 2005 etc. Increased awareness of domestic violence and abuse in MSM relationships.
- Development of a more consistent approach to audit and risk assessment within medical practices.
- The need for multi-agency guidance for GP's on working with complex cases, including frequent users who present with the 'Toxic Trio'.(Development of a multi-agency care pathway, with consideration of capacity/thresholds/staff engagement and interaction, that ensure the appropriate access to and responsiveness of other services, so that there are no gaps, or undue delays in provision. This will prove challenging within the current financial climate and so if waiting list times directly increase the risks, particularly for vulnerable people, this should formally be flagged and actioned by the organisation concerned).

Recommendation[116]

8.57 Medical Director NHS England to be invited to act as a champion for the proposal that South West Peninsula Postgraduate Medical Education considers reviewing their GP curriculum in relation to Domestic Violence and Abuse and the Mental Capacity Act 2005 training.

[116] Please see additional comments from the LGBT expert at: page100, paragraph 14.17 and page 112, paragraph 16.5.

9 Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT[117]) - Mr Smith

9.1 Between **[redacted]** and **[redacted]** Mr Smith had been a service user of the AMHS Organisation, for his **[redacted]** dependency and **[redacted]** in **[redacted]**, the AMHS Organisation developed specialist **[redacted]** services for **[redacted]** called the **[redacted]**. This was part of the Adult Community Services within the AMHS Organisation and **[redacted]** delivered this service up until **[redacted]**, when **[redacted]** became the provider of **[redacted]** services.

9.2 Mr Smith was a service user of **[redacted]** from **[redacted]** until **[redacted]**. The remit of **[redacted]** was to prioritise clients who were at **[redacted]** of hospital admission, or **[redacted]** and to try and prevent admission. This was achieved by providing:

- Specialist prescribing intervention.
- Case management for those with the most **[redacted]** needs.
- Signposting to those where **[redacted]** was not best placed to support an individual.
- Offer joint assessment and management where appropriate for those with dual diagnosis.

Review of Involvement

9.3 Mr Smith was referred to **[redacted]** on **[redacted]** by his GP and his first appointment was on **[redacted]**, with an assessment then carried out on **[redacted]**.

Comment

9.4 Since **[redacted]** service users should be engaged with treatment within a maximum three weeks from the date of referral. Mr Smith's assessment was brief and no mental health assessment tools were used. It was not the comprehensive assessment required, or one which would now be conducted.

9.5 Mr Smith was offered two further appointments and in **[redacted]**, was admitted to **[redacted]** for **[redacted]**. In **[redacted]**, at a **[redacted]** assessment he said he had **[redacted]**.

Comment

9.6 There were no care plans in place post **[redacted]** discharge, or to address his **[redacted]**.

9.7 By **[redacted]** Mr Smith had **[redacted]** and the **[redacted]** letter to his GP said **[redacted]**. Mr Smith was offered monthly **[redacted]** Team Clinic appointments

[117] DAAT (Cornwall Council) ensures the delivery of national and local drug and alcohol strategies and staff work with partner agencies, including those for social care, health and criminal justice services. DAAT commission a range of services for individuals and families and coordinate activity, so organisations work closely and cooperatively.

and in **[redacted]**, was seen by a Specialist Consultant Psychiatrist, who noted Mr Smith's **[redacted]**.

Comment

9.8 This was the first time he was seen by a Psychiatrist who actively addressed his **[redacted]**. There was nothing recorded concerning any help or care, regarding the **[redacted]**. This could have been explored further, with consideration of counselling for Mr Smith. He was referred to other services, but there was no coordinated plan to address his **[redacted]** and **[redacted]** jointly. There was a lack of care coordination as it is understood and complied with now.

9.9 Mr Smith was offered further monthly appointments at the **[redacted]** Team Clinic through to **[redacted]**. On **[redacted]**, his GP was sent a letter, noting Mr Smith had been discharged from **[redacted]**. It said he had **[redacted]** for four months and is 'considering contacting **[redacted]** to resume counselling, since he was **[redacted]** '. The **[redacted]** clinician recorded Mr Smith had been spoken to again following this and said he 'no longer **[redacted]**. The **[redacted]** notes said: 'He (Mr Smith) said he has not been in contact with **[redacted]** and he does not need counselling/support from the service at the present time. I have advised Mr Smith to contact **[redacted]** if he is in need of support in the future'.

Comment

9.10 There did not appear to be any formal assessment of Mr Smith's **[redacted]** health, **[redacted]** or follow up. Now, follow up is required within 30 days of discharge and it should also include an assessment of **[redacted]** health and risk.

Analysis of Involvement

9.11 Mr Smith did not give any indication to suggest he lived in a domestic violence and abuse environment. The focus of treatment for Mr Smith was almost entirely upon his **[redacted]** and **[redacted]**. There was evidence of gaining consent to share information with his family, GP and other treatment services, but assessments did not include a more thorough investigation of who else was involved with Mr Smith at the time and whether they could facilitate a more holistic care plan. This is now common practice. There was no evidence of any information from any other agencies, to any plans, apart from the GP, or of Mr Smith's family being signposted or referred.

9.12 The assessment of Mr Smith on **[redacted]**, by the Specialist **[redacted]** Nurse, did not meet national standards, or guidance, for a holistic assessment of need. There was a lack of a care plan, which is **[redacted]** a standard requirement, for both **[redacted]** and **[redacted]** treatment[118]. Addressing the joint health issues should have been evident within the assessment and the care plan. There was little evidence available regarding how his **[redacted]** and **[redacted]** had developed.

[118] Department of Health, 2002, Models of Care: Department of Health 2006 Models of Care for **[redacted]** Misuse (MOCAM).

This missed the key understanding about the link between Mr Smith's **[redacted]** and his dependent **[redacted]**, which would be addressed differently, depending upon the relationship between the two.

9.13 The assessment did not cover the **[redacted]** needs, or history of Mr Smith, until twenty weeks post **[redacted]**. The **[redacted]** took place in **[redacted]** and the appointment with the Specialist Consultant Psychiatrist on **[redacted]**. By **[redacted]**, Mr Smith had **[redacted]**, so the Consultant appointment could have been arranged earlier and as part of the post **[redacted]** package of care. No care plan resulted from the review with the Specialist Consultant Psychiatrist, only the GP letter advising about medication options. There was no evident plan to address Mr Smith's **[redacted]**, or evidence-based tools to assess the **[redacted]**, or a clearly identified response. Best practice with associated **[redacted]** and **[redacted]** indicates that if **[redacted]**, or **[redacted]** after more than four weeks post **[redacted]**, then it should be addressed.

9.14 There was some consideration given in this case to Mr Smith's **[redacted]** and physical health, but there was no assessment of any of the other areas, or any vulnerability. A more holistic assessment would now be undertaken to identify how both the **[redacted]** and the **[redacted]** developed; the interrelationship between the two and a more detailed assessment of other aspects of Mr Smith's life. Recovery would focus upon issues beyond the **[redacted]**; peer mentors would be available and post **[redacted]** recovery support is more widely available.

9.15 Since 2014 DAAT have had a training package prepared in relation to dual diagnoses[119]and has been delivering staff training to drug and alcohol treatment providers within Cornwall and the Isles of Scilly. The DHR Panel supports this ongoing training. **(Recommendation at page 112, paragraph 16.7).**

9.16 DAAT have now reviewed and implemented assessment and care planning tools within drug and alcohol treatment(re: domestic abuse, a more robust assessment of historic use and development of problems; risk within the home and within relationships and managing escalating risk behaviours). The DAAT IMR author was also in the process of drafting a joint drug and alcohol and domestic violence protocol. This will now be covered by a multi-agency practitioners guide/flow chart on how to respond to cases of domestic violence and abuse and sexual violence. **(Recommendation at page 114, paragraph 16.16).**

9.17 From **[redacted]**, services were no longer commissioned from the AMHS Organisation. This highlighted a potential concern to the DHR Panel. **[Redacted]** is the current provider of these community services, although primary rehabilitation continues to be available from mental health in-patients services at **[redacted]** and **[redacted]** detoxification unit in Cornwall. With the change in commissioning of alcohol services to **[redacted]**, service users have access to generic drug and alcohol workers, but may only have limited access to mental health trained clinicians. Whilst this provides specialist intervention for alcohol use, it may not be as effective

[119] Combined alcohol, drug and mental health issues.

in identifying mental health needs and may result in related risks going unidentified, or untreated.

9.18 This IMR has identified there was little evidence with regard to dual diagnosis being followed, or delivered. Since **[redacted]** these gaps are now identified through annual care plan audits. However, there is still a lack of a local dual diagnosis strategy signed off by local partner agencies, with agreed pathways, protocols in place and staff awareness. This will continue to leave a gap in assurance about effective dual diagnosis work and be a potential risk in future instances if not addressed.

9.19 The IMR author highlighted Mental Health Services and Commissioners should lead and deliver best dual diagnosis provision locally. The DHR Panel believes NHS Kernow[120], as the Commissioners for Mental Health Services, should set up a working group, to review and progress a local dual diagnosis strategy; pathways and protocols; supported by training; with also a conflict resolution process. It will be important for both the AMHS Organisation and **[redacted]** to be invited to have representation on the working group. **(Recommendation at page 113, paragraph 16.8).**

9.20 The term 'Toxic Trio' is used to describe the co-occurrences of mental ill health, substance and alcohol misuse and domestic abuse in families. The DHR Panel believes the 'Toxic Trio' should part of Cornwall's Joint Strategic Needs Assessment[121] and be an identified priority for Cornwall's Health and Wellbeing Board[122]. The DHR Panel Chair wrote to the Chair of the Health and Wellbeing Board asking for this to be considered and highlighted the potential impact on Cornwall Council's 'Living Well'[123]programme. The DHR Panel welcomes the response from the Chair, which indicated the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy do reflect the 'Toxic Trio' and the community safety needs assessment is an important part of it. The Chair of the Board would be pleased to receive the recommendations from this DHR and would be considering a review of the Joint Health and Wellbeing Strategy.

9.21 The IMR author indicated the need for joint multi-agency pathways in relation to the 'Toxic Trio'. This will be addressed through the DHR recommendation covering the development of multi-agency guidance for GP's on working with frequent service users who present with the 'Toxic Trio'.**(Recommendation at page 114, paragraph 16.17).**

[120] Clinical Commissioning Group for Cornwall and the Isles of Scilly established on 1 April 2013. Role is to buy health services for the local population, including hospitals and mental health services. The AMHS Organisation **[redacted]**.

[121] The assessment identifies the 'big picture' in terms of the current and future health and wellbeing needs and inequalities of the population; provides a comprehensive map of local service provision and future service planning.

[122] Established in April 2013 as a statutory committee of Cornwall Council. The strategy of the Board is to help people live longer and have healthier lives; improve the quality of people's lives and fairer life chances for all.

[123] Supports people to live the lives they want to the best of their ability (Quality of life, health and wellbeing).

Effective Practice/Learning

9.22 Effective Practice:

- Regular appointments were delivered to Mr Smith with follow up and there were contact notes from each session.
- The in-patient **[redacted]** of **[redacted]** met clinical standards and was commented on as a 'positive experience' by Mr Smith.
- A post **[redacted]** on **[redacted]** was constructively managed by the Specialist Nurse and Mr Smith's GP.

9.23 Learning:

- There was a lack of a comprehensive assessment, care plan and care plan review. The opportunities missed were those which might have helped Mr Smith to understand why he was **[redacted]** dependent. These might have in turn, helped explore **[redacted]**.
- Neither Mr Smith's **[redacted]**, nor his **[redacted]** dependency, which were **[redacted]**, were **[redacted]** and the **[redacted]** were not addressed through treatment. This could be said to have contributed to his **[redacted]**. There appeared to be little evidence of assertively following up and supporting Mr Smith post treatment. It is also of note that whilst he continued to have **[redacted]** dependency issues, Mr Smith did not seek further help from **[redacted]** again.

Recommendations[124]

9.24 DAAT to offer provision of staff training to treatment providers in dual diagnoses.

9.25 NHS Kernow (Commissioners of Mental Health Services) to set up a working group to review and progress a local dual diagnosis strategy, pathways and protocols, supported by training, with also a conflict resolution process.

[124] Please see additional comments from the LGBT expert at : page 102, paragraph 14.22 and page 113, paragraph 16.8

10 LGBT Organisation - Mr Smith

10.1 The LGBT Organisation is a Lesbian, Gay, Bisexual and Tran's (LGBT) people and community resource in **[redacted]**. It works in partnership with various other organisations to help develop LGBT communities and provides help and advice against homophobic and transphobic prejudice; crime and discrimination.

Review of Involvement

10.2 On **[redacted]**, a member of the LGBT Organisations dedicated team of Community Advocates telephoned Mr Smith. This was at a time when Mr Smith already knew Mr Barnes. The Advocate recorded that Mr Smith spoke to him about '**[redacted]**'. He verbally provided some information to Mr Smith, but Mr Smith asked if it was written down as he was 'older'. The Community Advocate offered to visit Mr Smith in his home town and they agreed to meet on **[redacted]**.

Comment

10.3 Although it is not documented, it would appear that Mr Smith may have left a telephone answer message for the LGBT Organisation to make contact with him.

10.4 On **[redacted]** Mr Smith met with the Community Advocate. He explained that '**[redacted]** wanted to meet someone and have a full time relationship, **[redacted]**'. Mr Smith told the Community Advocate he '**[redacted]**' locally and was unable to drive due to a car accident that caused him to lose confidence. He said he used the buses, but they were restrictive when going to places, 'so he wants to meet people and hopes to be able to get a lift to **[redacted]**'. Mr Smith said he 'had two friends he sees occasionally, but wants to meet more people'. The Community Advocate provided details of **[redacted]**. Mr Smith said he **[redacted]**.

10.5 On **[redacted]** the Community Advocate telephoned Mr Smith to provide details of a **[Redacted]** Outdoors Club walk. There was no reply on Mr Smith's telephone, so a brief message with the relevant details, was left on the answer machine. The LGBT Organisation had no other contact with Mr Smith.

Analysis of Involvement

10.6 Around the time of his contact with the LGBT Organisation in **[redacted]**, Mr Smith had told his GP he **[redacted]**, although he regularly saw his family. This information paints a picture of Mr Smith's personal situation; of someone who may have **[redacted]** and wanted new friendships, albeit Mr Barnes had given Mr Smith's address as his temporary address from **[redacted]**. The fact his close family **[redacted]**.He said all they wanted was for him to be 'happy'. The LGBT expert commented Mr Smith's **[redacted]** may have been compounded by his **[redacted]**.

10.7 Whilst acknowledging what his son Tony said, it may still have been a concern for Mr Smith, how his close family and others, would feel if they knew and therefore he may have felt he could not talk to those closest to him, about **[redacted]**. This may have been a barrier to him getting help. Whilst there was no evidence reported of Mr Smith being in an **[redacted]** relationship, if he had been, then he may have felt it could

have been difficult to talk to anyone, which in turn might have exposed him to more risk.

10.8 The LGBT Organisations IMR author stated this was a 'very routine case **[redacted]**'. The LGBT Organisations Community Advocates are highly trained to observe and evaluate in even the most routine cases. In this case there were no signs at all that might have indicated Mr Smith was vulnerable to domestic violence or abuse; or vulnerable in any other way, other than being **[redacted]**. It is however, unlikely that Mr Smith would have said anything about **[redacted]**, unless he had been explicitly asked and possibly not even then[125].

10.9 During **[redacted]**, the LGBT Organisation embarked on a **[redacted]** survey for **[redacted]**.This was in relation to the key issues affecting people, with a view to helping influence services in the **[redacted]**. This is an opportune time for the Cornwall Council Domestic Abuse and Sexual Violence Strategic Group, to review the findings of this survey. **(Recommendation at page 114, paragraph 16.18).**

10.10 As highlighted in the Devon and Cornwall Police IMR, a more coordinated gender specific approach is needed to encourage LGBT victims and in particular older male victims, to report abuse and access services. The statistics detailed at pages 38 - 39, paragraphs 4.56 - 4.57, evidences this.

10.11 There are specialist LGBT services such as the LGBT Organisation, which LGBT people and communities may feel more confident and able to access. The DHR Panel recommends these organisations are identified and offered the two day ACPO DASH Awareness/Risk Assessment and Routine Enquiry into Domestic Violence and Abuse training, so staff are able to identify, risk assess and refer where appropriate high risk cases of domestic abuse. The LGBT Organisation would like to be offered this training. It is important with the two day training being delivered to nearly 5,000 people, that it has appropriate reference to domestic abuse within the LGBT community, including older people. Additionally, the DHR Panel believes there should be a scoping exercise to identify LGBT services that are willing to provide LGBT awareness training for non LGBT specialist services. **(Recommendations at page 113, paragraphs 16.10 - 16.13).**

Effective Practice/Learning

10.12 Effective Practice:

- This case was handled professionally, with all assessments and decisions made exactly according to the policies and procedures laid down by the LGBT Organisation at that time. There was no reason to believe there was any issue in Mr Smith's life that would have indicated there was further information to look for, with no safeguarding issues etc. to escalate. The Community Advocate made it clear to Mr Smith that the LGBT Organisations Help, Support and Advocacy Service, was always available at the end of the helpline and that they were able to provide help against many issues, including **[redacted]**.

[125] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

- The LGBT Organisations **[redacted]** call logs are checked daily by the Head of Service and then checked for a second time during the following month by the Helpline Administrator.
- The Executive Director personally reviews and quality assures the **[redacted]** casework client records completed by Community Advocates. This evidenced good managerial oversight of the Organisations actions.

Recommendation

10.13 Please see additional comments and a recommendation from the LGBT expert, at page 101, paragraph 14.21 and page 113, paragraph 16.9.

11 Registered Social Landlord (RSL) 1 - Mr Smith

11.1 RSL 1 is an independent, not for profit Housing Association, which own and manage over **[redacted]** homes, predominantly in **[redacted]**. It is a member of the RSL[126] Group in Cornwall.

Review of Involvement

11.2 Following receipt of Mr Smith's housing application a representative of the **[redacted]** completed a home visit on **[redacted]**. It was recorded Mr Smith was on **[redacted]** 'and had **[redacted]** and **[redacted]** issues'. He was not classed as 'vulnerable' and so was rehoused in 'general needs accommodation', a one bedroomed, first floor flat, **[redacted].** Mr Smith signed the tenancy agreement on **[redacted]** and remained living at this property[127] for nearly **[redacted]** years, up until his death.

11.3 Between **[redacted]** and **[redacted]**, there were a **[redacted]** number of contacts between Mr Smith and RSL 1. Many of these related to him checking how much rent he owed and on what date he had to pay. It appeared he had difficulty **[redacted]**, when trying to make payments. A number of the contacts were in relation to repairs at his property: all of which were dealt with promptly.

11.4 On **[redacted]** Mr Smith contacted RSL 1 to query how he could move home. The transfer and 'HomeSwapper'[128] process was explained to him. When asked if he needed any help with the application forms, he said his daughter Chloe would help him. The relevant paperwork was posted to Mr Smith, but nothing was received back.

Comment

11.5 There was no information recorded why Mr Smith may have wanted to move, but Mr Smith told his family he wanted to live in a ground floor property with a garden.

11.6 On **[redacted]** RSL 1 records indicated Mr Smith reported being **[redacted]** of a **[redacted]** property. On **[redacted]**, a letter was issued to **[redacted]**. The case was subsequently closed on **[redacted]**, after no further issues were raised.

Comment

11.7 This incident was dealt with in accordance with RSL 1's Anti-Social Behaviour (ASB) policy and procedures. It was recorded that the police had been asked to put on 'extra patrols', but there was nothing recorded in the Devon and Cornwall Police IMR to indicate this.

[126] RSL Group as listed on page 1 of the Cornwall Council 'Cornwall Homechoice Policy' document of 'The Council's Policy for the Allocation of Council properties and Nominations to Registered Social Landlords,' 19 May 2009.

[127] The ownership of the property transferred to RSL 1 on **[redacted]** and Mr Smith signed a new tenancy agreement to reflect this.

[128] For tenants looking for a home swap, either for a housing association or council house exchange.

11.8 A tenancy visit, along with a Home Fire Safety Check, was completed on **[redacted]** and on **[redacted]**; Mr Smith made his last rent payment. Although it is not documented in this IMR, two **[redacted]** were requested to visit Mr Smith's home on **[redacted]**, by RSL 1. By description, it appears both Mr Smith and Mr Barnes were in the property at this time. The **[redacted]** were unable to complete their repair work that day and left. During the week of **[redacted]**, they planned to return to Mr Smith's home to complete their work, but were unable to get any reply from Mr Smith's home and mobile telephone numbers.

11.9 All contacts with Mr Smith did not provide any indication of domestic violence or abuse, or vulnerability. There were no signs of risks identified, or need for contact with other agencies. There was no record of any concerns of him being unable to access services. As far as RSL 1 were aware Mr Smith lived on his own **[redacted]**.

Analysis of Involvement

11.10 RSL 1 knew very little about Mr Smith and staff were 'shocked at his death'. The IMR author indicated they had no information to indicate Mr Smith was **[redacted]**, apart from the information contained in the **[redacted]** housing application form, relating to his **[redacted]**. Mr Smith was in general needs accommodation; was not identified as vulnerable and assessed as able to lead an independent life, without any support needs. Neither Mr Smith nor members of his immediate family, sought help from RSL 1, beyond the repair and maintenance of Mr Smith's home, which was attended to promptly.

11.11 Reviewing the **[redacted]** contacts between Mr Smith and RSL 1, many related to requests for repairs and rent queries over how much he owed. Looking at them collectively it shows Mr Smith, as someone who it appeared at times **[redacted]** in need of help to answer his queries. It appears there was no process within RSL 1, at that time, to identify his **[redacted]** contact. Apart from all contacts with client's being recorded on their contact management system, RSL 1 is developing a Customer Access strategy and has noted a policy in relation frequent callers could be considered and included.

11.12 There may have been a breakdown of information sharing between Devon and Cornwall Police and RSL 1 in relation to: an alleged anti-social behaviour incident of **[redacted]** and an alleged **[redacted]** dispute on **[redacted]**.The police investigation into Mr Smith's death showed there may have been **[redacted]**. It appears RSL 1 were unaware of this.

11.13 There is no information available as to why Mr Smith had asked for a home transfer on **[redacted]**. The relevant paperwork was sent to him but not returned. Historically by paperwork application and more recently also by on-line, customers register their wish to exchange with Homeswap. RSL 1, as the Landlord, only becomes informed once the customer has found an appropriate exchange. They then book a home visit with customers, to progress the paperwork and exchange.

11.14 As the paperwork does not appear to have been completed, RSL 1 would not have been aware of Mr Smith's reasons for wanting a Homeswap. This is a different

process to registering for a transfer on the Cornwall Homechoice[129] system, where RSL 1 would know of the application and reasons for the proposed move. Knowing the reasons why customers want to move is important. It could be for a variety of reasons, including personal choice; through to harassment; anti-social behaviour and domestic violence and abuse. In this particular case, Mr Smith's family believe it was due to the fact he wanted to move from a first floor property, to a home on the ground floor, with a garden.

11.15 Little was known by RSL 1 about Mr Smith. It is important for all RSL's to be aware of any of their client's potential vulnerabilities. In terms of RSL 1, if equality and diversity data is disclosed by customers, they record it on their housing management IT system **[redacted]**. Any particular needs of customers appears on the first screen of their records to alert staff. This process has been scrutinised by an internal audit and a recent anti-social behaviour process.

11.16 It is possible that other RSL's in Cornwall will have customers who frequently call them. Whilst acknowledging the processes RSL 1 have put in place, the view of the DHR Panel is the RSL Group within Cornwall should review their processes for identifying and managing potentially vulnerable customers, including those at risk, with consideration of a frequent caller policy. This could be adopted by the RSL Group and subject of an audit at a later time, to ensure compliance by all members**. (Recommendation at page 114, paragraph 16.20).**

Effective Practice/Learning

11.17 Effective Practice:

- Staff completing tenancy visits and in the Contact Centre, receive regular and comprehensive training for dealing with safeguarding vulnerable adults; managing conflict and complaints; customer care and equality and diversity.
- The domestic violence and abuse policy provides clear guidance for staff and customers dealing with, or affected by domestic violence and abuse. The policy is due for review and reference to the new Cross Government definition and details of LGBT help and support services could be considered.
- The Anti-Social Behaviour policy was adhered to with relevant interventions.

Recommendation[130]

11.18 The Registered Social Landlord Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk, including consideration of a frequent caller policy.

[129] This is the choice based system for letting council and housing association homes to rent in Cornwall. Those in most urgent need have the best chance of bidding successfully for social housing.

[130] Please see additional comments from the LGBT expert at: page 102, paragraph 14.23 and page 114, paragraph 16.19.

12 Registered Social Landlord (RSL) 2 - Mr Barnes

12.1 RSL 2 is a large scale voluntary transfer Housing Association, which took over the ownership of the local Council's housing stock in **[redacted]**. It is also a member of the RSL Group in Cornwall.

Review of Involvement

12.2 Mr Barnes signed a legal tenancy agreement on **[redacted]**, at which point he was the only resident of the property. The previous named legal tenants, as at **[redacted]**, were his Father and Mother Mr and Mrs B. Barnes, who died in **[redacted]** respectively and his Uncle Mr Newton, for whom he cared for up until **[redacted]**, when Mr Newton went into residential care.

12.3 RSL 2's records regarding Mr Barnes and his home cover the period between **[redacted]** and **[redacted]**. During that time there were a range of **[redacted]** repairs and maintenance works recorded. This included a three year break from **[redacted]**, through to **[redacted]**. There were no records of any concerns raised regarding Mr Barnes, or the condition of his home, during these visits.

12.4 On **[redacted]** the Neighbourhood Services Officer[131] (NSO) saw that the garden at Mr Barnes's home was poorly maintained. A letter was then sent to Mr Barnes regarding its condition. On **[redacted]**, following a report from a Community Warden[132] that the property was potentially abandoned, the NSO visited, but was unable to gain access, or speak to anyone at the property. A neighbour referred the NSO to Mrs East, who confirmed Mr Barnes was still living at the property. Mrs East informed the NSO that Mr Barnes **[redacted]** and avoided contact with people. This information was noted in the RSL 2 management database and Mrs East was asked to contact RSL 2 to confirm 'Mr Barnes was Ok'. She did so on **[redacted]**, but there are no details available of the conversation.

12.5 After **[redacted]**, the property was last visited on **[redacted]**, when an electrical check and refurbishment were carried out. The property was secured on **[redacted]**, following Mr Barnes's arrest on suspicion of the murder of Mr Smith.

Comment

12.6 The evidence from the police suggests Mr Barnes went to stay at Mr Smith's home on a daily and then a more regular basis from **[redacted]** onwards. He still retained his own home which he returned to when he and Mr Smith had disagreements, resulting in Mr Smith asking him to leave, before then asking him to return.

[131] NSO: Point of contact with RSL 2 as the Landlord and whom clients can talk to if any help is needed. They deal with sensitive issues in confidence and carry out 'Estate Walkabouts'.

[132] Community Warden: encourage good community relationships, making the community look more attractive, helping to reduce the fear of crime. Introduced by RSL 2.

Analysis of Involvement

12.7 The IMR indicated that RSL 2 had no information to indicate Mr Barnes was a risk to himself, or others, or that there was any information or intelligence that would require sharing between agencies. There were no interactions with Mr Barnes which indicated concerns about his wellbeing, or reports of anti-social behaviour (ASB) by **[redacted]** members of the **[redacted]** towards Mr Barnes. Neither Mr Barnes nor members of his immediate family, sought help from RSL 2, beyond the repair and maintenance of Mr Barnes's home which was attended to promptly.

12.8 RSL 2 did not know the full details of Mr Barnes's potential **[redacted]**, apart from being told by Mrs East, on **[redacted]** that he **[redacted]**. This was noted on their Housing Management system, should it become relevant for future interactions. Also, no information regarding Mr Barnes's (or any other tenants) beliefs or ethnic origins were collected. Information of this nature, as well as vulnerabilities and disabilities is now requested from all RSL 2 tenants and is used to inform service delivery where appropriate.

12.9 Whilst RSL 2 had no information recorded to suggest Mr Barnes had any concerns with **[redacted]** and the property, information from the AMHS Organisation, NHS England and Devon and Cornwall Police IMR's for Mr Barnes, indicated the following issues:

- **[Redacted]**: GP records: 'discussions re problems **[redacted]**'.
- **[Redacted]**: GP records: 'has same issues with **[redacted]**'.
- **[Redacted]**: GP records '**[redacted]** are perceived as **[redacted]** in order to annoy him… trying to leave the house as much as possible, feels **[redacted]**, finds **[redacted]** distressing'. The notes said 'GP to write to housing to request a transfer asking for **[redacted]**'.
- **[Redacted]**: GP records: 'still wants to **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'hypersensitivity to **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'described aggressive outbursts to the extent he kicked **[redacted]** car'.
- **[Redacted]**: GP records: 'worked up re **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'supported housing offered and discussed and declined'.
- **[Redacted]**: AMHS Organisation records: 'being **[redacted]** by **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'feels **[redacted]** will insult him if he **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: '**[redacted]**, not going out **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'concern about **[redacted]** noise **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: '**[redacted]** deteriorating focussed on **[redacted]** making him angry, going out early to avoid people'.
- **[Redacted]**: AMHS Organisation records: 'Convinced that **[redacted]** are **[redacted]** to annoy him'.
- **[Redacted]**: AMHS Organisation records: '**[redacted]** upsetting him has been given the offer to exchange to a smaller bungalow'.

- **[Redacted]**: AMHS Organisation records: 'ventilating **[redacted]** about **[redacted]**''.
- **[Redacted]**: AMHS Organisation records: 'concerned about **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'noises from **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'Mrs East contacted…concerned that Mr Barnes being **[redacted]**. Previous night (Halloween) **[redacted]** had been **[redacted]** at him being **[redacted]**.Mr Barnes visited at home (**[redacted]**) and encouraged to contact the police'.
- **[Redacted]**: AMHS Organisation records: 'worked on fears of verbal intimidation from **[redacted]**'.
- **[Redacted]**: GP records: 'various disputes with **[redacted]**, gradually becoming more **[redacted]**'.
- **[Redacted]**: AMHS Organisation records: 'I would support his application to move house if he decided to move'.
- **[Redacted]**: AMHS Organisation records: 'Two significant problems …1. Harassment **[redacted]**, does not want to move…'
- **[Redacted]**: Police: 'Theft of garden gate'.
- **[Redacted]**:Police: noting the condition of Mr Barnes's home both inside and outside; bags of rubbish stored inside and the appearance that Mr Barnes was living in one room, which was '**[redacted]**'. In his police interviews, having been arrested on suspicion of murder, Mr Barnes described living at his home as 'very uncomfortable'.

12.10 It is acknowledged that RSL 2 only took over management of Mr Barnes's home from **[redacted]**. Despite the **[redacted]** Mr Barnes prior to **[redacted]**, he chose to sign the tenancy agreement to remain at the property. Given all of information about Mr Barnes's alleged **[redacted]** about **[redacted]**, it is of note there does not seem to be any communication between agencies of any information held. It is unknown whether over the years Mr Barnes's **[redacted]** members of the **[redacted]** had **[redacted]** him. One would have expected the NSO's, the ASB Co-ordinator and local Neighbourhood Policing Team to have been aware, **[redacted]**, but there is no record of this available.

12.11 Following the visit of the NSO on **[redacted]** and subsequent telephone call from Mrs East on **[redacted]**, there was no contact with Mr Barnes and his property, apart from one further check on **[redacted]**. It appears the property was not visited again, until the day of his arrest on **[redacted]**. The IMR author said an experienced NSO made investigations to determine whether or not Mr Barnes lived at the property and given their lack of concerns, or reports in relation to his wellbeing, or any **[redacted]** issues, no further action and or referral to a statutory agency, was required. The IMR author said '…there does not appear to be anything further that RSL 2 could have reasonably done as his Landlord'.

12.12 In reviewing this IMR the DHR Panel **[redacted]**. RSL 2 were asked to review Mr Barnes's case, given the information from various agencies, concerning alleged **[redacted]**, to consider whether or not there was anything else they could have done. **[Redacted]**.

12.13 RSL 2 confirmed they had no record of any **[redacted]** relating to Mr Barnes's **[redacted]**, raised by him, or any agency on his behalf. They investigated the report concerning a potential abandonment of the property and spoke to Mrs East. An experienced NSO did not believe any further action and or referral to a statutory agency was necessary, or could reasonably be done. **[Redacted]**.

12.14 RSL 2 stated that in **[redacted]**, they introduced a 'Services for Vulnerable People Policy' and have improved their monitoring and recording of interactions and involvement with this group. Individuals are identified and assessed according to their need, based upon information provided, or as a result of any interaction. The range of interaction and intervention is based upon the specific needs of each case. Emphasis is placed upon working in partnership with the person and any other statutory or voluntary agency that can provide support.

12.15 RSL 2 indicated they continue to review their approach to vulnerable people and are currently developing improved computer based solutions to assist with case management. A Tenancy Sustainment Coordinator has been appointed to their Neighbourhood Services Team, who is responsible for overseeing interactions with 'vulnerable and challenging' people, as well as taking action against perpetrators of ASB where appropriate. An Older Persons Services Manager is responsible for working with older people who are unable to manage their tenancy, due to health and or support needs.

12.16 Whilst acknowledging the policies and processes RSL 2 has already put in place, the view of the DHR Panel is that the RSL Group within Cornwall should consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk, including consideration of a frequent caller policy. **(Recommendation at page 114, paragraph 16.20)**.

Effective Practice/Learning

12.17 Effective Practice:

- No information regarding Mr Barnes's beliefs or ethnic origins was collected at the time. Information of this nature, as well as vulnerabilities and disabilities, is now requested from all RSL 2 tenants and is used to inform service delivery where appropriate.
- The Tenancy Sustainment Coordinator and Older Persons Services Manager roles are regarded as positive moves to improve the quality of service to RSL 2 customers.

Recommendation[133]

12.18 Please see page 89, paragraph 11.18, of the RSL 1 IMR.

[133] Please see additional comments from the LGBT expert at: page 102, paragraph 14.23 and page 114, paragraph 16.19.

13 Involvement of other Agencies

Other agencies listed here, were contacted as part of the DHR process as they may have been expected to have had contact with either Mr Smith or Mr Barnes, or both. Where there was none or little contact, the potential reasons for this, for example barriers to accessing the services, have been considered.

13.1 National Probation Service (South West & Central)

13.2 The National Probation Service has not identified any involvement, or contact, with either Mr Smith or Mr Barnes. With their minimal involvement in the Criminal Justice System, it is unsurprising that no involvement has been identified with this agency.

13.3 Specialist Domestic Violence and Abuse Services in Cornwall

13.4 None of the specialist domestic violence and abuse services within Cornwall listed here identified any involvement, or contact, with either Mr Smith or Mr Barnes. This lack of involvement corroborates the information known from the police investigation and from other agencies IMR's, that there were no known previous incidents of domestic violence or abuse, involving either Mr Smith or Mr Barnes[134]:

- Cornwall Women's Refuge Trust (CWRT): Independent Domestic Violence Advocacy service provider in the time period prior to November 2012.
- DAISI Project: Domestic Abuse Intervention and Support Initiative. A confidential support service provided through CWRT, for anyone experiencing domestic abuse in Cornwall. Services offered include support and advice for men (ESTEEM)[135]; domestic violence/abuse counselling and outreach service for anyone regardless of their sex (WAVES) and LGBTQ (Lesbian, Gay, Bisexual, Trans and Questioning) support service.

13.5 Education, Health and Social Care

13.6 This is part of Cornwall Council and provides help for older people: adults with physical disabilities; hearing or sight loss; mental health and alcohol issues etc. This organisation did not identify any involvement with Mr Barnes. In respect of Mr Smith, the only recorded involvement was as a result of him **[redacted]** on **[redacted]**. He was dealt with by the Rapid Assessment Team and referred for **[redacted]**. He was discharged from **[redacted]** on **[redacted]**, which suggested there were no other social care needs. There was no other recorded involvement with Mr Smith.

13.7 Health Gay Cornwall

13.8 This agency is part of the Health Promotion Service, Cornwall & Isles of Scilly and works in partnerships to provide a cohesive range of services and opportunities that support and improve the lives of gay/bisexual men and MSM. Health Gay Cornwall has not identified any involvement or contact with either Mr Smith or Mr Barnes.

[134] Please see the comments at page 104, paragraph 15.8

[135] Now called Norda House Project.

13.9 Whilst Mr Smith did have brief contact with the LGBT Organisation, it appears he did not **[redacted]** any other agency or persons. There is no information to indicate Mr Barnes approached any agency such as Health Gay Cornwall. Once again, this lack of involvement corroborates the information known from the police investigation and from other agencies IMR's that both Mr Smith and Mr Barnes, led independent lives and did not actively seek outside support.

14 Independent LGBT Domestic Violence and Abuse Expert

14.1 The DHR Panel sought additional expertise from an independent LGBT domestic violence and abuse expert. The LGBT expert has provided observations and identified further recommendations (both locally and nationally), which will contribute further to safeguarding future victims and or their families. The LGBT expert identified a range of issues, which in her opinion, may have contributed to agencies considerations of wider issues in respect of Mr Barnes. These included a lack of appropriate: response and action, regarding allegations of domestic violence and abuse behaviour, perpetrated by Mr Barnes over a period of time; understanding of domestic violence and abuse and specifically, knowledge, understanding and response to such abuse in MSM relationships; multi-agency approach and response e.g. formalised multi-agency networks, including direct links with and pathways to, specialist domestic violence and abuse services. The LGBT expert's observations in respect of the agencies are now summarised.

Role of Police.

14.2 The LGBT expert commented that given the level of guidance for the police regarding domestic violence and abuse incidents already in place in **[redacted]**, they should have identified and dealt with Mr Barnes's false imprisonment of Mr Kay as a domestic violence incident. The LGBT expert questioned whether if Mr Barnes's partner was a woman, would he (Mr Barnes) have been deemed a domestic violence and abuse perpetrator? The LGBT expert also queried whether the police may not have been inclined to identify this MSM domestic violence and abuse in a similar way. The LGBT expert cited research with MSM around the year **[redacted]**, where men who experienced domestic violence and abuse, talked of how their reporting of extreme violence to the police, was regarded as 'what men do with each other'; was not taken seriously by the police and not recorded in police records[136].

14.3 The LGBT expert said that given the police and criminal justice processes at the time, they were 'inclined to agree that the CPS would not have taken the case forward for prosecution'. The LGBT expert added '… the police records and approach from **[redacted]**, are still a crucial part of the jigsaw. If the police had assessed the incident as a very serious domestic violence incident as they should have…at least there would have been a record of dangerousness to refer to at a later date'.

14.4 The LGBT expert noted that the police service has made great efforts, since **[redacted]**, to create links with the LGBT community. However, there is still the need to know more about the attitudes and approach by front line police officers and police staff, to domestic violence and abuse in LGBT relationships. The LGBT expert proposed a national recommendation, that HMIC consider carrying out an inspection into the policing of domestic violence and abuse in LGBT relationships. **(Recommendation at page 114, paragraph 16.25).**

[136] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

Role of Health Sector and GP's.

14.5 The LGBT expert commented on the agencies levels of understanding and awareness of domestic violence and abuse[137] and specifically of such abuse in MSM relationships. The LGBT expert noted the Consultant Psychiatrists report, prepared following the false imprisonment of Mr Kay, which described Mr Barnes's actions of hitting Mr Kay as '…extremely brave, bearing in mind that Mr Kay is approx. 6 foot and Mr Barnes is 5 foot'. The LGBT expert said the stereotypical picture of heterosexual domestic violence and abuse tends to involve a smaller women and a larger abusive male partner, where the size and greater strength of the man is part of the physical threat that he poses. However, in LGB relationships, size does not play a similar role in domestic violence and abuse and the perpetrator can as easily be the shorter or weaker partner[138].

14.6 The LGBT expert said domestic violence and abuse in MSM relationships is especially likely to involve **[redacted]**.The LGBT expert noted a number of important boundaries were transgressed during the **[redacted]**, but the Consultant Psychiatrists report appeared to infer Mr Kay was compliant and allowed Mr Barnes to **[redacted]**.The LGBT expert suggested this may have indicated a 'belief that this is just something to be expected and just something MSM do'.

14.7 The LGBT expert also noted the **[redacted]** age difference, with Mr Kay probably aged **[redacted]** when **[redacted]** with Mr Barnes began, and Mr Barnes in his **[redacted]**. The LGBT expert said **[redacted]** age differences can be indicative of an abusive **[redacted]**, especially where one is a **[redacted]** and the other an adult. The LGBT expert commented that Mr Kay should have been seen as **[redacted]**. The LGBT expert also queried whether Mr Barnes tended to **[redacted]**, something which might have been identified as a pattern, by the agencies involved. There is no information available on this point. The LGBT expert cited research that control of spending may be another significant feature in MSM domestic violence and abuse[139]. The clinical notes indicated that Mr Kay **[redacted]** Mr Barnes's money, although the language suggests that it was Mr Barnes who was in control of the spending and was upset because Mr Kay wanted more. It is acknowledged that this is recent research and would not have expected to be known, or part of the Health Sector and GP's at that time.

14.8 The LGBT expert's view was that the evidence indicated the existence of domestic violence and abuse in Mr Barnes's **[redacted]** with Mr Kay (and Mr Smith), as well as alleged abuse by Mr Barnes to other family members. The LGBT expert said in '…terms of the highest risk of harm and dangerousness, we need to look for behaviour that is commensurate with 'coercive controlling violence''. The LGBT expert commented '…Mr Barnes's profile can be deemed to fit with Michael

[137] Domestic violence and abuse in intimate partner relationships can be seen as a pattern of coercive and controlling behaviour where the perpetrator may draw on a range of behaviours (physical, sexual, financial, emotional etc.), to exert power over their partner.

[138] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

[139] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

Johnson's 'coercive controlling' domestic violence and abuse[140], with Mr Barnes as the perpetrator e.g. controlling behaviour; use of physical violence; escalation of violence when he felt 'out of control'. The LGBT expert said that as of **[redacted]**, specialist domestic violence services such as Women's Aid (working with victims) and Respect (working with perpetrators in **[redacted]** and more recently also with male victims), were aware that domestic violence and abuse was a pattern of coercive controlling behaviour. (The Johnson research was published in 2008 and so was **[redacted]** to the Health Sector and GP's until after that time).

14.9 The LGBT expert commented that domestic violence and abuse was identified in Mr Barnes's **[redacted]**, but it appeared the way in which the various services and individuals involved with Mr Barnes and Mr Kay (and Mr Smith), viewed their **[redacted]**, caused important gaps in their interpretations of the **[redacted]** abuse. This led the agencies having difficulties in understanding the position of Mr Barnes as a perpetrator and also minimising the seriousness of his behaviour, which meant there was not an 'adequate' assessment of his risk. The LGBT expert added '…the services and Mental Health Services in particular, 'misread' the signs of MSM domestic violence and abuse, leading on the one hand, to them seeing Mr Barnes as victim, rather than perpetrator and on the other hand …construing the behaviour as just something to be expected of MSM'.

14.10 This observation needs to be considered in the context of what was the expected practice at that time. In Mental Health Services for example, when Mr Barnes was receiving services, knowledge and awareness of domestic violence and abuse and specifically of such abuse in MSM relationships, was not within their usual working practices or policies, or considered at that time, unlike it is now. As part of mental health assessments, clients would have been asked about relationships, but not about domestic violence and abuse. It has only recently come to the fore in Mental Health Services and even today, asking the question of domestic violence and abuse is not undertaken routinely in most Health Services. DHR Panel members advised that there was not the knowledge and awareness, in all of the relevant services at that time, in relation to domestic violence and abuse in MSM relationships. Today, whilst the AMHS Organisation is more progressive on LGBT issues, it is unlikely the knowledge of LGBT specialism is available widely in Mental Health Services. In the timeframe of **[redacted]** and **[redacted]**, such issues were not within the working practices of Mental Health Services.

14.11 The LGBT expert commented that in **[redacted]** Mr Barnes was seen as a victim and vulnerable to **[redacted]**. Research has shown that clinicians find it difficult to differentiate between men who are victims or perpetrators of domestic violence and abuse[141]. This is not surprising as men will often present as victims when they are

[140] Johnson, M. 2008: 'A typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence'. He identified what he calls 'coercive controlling violence' as the 'archetypal' domestic violence that usually involves one partner being violent and/or threatening, involves frequent abuse, and is likely to escalate and to result in serious injury.

[141] Williamson, Jones, Ferrari, Debbonaires, Feder and Hester, 2015; Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse.

indeed perpetrators. The reasons are complex and are linked to men's particular sense of entitlement, masculinity etc.[142]. Further recent evidence, collated from the National Domestic Violence and Abuse helpline for male victims, managed by the specialist domestic violence agency Respect (RESPECT, 2010), indicated that of 1,441 men who contacted their male helpline between 2007-2010, expert helpline workers, determined by the end of each call, that only 56.5% of callers would be classed as victims of abuse. Of the remaining callers, 13% were describing an unhappy relationship where abuse was not present; 1.6% talked about mutual violence; 16.3% described incidents where they had perpetrated abuse and in 12.5% of cases, the helpline worker, despite extensive training on the issue, was still not sure.

14.12 The LGBT expert said that distinguishing between domestic violence and abuse victims and perpetrators is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians such as GP's, psychiatrists or other mental health professionals. The LGBT expert said that specialist domestic violence and abuse services have, or should have a key role, because without their involvement, 'the other agencies are unlikely to have identified Mr Barnes as the perpetrator, rather than the victim, or adequately dealt with the risks'. The LGBT expert emphasised that it was 'crucial' for multi-agency meetings/networks to have direct links between the different health services and the specialist domestic violence and abuse services, providing support to victims and to perpetrators, so that an assessment could be made as to whether an individual was a victim and/or perpetrator.**(Recommendation at page 113, paragraph 16.14).**

14.13 The research highlighted here was published in 2010 and 2014 and so was not available to agencies in the **[redacted]**, for this DHR. The knowledge and information referred to by the LGBT expert would have required referral to specialist services at that time. Availability may have been limited and it would have required agencies and staff to have that knowledge readily available. It is unclear what pathways and multi-agency links were available within the relevant time period.

14.14 'Routine Enquiry' in Health Services, provides the opportunity for patients to disclose and for practitioners to signpost to the relevant, appropriate specialist services. Additionally, one of the important purposes of the ongoing, two day ACPO DASH awareness/risk assessment training, provided by the Safer Cornwall Partnership, is to provide staff in the various agencies, with enhanced skills and knowledge to make relevant assessments of risk and where, for example, a high risk case is identified, they are able to refer the case for a MARAC.

14.15 The LGBT expert said research on male perpetrators and on MSM, indicated these men use health services and in particular GP's, for help-seeking circumstances of domestic violence and abuse[143]. In one UK survey, 17 % of MSM experiencing

[142] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it? (Regarding MSM).

[143] Williamson, Jones, Ferrari, Debbonaires, Feder and Hester, 2015; Health professionals responding to men for safety(HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse; Donovan and Hester,2014 : Domestic Violence and sexuality: what's love got to do with it?.

domestic violence and abuse reported to their GP[144] and another survey reported a majority of perpetrators also seeking help from Health Services and especially from Mental Health Services[145]. The LGBT expert emphasised that health professionals should be a particularly important target for training and awareness-raising about domestic violence and abuse regarding MSM. The LGBT expert commented 'Mr Barnes is in many respects a classic example of such a help-seeking **[redacted]**'. She noted from **[redacted]**, he was in regular contact with his GP's; with notes regarding his problems following **[redacted]**.

14.16 The LGBT expert said the GP was the only agency to have contact with Mr Barnes across most of the period in question, although the last face to face consultation was on **[redacted]**. They were aware of his involvement in a domestic violence and abuse **[redacted]** and knew Mr Barnes's condition and behaviour might **[redacted]**, or at times of **[redacted]**. The LGBT expert commented that the GP contact could potentially have been a key point for knowledge about Mr Barnes and provide a focal point for the direct multi-agency links required (to include at least specialist domestic violence and abuse services); to assess his dangerousness and work more specifically with him. The LGBT expert said that it appeared the GP was generally concerned with Mr Barnes's presenting symptoms and used the Mental Health Services as the main or only referral pathway. This may potentially have been a lost opportunity.

14.17 The LGBT expert noted that in the UK there is now the well-established IRIS[146] approach, whereby GP's are trained to identify domestic violence and abuse with regard to women and to refer via a specialist advocate[147]. The IRIS approach is also recommended for commissioning by NICE[148]. Research on a similar approach with regard to men, has shown to be promising for men as victims, or as perpetrators[149]. The LGBT expert said 'I strongly recommend that all GP surgeries in Cornwall receive the IRIS training and set up the IRIS approach, if they had not already done so, to ensure that they are equipped to carry out domestic violence and abuse enquiry with patients' (female and possibly male patients).**(Recommendation at page 112, paragraph 16.5)**.

[144] Donovan and Hester, 2014: Domestic Violence and sexuality: what's love got to do with it?

[145] Donovan, Barnes and Nixon, 2014: The Coral Project: Exploring Abusive Behaviours in Lesbian, Gay, Bisexual and/or Transgender Relationships.

[146] Identification and Referral to Improve Safety-IRIS. This is a general practice based domestic violence and abuse training support and referral programme.

[147] Feder et al, 2011(Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial).

[148] NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

[149] Williamson, Jones, Ferrari, Debbonaires, Feder and Hester, 2015; Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced, or perpetrated domestic violence and abuse.

14.18 The LGBT expert also commented that the recommendations from the NICE Guidance[150], on the response of the Health Sector to domestic violence and abuse and its impacts on all patient groups, has identified the need for clinicians to address the needs of male patients as both victims and perpetrators of abuse. The LGBT expert said that the DHR '…must incorporate the NICE Guidance and recommendations as they relate to training, multi-agency working and 'routine enquiry'[151]. **(Recommendation at page 113, paragraph 16.10)**.

14.19 The LGBT expert said any training arising from the DHR recommendations, should include an understanding of the nature and dynamics of domestic violence and abuse, as a pattern of coercive controlling behaviour and involve specialist LGBT domestic violence and abuse agencies/trainers (such as Broken Rainbow, The Diversity Trust and Respect). The LGBT expert added that the training should be based on the NICE Guidance[152], which provides different levels and types of training for staff working in different areas of the Health Sector. This would also allow for early intervention, as well as high risk referral. **(Recommendation at page 113, paragraph 16.13).**

14.20 In the light of the suggested recommendations from the LGBT expert, it is important that the Safer Cornwall Partnership (SCP) review how any update training, as identified by the LGBT expert, can be delivered to all agencies. As an example, a large number of the AMHS Organisation staff, have already completed the SCP commissioned two day training. **(Recommendation at page 112, paragraph 16.4 and Recommendation at page 113, paragraph 16.11).**The LGBT aspect identified by the LGBT expert was not part of this and additionally, the NICE Guidance was published after the two day training started. It is recommended that the SCP review how the additional update awareness training information can be disseminated to those agencies and staff (and the police) who have already undertaken the training and to incorporate it into the current training from an agreed point. **(Recommendation at page 113, paragraph 16.13).** As part of this review, the SCP should also include how any potential LGBT awareness training, highlighted in the recommendation at page 113, paragraph 16.12, can be included.

<u>The LGBT Organisation</u>.

14.21 The LGBT expert commented that an LGBT Organisation Advocate had left a voicemail on Mr Smith's telephone which potentially could have increased the danger for Mr Smith, given Mr Barnes's coercively controlling behaviour. The LGBT expert recommended the LGBT Organisation reconsider their policy in relation to making follow up contact, in particular with regard to the safety of those concerned. **(Recommendation at page 113, paragraph 16.9).** The LGBT expert also agreed

[150] NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

[151] Recommendations 2, 5, 6,15,16,17 NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014

[152] National Institute for Health and Excellence (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

the LGBT Organisation should be offered to attend the ongoing two day ACPO DASH awareness/risk assessment training.

Other Agencies.

14.22 The LGBT expert noted Mr Smith's **[redacted]** involvement with **[redacted]** services and emphasised that a 'dual diagnosis' of **[redacted]** and **[redacted]**, should automatically result in clients being asked about relationship problems and domestic violence and abuse. This also fits with the NICE Guidance[153] and could be included as part of the dual diagnosis strategy and protocols to be developed through NHS Kernow. **(Recommendation at page 113, paragraph 16.8).**

14.23 The LGBT expert said that despite a number of alleged instances of harassment against Mr Barnes and other alleged incidents **[redacted]**, recorded by the Health Services involved with him, RSL 2 had no knowledge of this. The LGBT expert recommended that policy should be developed to ensure that Housing Associations (the RSL Group in Cornwall), are part of multi-agency work on domestic violence and abuse and also hate crime. The SCP Domestic Abuse and Sexual Violence Strategic Group have the strategic overview to be able to make sure this is considered.[154] **(Recommendation at page 114, paragraph 16.19).**

[153] NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014

[154] Recommendation 2, NICE Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014 says housing should participate in local strategic multi-agency partnership, to prevent domestic violence and abuse.

15 Conclusions

15.1 A natural question to ask is if Mr Barnes had been dealt with differently in relation to the false imprisonment crime of **[redacted]**, might there have been a different outcome in relation to Mr Smith? It cannot be said with certainty that an intervention at that stage could have led to a different outcome.

15.2 There had been a period of over a decade **[redacted]** between the false imprisonment crime and the death of Mr Smith. At the time of Mr Smith's death it is probable the two men had known each other for over **[redacted]** years; with no information known in any organisation, to indicate Mr Smith was the victim of domestic violence or abuse, or at risk from Mr Barnes. The only known agency that was involved with Mr Smith and Mr Barnes to any extent, at that time, were the two GP Practices. The family of Mr Smith had no concerns over Mr Barnes; regarded him as a positive influence on Mr Smith and could not see how Mr Smith's death could have been prevented. They added that even if Mr Smith had known of Mr Barnes's past history, they believe it would have made no difference to him allowing Mr Barnes to stay in his home.

15.3 Clearly, responsibility for Mr Smith's death rests with Mr Barnes. The DHR Panel concluded there was no immediate or obvious point, at which action could have been taken, by an individual or single agency, to prevent what happened to Mr Smith. The DHR Panel has also concluded, from the accumulated evidence, it is very unlikely Mr Smith's death, in **[redacted]**, could have been predicted, or was preventable.

15.4 When reviewing the time period leading up to **[redacted]** and beyond, it is important to be proportionate and balanced, when considering what were the expectations of the various agencies and their staff, at that particular time of their involvement. The working practices, policies, procedures and knowledge of all the agencies and their staff in the year **[redacted]** as an example, will have been different to what they are now. Today, services are more robust and cover a much wider knowledge, understanding, approach and response to domestic violence and abuse; LGBT specialism; adult safeguarding; multi-agency networks, including direct links to specialist domestic violence and abuse services, etc. There would for example, be a more accurate assessment of levels of risk and dangerousness. This is due to the fact that all agencies now have much more robust practices and these issues are embedded into their everyday working practices, policies and procedures.

15.5 DHR's are not about apportioning blame: they provide a very important opportunity to learn lessons and improve services. This DHR has brought into focus, the need to ensure agencies: receive, or have received appropriate training; adhere to the NICE Guidelines[155] and use the IRIS approach. A number of recommendations have been made; agreed at a senior level and an Action Plan produced. It is now important to ensure the plan is implemented and delivered by Safer Cornwall Partnership (SCP), within agreed timescales. The recommendations are based on the learning and conclusions reached in this Overview Report. They include, but are not limited to

[155] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

those made in the agencies IMR's and are focussed; specific and capable of being implemented.

15.6 Devon and Cornwall Police should not have made the decision to caution Mr Barnes for false imprisonment in **[redacted]**, without firstly referring the evidential file to the CPS for advice. It was recognised policy and procedure at that time and remains so now. It is unknown what the CPS may have advised, but it is the view of the DHR Panel is that this was a very serious incident, including false imprisonment and domestic violence and abuse and Mr Barnes should have been prosecuted through the criminal justice system. The police should have assessed the incident appropriately, given the police guidance available at the time. Today, the false imprisonment and domestic violence and abuse crimes; conviction and potential prison sentence for violent crimes, would have led to a MARAC Panel and Mr Barnes potentially being made subject of a Level 2/3 MAPPA, with a medium to high level of risk. This may have afforded appropriate levels of safeguarding management for his onward return back into the community.

15.7 It is important for Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences are being referred to the CPS for charging advice.

15.8 Mr Smith was **[redacted]** years of age at the time of his death. It was unknown to what extent, that he had been the victim of domestic violence and abuse from Mr Barnes or anyone else. If he had been then he did not appear to disclose this to anyone. Devon and Cornwall Police had no evidence of any reported domestic violence, or abuse, between Mr Smith and Mr Barnes. The only information they had was the anonymous telephone call, reporting a 'disturbance' at Mr Smith's home on **[redacted]**. Even then, when the police attended, they found no evidence to confirm the anonymous report. It was only when the police investigation began into Mr Smith's death that one **[redacted]** reported Mr Smith and Mr Barnes had a disagreement at the end of May **[redacted]** and **[redacted]** of Mr Smith, said **[redacted]** Mr Barnes throwing a saucepan at Mr Smith's arm, on one unknown occasion.

15.9 This DHR has highlighted the need to raise awareness regarding LGBT and older male victims of domestic violence and abuse. LGBT domestic violence and abuse are under reported. The Crime Survey, England and Wales, suggests that 17% of all victims are male, although that covers mainly heterosexual men. A more coordinated gender specific approach is needed to encourage LGBT victims and in particular older male victims, to report domestic violence and abuse and access services. The findings of the LGBT Organisations **[redacted]** survey may also provide an opportunity to identify any relevant themes.

15.10 The introduction of Devon and Cornwall Police's Sexual Offences and Domestic Abuse Investigation Teams (SODAIT) and their action plan arising from recommendations made following the Her Majesty's Inspector of Constabulary's inspection of 2014, into 'Devon and Cornwall Police's approach to tackling Domestic Abuse', provide opportunities to improve services. This includes reviewing training plans so members of the SODAIT and Call Handlers, Call Takers and Control Room

Staff, can receive LGBT and older male victims of domestic abuse awareness training. This training could also form part of the domestic abuse training given to new recruits. The DHR Panel welcomes the HMIC report of December 2015, which acknowledges the progress Devon and Cornwall Police has made with their action plan, since 2014. However, the HMIC report of 2015 highlights the need to ensure investigations into serious crimes are of the required standard, with proper supervision and the SODAIT has sufficient staff, with the appropriate professional skills and experience, to investigate cases.

15.11 It is important to scope local specialist LGBT services, to offer the Safer Cornwall Partnership (SCP) two day Association of Chief Police Officers (ACPO) Domestic Abuse, Stalking and Harassment and Honour based Violence (DASH) Awareness/ Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training. This training will help staff identify, risk assess and refer where appropriate, high risk cases of domestic abuse and allow early intervention. The two day SCP training should also have reference to domestic abuse within the LGBT community, including older people. The DHR Panel also believes it is important to identify LGBT groups who are willing to provide LGBT awareness training to non LGBT specialist agencies. The LGBT expert has emphasised the point that any training delivered as a result of this DHR must involve specialist LGBT domestic violence and abuse agencies/trainers such as Broken Rainbow, the Diversity Trust and Respect.

15.12 The SCP will also need to review how additional update awareness training information, can be delivered to those agencies (and the police), who have already undertaken the two day training and to incorporate it into the current training programme from an agreed point. As part of this review, the SCP should also include how any potential LGBT awareness training can be delivered by LGBT services to non LGBT specialist agencies. The training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and have reference to the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014)[156].

15.13 There has been detailed consideration throughout this DHR process as to whether or not Mr Smith and Mr Barnes were 'vulnerable' adults, with reference to the 'No Secret's' definition and had mental capacity with reference to the Mental Capacity Act 2005. The DHR Panel concluded that whilst both men had well documented complex needs, neither reached the threshold. Both could have met the disability definition in the Equality Act 2010, but being disabled and in Mr Smith's case an older person, does not necessarily make you vulnerable. Both Mr Smith and Mr Barnes had capacity, were able to make decisions, protect themselves and able to access services.

15.14 The Government Response in July 2012, to the Law Commission Report 326 on Adult Social Care May 2011, made the following observations:

[156] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

- …'the person is the best judge of their own wellbeing, except in cases where they lack capacity to make the relevant decision.
- …follow the individual's views, wishes and feelings wherever practical and appropriate.
- …ensure that decisions are based upon the individual circumstances of the person and not merely on the person's age or appearance, or a condition or aspect of their behaviour, which might lead others to make unjustified assumptions'.

15.15 Whilst Mr Smith was involved with the secondary care AMHS Organisation between **[redacted]** and **[redacted]**, today, his mental health needs would be met in primary care, rather than the secondary care provided by the AMHS Organisation. He would not meet the threshold for the secondary care AMHS Organisation. At that time he was not assessed as high risk for the AMHS Organisation Supervision Risk Register; not subject to the Care Programme Approach (CPA), or a Community Care Assessment (CCA). With his **[redacted]** documented **[redacted]** dependency and periods of **[redacted]**, his needs were best met by the AMHS Organisation, rather than through Adult Social Care. That was accepted practice then and is so now. He led an independent life; was offered appropriate treatment and interventions and his risks were identified and effectively managed.

15.16 Whilst Mr Barnes was involved with the secondary care AMHS Organisation between **[redacted]** and **[redacted]**, it is most likely that today his mental health needs would be met in primary care, as he would not meet the threshold for the secondary care AMHS Organisation. This view is supported by the assessment carried out following his arrest on **[redacted]**, when no mental health disorder was detected. The level of care provided was good practice at the time and would be considered good practice now.

15.17 The disclosures made by Mr Barnes of **[redacted]**, of him 'hitting' Mr Kay and on **[redacted]**, when he said he had purchased tape regarding tying Mr Kay up, were not taken further, other than asking questions and documenting the details. (As were the allegations of potential assaults by Mr Barnes upon his Uncle, Mr Newton and Aunt, Mrs East).The importance of Mr Barnes's behaviour and comments can now be seen in the light of the subsequent false imprisonment of Mr Kay. This was a significant crime committed by Mr Barnes and the outcome could have been even more serious, as evidenced by what Mr Barnes went on to commit against Mr Smith in **[redacted]**.He was not seen as a perpetrator of violent offences and the professional focus was of his risk to himself from **[redacted]**.

15.18 The AMHS Organisation psychiatric report on Mr Barnes, dated **[redacted]**, offset his risk. The result was that normal processes, from either becoming 'High Risk' under the AMHS Organisation Supervision Risk Register, or being placed into the criminal justice system, did not happen. The effect of this was that despite effective use of the CPA, Mr Barnes was not afforded a level of monitoring and assessment he may have received under the criminal justice system e.g. monitoring by the Probation Service. Whilst it is likely that the outcome may not have been any different, in **[redacted]**, Mr Barnes should have received a face to face assessment, to determine whether he should be referred to the secondary care AMHS

Organisation, or not. Getting a more up to date assessment of his mental state and potential risk would have been good practice.

15.19 The timely sharing of the AMHS Organisation risk information must be made available through the **[redacted]** There is a need for the AMHS Organisation to resolve how potentially important information held in **[redacted]** for service users, who are not on **[redacted]**, will be made easily available to the AMHS Organisation clinical staff, who may become involved with service users, who are re-referred to the AMHS Organisation, such as Mr Barnes was. It is acknowledged this is important, so that all known information about risk is readily available.

15.20 This DHR Panel welcomes the fact that the AMHS Organisation continues to prioritise and target **[redacted]** staff to complete safeguarding, domestic violence and risk training; including ensuring that between 2014 and 2016, all staff attend the SCP two day ACPO DASH awareness/ risk assessment training, followed by structured roll out of priority training for Routine Enquiry into Domestic Violence and Abuse in appropriate Mental Health Services. Making this training mandatory for all staff evidences the importance placed upon it by the AMHS Organisation.

15.21 The care and support provided by both NHS England GP Practices for Mr Smith and Mr Barnes and in particular the two main GP's, was evident, with a consistent approach between the primary care GP Practices and the secondary care AMHS Organisation, as and when required.

15.22 The DHR Panel has considered the question as to whether either GP Practice could have shown any more professional curiosity, or done any more. Although patients may not display obvious signs of symptoms of abuse, the volume of visits to healthcare environments, with a range of issues, over a period of time, may be a cry for help, where patients are not able to make informed decisions about their welfare. It is they who require ultimate support and guidance and intervention and are unlikely to seek it of their own volition.

15.23 However, unless patients lack competence, the acceptance of care and support rests with individuals. Adults are in charge of their decisions that affect their lives, even though those decisions might not be thought by others to be in their best interests. The DHR Panel concluded that both Mr Smith and Mr Barnes: had mental capacity; could make decisions; were able to protect themselves and access services.

15.24 Given the existence of various known risk factors e.g. **[redacted]** health etc., the DHR Panel considered whether there may possibly have been any opportunities for the GP Practices to be more proactive in enquiring about any potential domestic violence and abuse. It appears that Mr Smith was someone who kept his private life to himself. Was it likely that he would have disclosed anything, for example, **[redacted]**, or had been subject to domestic violence or abuse? The DHR Panel believes it is important for all GP surgeries in Cornwall to receive the IRIS training and use its approach, if they have not already done so. This will ensure that they are equipped to carry out domestic violence and abuse enquiry with female and possibly male patients. This DHR Panel welcomes the NHS England review of individual and joint training needs and has sought the support of the Medical Director regarding a

potential review of the curriculum for GP's, specifically in relation to domestic violence and abuse and the Mental Capacity Act 2005.

15.25 With their strategic overview SCP need to ensure agencies incorporate the NICE guidelines and recommendations[157], as they specifically relate to training; multi-agency working and 'routine enquiry'. It is also important for SCP to ensure there are multi-agency networks, which include direct links between the health services and specialist domestic violence and abuse services, providing support to victims and perpetrators. The LGBT expert said that distinguishing between domestic violence and abuse victims and perpetrators is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians.

15.26 This DHR has highlighted the need for the development of multi-agency guidance for GP's, on working with frequent service users who present with the 'Toxic Trio' e.g. consideration of a multi-agency forum for them to discuss such complex cases with multi-agency partners. At the present time there is no mechanism in place, unlike there is with high risk domestic violence and abuse cases, through the MARAC process. The development of multi-agency guidance would also ensure a more consistent approach to regular risk assessments, which can be shared with other agencies; improve multi-agency pathways of care and potentially reduce delays in referrals between agencies for patient's treatment. The DHR Panel also believes that the 'Toxic Trio', with its potential impact on the 'Living Well' programme in Cornwall, should be part of the joint strategic needs assessment and a priority for the Cornwall Health and Wellbeing Board. The DHR Panel welcomes the supportive comments of the Chair of the Health and Wellbeing Board in this respect.

15.27 The IMR process has drawn agencies to examine adult safeguarding and child protection policies, relating to domestic violence and abuse. This DHR Panel considers the SCP should support the Local Safeguarding Children's and Adults Board's, in consideration of a wider review of the South West Child Protection Procedures, in relation to domestic violence and abuse and also a review of the Cornwall and Isles of Scilly Safeguarding Adult Policy.

15.28 Additionally, the DHR Panel believes it is important that a multi-agency practitioner's guide/flow chart is developed, on how to respond to potential cases of domestic abuse and sexual violence. It is vital staff have the right information to make decisions and are clear about their roles and responsibilities.

15.29 There was little evidence with regard to dual diagnosis. Neither Mr Smith's **[redacted]**, nor his **[redacted]** dependency, was interlinked, with the focus of his treatment on his **[redacted]** dependency. The impact on his overall wellbeing may have been reduced if his **[redacted]** and **[redacted]** had been treated jointly. DAAT have offered and are delivering a training programme to treatment providers in dual diagnoses. The DAAT IMR highlighted the need for a review and development of a local multi-agency dual diagnosis strategy, with agreed pathways and protocols in

[157] (NICE) Guidelines [PH50]; Domestic violence and abuse; multi-agency working, 2014.

place, supported by training, with also a conflict resolution process. The Commissioners of Mental Health in Cornwall (NHS Kernow) are acknowledged as the most appropriate agency to set up a working group, which should include the AMHS Organisation and **[redacted]**, to drive this recommendation forward. The new strategy should highlight that a 'dual diagnosis' of alcohol/substance misuse and depression, should automatically result in clients being asked about relationship problems and domestic violence and abuse.

15.30 The LGBT Organisation should review their policy in relation to making follow up contact with clients. Also, Mr Smith's frequent contact with Registered Social Landlord 1 and Mr Barnes's lack of contact with Registered Social Landlord 2 has highlighted the need for the Registered Social Landlord (RSL) Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk and the implementation of a frequent caller policy. Whilst both RSL's in this DHR have introduced a number of positive initiatives, the DHR Panel believes this recommendation should be considered and adopted by the whole RSL Group and subject to a later audit regarding compliance. The RSL Group should also be part of multi-agency work on domestic violence and abuse and also on hate crime. The SCP is best placed to ensure this happens.

15.31 Arising from this DHR and its specific themes, the DHR Panel asked that the Commissioners for: Cornwall Council (Education, Health and Social Care); Cornwall Community Safety Protection Team; NHS England; NHS Kernow and Dorset, Devon and Cornwall Rehabilitation Company, develop standard service specifications for providers in relation to: Contributing to Domestic Homicide Reviews; Being able to identify, risk assess and refer(where appropriate) cases of domestic violence and abuse; Guidance for the implementation of Routine Enquiry and also that Commissioners should negotiate this inclusion in existing contracts and identify standard text in future tendering opportunities.

15.32 This has been included in this DHR Action Plan as a recommendation to be taken forward by the SCP. Stipulating such requirements, within contract arrangements with providers, is regarded as an effective way to ensure compliance of the key issues. Audit compliance could be through contract management. This recommendation should help to enhance the quality of service to service users. **(Recommendation at page 114, paragraph 16.21).**

15.33 At a national level, the DHR Panel believe there are four areas which required further consideration by the Home Office Violent Crime Unit. Firstly, it is important, where relevant, that learning from all Domestic Homicide Reviews should be shared with both Local Safeguarding Children's and Adult's Boards. This is so as to try and alter the cyclical nature of some of these events. Secondly, this DHR was delayed due to NHS England not being able to gain access to relevant information. All Health partners need to appreciate information should be shared in a timely fashion. Thirdly, the comment by the sentencing Judge that the case was not a domestic incident and could not be categorised as such, may indicate a potential training matter for the Judicial College. The comment was highlighted by the Home Office DHR Quality Assurance Panel and it is the view of the DHR Panel this was a domestic incident. Finally, it is clear the police have made great efforts since **[redacted]**, to create links

with the LGBT community. However, it is suggested that we still need to know more about the attitudes and approach by front line police officers and police staff, to domestic violence and abuse in LGBT relationships. It is proposed that HMIC should consider carrying out an inspection into the policing of domestic violence and abuse in LGBT relationships.

15.34 A very important aspect of this DHR has been to ensure the three questions raised by Mr Smith's family have been answered. The DHR Panel are confident that this DHR has sought, obtained and reviewed all relevant information to establish the answers to the questions. The answers are briefly summarised again now.

15.35 In terms of the police decision to caution Mr Barnes for the offence of false imprisonment in April **[redacted]**, this DHR has shown, given the serious nature of the crime, the CPS should have been consulted and involved in the charging decision. It is the view of the DHR Panel that Mr Barnes should have been prosecuted.

15.36 With reference to risk assessments and levels of community based supervision of Mr Barnes from February **[redacted]** through to June **[redacted]**, this DHR has shown he was effectively managed under the Care Programme Approach, up until September **[redacted]**, when he was discharged from the secondary care AMHS Organisation. After that time Mr Barnes was managed through his GP Practice in primary care. It would have been good practice for Mr Barnes to have been given a face to face assessment in April **[redacted]**, which could have afforded the opportunity to gain an up to date assessment of his mental health and any potential risk. However, in April **[redacted]**, it was highly likely that Mr Barnes would not have met the threshold for the secondary care AMHS Organisation. Today, it is also most likely he would not have met the threshold and would have been dealt with through his GP Practice. It is of note at his mental health assessment on **[redacted]**; no mental health disorder was detected.

15.37 Lastly, with reference to the involvement of Mr Barnes's GP/GP Practice and **[redacted]**/their awareness of Mr Barnes's history, the NHS England IMR details **[redacted]** entries from his GP notes. It remains unclear as to exactly when the main GP knew of the false imprisonment incident. This is due in part to the passage of time and also due to the fact that some of Mr Barnes's medical notes may have been misfiled, but again this is unclear. It is of note however that whilst there are detailed notes, letters etc., described in the IMR from the GP Practice, in relation to the specific period February **[redacted]**, through to June **[redacted]**, there is nothing recorded.

15.38 If the AMHS Organisation had sent a discharge letter from **[redacted]** to the GP Practice after the false imprisonment incident, it would have been expected to be documented in Mr Barnes's GP notes. There was an AMHS Organisation letter of **[redacted]**, which referred to Mr Barnes as 'previously held **[redacted]** hostage', so this may be the first time the GP or GP Practice knew. This is something again which may never be known. The DHR Panel believes Mr Barnes's GP Practice and in particular his main GP, provided Mr Barnes with a consistent level of care.

15.39 Having had the opportunity to go through the original draft overview report with his mother Joyce, the following comments were made by Tony, on behalf of Mr Smith's family:

> 'We just want to say it's fantastic the way you have gone into this review in such depth. As far as we are concerned you have been able to thoroughly answer all the questions we asked of you. We are very happy with the review that has been done. Thank you and the team for all your hard work. We have no issues with the GP's at the time, but still feel there were failings at the beginning when he was arrested and admitted to **[redacted]**. The Mental Health Services shouldn't have dealt with him as a victim. He was treated as a victim rather than someone who committed a serious crime. The nature of the crime beggars belief he was not charged and sent to prison. If he had been prosecuted he would have been monitored when released. The police didn't refer it to the CPS. We are shocked that they didn't prosecute given the severity of the crime. It is of some comfort to us that things are done differently now a day's. We are reassured there are processes in place to stop people like him falling through the system and it happening to others. After reading the report we can now see that services provided are considerably more robust than they were at that time in **[redacted]** and we welcome the action plan and look forward to its outcome.'

15.40 Having also now had the opportunity to go through the revised draft overview report, the following comment was made by Tony, on behalf of Mr Smith's family:

> 'I appreciate how thorough you have been and I'm glad that something good will come of it'.

15.41 It is evident that Mr Smith's family acted with great dignity following the death of Mr Smith. This is acknowledged by this DHR Panel, as is the invaluable contribution they have made to the DHR. The sentencing Judge said, Mr Smith was 'a much loved and missed man'. Mr Smith's family should draw some comfort from the fact that this DHR and the DHR Action Plan will help towards preventing domestic violence and abuse homicide and improve services for all domestic violence and abuse victims and their children.

16 Recommendations

Single Agency

Devon and Cornwall Police

16.1 Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences, are being referred to the Crown Prosecution Service for a charging decision.

16.2 Devon and Cornwall Police to take account of recommendations 1, 2, 4, 6 and 10 of the HMIC 2014 report on 'Devon and Cornwall Police's approach to tackling Domestic Abuse'; to review the SODAIT Training Plan to establish whether team members, as part of their continued professional development, can receive additional training in respect of increased understanding of 'specialist' groups e.g. LGBT and older male victims; and establish whether domestic violence and abuse incidents involving members of LGBT communities and particularly older male victims, could be introduced into the Police Training Programme, for all police officers and police staff from call handlers to responders.(Any training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and involve specialist LGBT domestic violence and abuse agencies/trainers).

Adult Mental Health Services (AMHS) Organisation

16.3 AMHS Organisation to consider how pertinent risk information held in **[redacted]** for service users who are not on **[redacted]**, is easily available to clinical staff, if the service user is re-referred to Adult Mental Health Services.

16.4 AMHS Organisation to ensure staff complete two day ACPO DASH Awareness/Risk Assessment training, as commissioned by Safer Cornwall Partnership between 2014 and 2016, followed by a structured roll out of 'Routine Enquiry into Domestic Violence and Abuse' in appropriate mental health services, to ensure staff are able to identify, risk assess and refer where appropriate, high risk cases of domestic violence and abuse.

NHS England

16.5 All GP surgeries in Cornwall should receive the IRIS training and use the IRIS approach, if they have not already done so, to ensure that they are equipped to carry out domestic violence and abuse enquiry with female and possibly male patients.

16.6 Medical Director NHS England to be invited to act as a champion for the proposal that South West Peninsula Postgraduate Medical Education considers reviewing their GP curriculum in relation to Domestic Violence and Abuse and the Mental Capacity Act 2005.

Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT)

16.7 DAAT to offer provision of staff training to treatment providers in dual diagnoses.

NHS Kernow

16.8 NHS Kernow (Commissioners of Mental Health) to set up a working group to review and progress a local dual diagnosis strategy, pathways and protocols, supported by training, with also a conflict resolution process.

LGBT Organisation

16.9 The LGBT Organisation should review their policy in relation to making follow up contact, in particular with regard to safety of those concerned.

Multi-Agency (Safer Cornwall Partnership)

16.10 Safer Cornwall Partnership to ensure agencies incorporate the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014), as they relate to training, multi-agency working and 'routine enquiry'.

16.11 The two day ACPO DASH Awareness/Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training, as commissioned by Safer Cornwall Partnership (SCP) to statutory and voluntary organisations, between 2014 and 2016, to have appropriate reference to Domestic Violence and Abuse within the LGBT community, including older people to ensure staff are able to identify, risk assess and refer (where appropriate) high risk cases of domestic violence and abuse.

16.12 The Cornwall Voluntary Sector Forum 'Equality and Diversity' Sub Group to scope any specialist LGBT services and offer the two day ACPO DASH Awareness/Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse' training to those groups and scope any LBGT services that are willing to provide LGBT awareness training to non LGBT specialist agencies.

16.13 Safer Cornwall Partnership to review: a) How additional update awareness training information can be delivered to those agencies (and the police) who have already undertaken the two day training: b) When best to incorporate it into the current training programme from an agreed point; c) How any potential LGBT awareness training can be delivered by LGBT services to non LGBT specialist agencies. The training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and have reference to the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014), which provides different levels and types of training for staff working in different areas of the Health Sector.

16.14 Safer Cornwall Partnership to ensure that there are multi-agency networks that include direct links between the health services and specialist domestic violence and abuse services providing support to victims and perpetrators. Distinguishing between domestic violence and abuse victims and perpetrators is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians.

16.15 Cornwall Local Safeguarding Children's Board with, support from Safer Cornwall Partnership, to consider reviewing the South West Child Protection Procedures in relation to Domestic Violence and Abuse and Cornwall Local Safeguarding Adults Board, with support from Safer Cornwall Partnership, to consider reviewing the

Cornwall and Isles of Scilly Multi-Agency Safeguarding Adults Policy, in relation to Domestic Violence and Abuse.

16.16 Safer Cornwall Partnership to develop a multi-agency practitioner's guide/flow chart on how to respond to potential cases of Domestic Abuse and Sexual Violence.

16.17 Safer Cornwall Partnership to develop multi-agency guidance for GP's on working with frequent service users who present with the 'Toxic Trio'.

16.18 Cornwall Council Domestic Abuse and Sexual Violence Strategic Group to review the findings of the LGBT Organisations **[redacted]** survey **[redacted]** to identify any themes.

16.19 Safer Cornwall Partnership to ensure the Registered Social Landlord Group in Cornwall is part of multi-agency work on domestic violence and abuse and also on Hate Crime.

16.20 The Registered Social Landlord Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk, including consideration of a frequent caller policy.

16.21 Commissioners for: Cornwall Council (Education, Health and Social Care); Cornwall Community Safety Protection Team; NHS England; NHS Kernow and Dorset, Devon and Cornwall Rehabilitation Company, to develop standard service specifications for providers in relation to: Contributing to Domestic Homicide Reviews; Being able to identify, risk assess and refer(where appropriate) cases of domestic violence and abuse; Guidance for the implementation of Routine Enquiry and for Commissioners to negotiate inclusion in existing contracts and identify standard text in future tendering opportunities.

National

16.22 Where relevant, learning from Domestic Homicide Reviews, is routinely shared with Local Safeguarding Children's Boards and Local Safeguarding Adults Boards, to facilitate an early approach to alter the cyclical nature of some of these events.

16.23 The Home Office Violent Crime Unit and the Medical Director of the General Medical Council to resolve consent issues, pertaining to engaging and sharing information in a timely way, for the purposes of contributing to Domestic Homicide Reviews, so as to minimise any unnecessary disputes or delays.

16.24 The Home Office Violent Crime Unit to raise a potential training matter with the Judicial College, concerning the Trial Judge's sentencing comments that Mr Smith's murder was not a domestic incident and could not be properly categorised as such.

16.25 The Home Office Violent Crime Unit to request HMIC to carry out an inspection into the policing of domestic violence and abuse in LGBT relationships.

Action Plan Template

Recommendation 1 ***(What is the over-arching recommendation)***	**Scope** ***(local, regional or national)***	**Action to be taken (SMART)** ***(How exactly is the relevant agency going to make the recommendation happen?*** ***What action needs to occur?)***	**Lead Agency** ***(For monitoring progress and enactment)***	**Key milestones and progress** **(RAG rating)** ***On Target*** ***Below Target but acceptable level*** ***Worse than Target – unacceptable level*** ***Have there been key steps that have allowed the recommendation to be enacted?)***	**Target date** ***(To be done by)***	**Date of completion and outcome** ***(When is completed and what does the outcome look like?)***
Devon and Cornwall Police to carry out an audit to establish if prosecution advice files, containing allegations of indictable only offences, are being referred to the Crown Prosecution Service for a charging decision.	**Local**	**Operations, Business and Executive Board to meet to establish how best to complete the Audit.** **Audit to be completed by the Transforming Summary Justice Work Group.** **Findings of Audit to be presented to the Operations, Business and Executive Board.**	**Police**	**Meeting of Board's.** **Completion of Audit.** **Presentation and review of findings.**	**31/03/17** **30/09/17** **31/12/17**	**Audit will identify whether or not Police policy and procedures are being adhered to and if not what needs to happen to ensure compliance. The outcome of this will ensure effective decision making processes are followed.**

Recommendation 2	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Devon and Cornwall Police to take account of recommendations 1, 2, 4, 6 and 10 of the HMIC 2014 report on 'Devon and Cornwall Police's approach to tackling Domestic Abuse'; to review the SODAIT Training Plan to establish whether team members, as part of their continued professional development, can receive additional training in respect of increased understanding of 'specialist' groups e.g. LGBT and older male victims; and establish whether domestic violence and abuse incidents involving members of LGBT communities and particularly older male victims, could be introduced into the Police Training Programme, for all police officers and police staff from call handlers to responders.	**Local**	**Production of Action Plan to specify in detail what steps are to be taken to improve its approach to Domestic Abuse with specific reference to recommendations 1,2,4,6 and 10 for this DHR.** **LGBT and male victims of domestic abuse training to be provided to all SODAIT police officers and police staff and 100 police control room staff call takers and call handlers. This is to form part of Domestic Abuse Training given to Police Officers during their initial training and will be an ongoing process.**	**Police**	**Submission of Force Action Plan which incorporated [redacted] actions. Regularly scrutinised by the ACPO Domestic Abuse Lead and HMIC, as well as quarterly meetings at the Home Office with the Home Secretary.** **Provision of relevant training.** **Review and evaluation of training**	**30/09/14** **30/09/17** **31/12/17**	**Completed 27/09/14. Action Plan completed and under regular review. Improvements in the way in which Devon and Cornwall Police and its staff deal with incidents of Domestic Violence and Abuse. Increased quality of service to victims of domestic violence and abuse.** **Increased understanding of domestic violence and abuse within the LGBT communities and older male victims.**

Recommendation 3	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
AMHS Organisation to consider how pertinent risk information held in [redacted] for service users who are not on [redacted], is easily available to clinical staff, if the service user is re-referred to Adult Mental Health Services.	**Local**	**AMHS Organisation Operational Managers Group to meet to consider the most effective way to transfer paper information to the [redacted] system.** **AMHS Organisation Operational Managers Group to agree the transfer process and implement it.**	**AMHS**	**Initial meeting to consider the issue.** **Process agreed how referrals into services, will ensure information held on the [redacted] electronic archive, is reviewed for relevant information about risk and used in the current [redacted] risk assessment.**	**31/03/17** **30/09/17**	**Potentially important paper information will be available electronically to all AMHS Organisation staff which will help to reflect the most accurate information known about service users. AMHS Organisation professionals will then be clear about service users and be able to make informed decisions about risk and management/treatment of service users.**

Recommendation 4	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
AMHS Organisation to ensure staff complete two day ACPO DASH Awareness/ Risk Assessment training, as commissioned by Safer Cornwall Partnership between 2014 and 2016, followed by a structured roll out of 'Routine Enquiry into Domestic Violence and Abuse' in appropriate mental health services to ensure staff are able to identify, risk assess and refer where appropriate, high risk cases of domestic abuse	Local	AMHS Organisation priority staff (redacted) to complete the training and AMHS to have a process in place to monitor attendance compliance.	AMHS	AMHS to identify priority staff to attend the training and a process to be able to monitor compliance. AMHS to ensure staff complete the training. AMHS to monitor results of the Safer Cornwall Partnership evaluation of the training.	30/09/14 31/03/17 30/09/17	AMHS Organisation staff are able to identify, risk assess and refer where appropriate high risk cases of domestic abuse. AMHS Organisation able to support victims effectively and safely; understand their responsibilities to share information; clear processes for the management and support of clients at risk or experiencing domestic abuse.

Recommendation 5	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
GP surgeries in Cornwall should receive the IRIS training and use the IRIS approach, if they have not already done so, to ensure that they are equipped to carry out domestic violence and abuse enquiry with female and possibly male patients.	Local	NHS England to ensure provision of IRIS training to all GP surgeries in Cornwall. Post training evaluation.	NHS England	Delivery of training. Post training evaluation.	30/06/17 31/12/17	Improved quality of service to victims and perpetrators of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims and perpetrators.

Recommendation 6	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Medical Director NHS England to be invited to act a champion for the proposal that South West Peninsula Postgraduate Medical Education consider reviewing their GP curriculum in relation to Domestic Violence and Abuse and the Mental Capacity Act 2005 training.	**Local**	**NHS England to meet with Deanery Curriculum Leader to review the content of the current course programme.** **NHS England to work with local experts to develop the expected learning outcome for the Domestic Abuse and Mental Capacity Act element of the curriculum.** **NHS England to review elements of the training commissioned with the Deanery to ensure that from September 2015 medical students within the Peninsula Medical School receive the agreed programme.**	**NHS England**	**For review.** **For agreed criteria for success.** **Commencement of implementation of course.**	**31/12/16** **31/03/17** **31/12/17**	**GP's are able to identify and support victims of domestic abuse effectively and safely; clear about responsibilities to share information appropriately and proportionately; clear understanding of Domestic Abuse, its triggers and effects on their patients; clear understanding of Mental Capacity Act.**

Recommendation 7	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
DAAT to offer provision of staff training to treatment providers in dual diagnoses.	Local	Development of training course in dual diagnoses. Identification of key personnel to attend training course. Provision of training. Review and evaluation of course.	DAAT	Completed September 2014. Provision of two courses in November 2014 and February 2015. Evaluation of training May 2015.	30/09/14 28/02/15 31/03/17	Drug and Alcohol treatment providers have a clearer understanding of dual diagnoses and how best to provide appropriate support, treatment, signposting or referral to other specialist agencies.

Recommendation 8	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
NHS Kernow (Commissioners of Mental Health) to set up a working group to review and progress a local dual diagnosis strategy, pathways and protocols, supported by training, with also a conflict resolution process.	Local	Work group to review and develop a dual diagnosis strategy, pathway and protocols, with training and a conflict resolution process.	NHS Kernow	Identify work group members and terms of reference. Report and recommendations for Safer Cornwall Partnership.	31/03/17 31/12/17	Clear processes for the management and appropriate support, signposting or referral of clients to specialist agencies. Number of clients identified with dual diagnosis and successfully treated.

Recommendation 9	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The LGBT Organisation should review their policy in relation to making follow up contact, in particular with regard to safety of those concerned.	Local	The LGBT Organisation to complete their policy review and make any changes if relevant.	The LGBT Org.	Review of policy document. Identify any potential changes and make them accordingly	31/03/17 30/09/17	The review of the policy in relation to making follow up contact will establish if any changes are required to e.g. the safety of any potential clients. Increased understanding of and quality of service given to clients regarding domestic violence and abuse.

Recommendation 10	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to ensure agencies incorporate the NICE Guidelines and recommendations [PH50]: Domestic Violence and Abuse: Multi-Agency working, 2014, as they relate to training, multi-agency working and 'routine enquiry'.	Local	Strategic multi-agency work group to develop and implement multi-agency guidance.	Multi-Agency. Led by the 'SCP'	Working plan and first draft. Implementation. Evaluation and review.	31/03/17 30/09/17 31/12/17	Improved quality of service to victims and perpetrators of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims and perpetrators.

Recommendation 11	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The two day ACPO DASH Awareness/ Risk Assessment and 'Routine Enquiry into Domestic Violence and Abuse training, as commissioned by Safer Cornwall Partnership (SCP) to statutory and voluntary organisations between 2014 and 2016, to have appropriate reference to Domestic Violence and Abuse within the LGBT community, including older people to ensure staff are able to identify, risk assess and refer (where appropriate) high risk cases of domestic abuse.	Local	Provision of training to 4,800 people from statutory and voluntary organisations in Cornwall and Isles of Scilly, followed by a post training evaluation.	Multi-Agency. Led by the 'SCP'.	Tendering process/identification of training provider. (Completed). Delivery of training to members from statutory and voluntary organisations. Post training evaluation by Plymouth University.	31/07/14 31/12/16 30/09/17	Improved quality of service to victims of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims.

.

Recommendation 12	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The Cornwall Voluntary Sector Forum 'Equality and Diversity Sub Group' to scope specialist LGBT services and offer the two day ACPO DASH Awareness/Risk Assessment training and identify any specialist LGBT services that are willing to provide LGBT awareness training to non LGBT specialist agencies.	Local	Provision of two day training to specialist LGBT services and identification of which LGBT services would provide LGBT awareness training.	Multi-Agency. Led by the 'SCP'.	Scope specialist LGBT services and offer of two day ACPO DASH training. Identification of LGBT services to provide LGBT awareness training. Identification of agencies to receive LGBT awareness training. Provision of LGBT awareness training.	31/03/17 31/12/17	Increased understanding of and quality of service given to specialist groups regarding domestic violence and abuse. Staff are able to identify, risk assess and refer where appropriate high risk cases of domestic abuse. Support victims effectively and safely; Clear processes for the management and support of clients at risk or experiencing domestic abuse.

Recommendation 13	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to review: a) How additional update awareness training information can be delivered to those agencies (and the police) who have already undertaken the two day training; b) When best to incorporate it into the current training programme from an agreed point; c) How any potential LGBT awareness training can be delivered by LGBT services to non LGBT specialist agencies.	Local	The training should include understanding of the nature and dynamics of domestic violence and abuse as a pattern of coercive controlling behaviour and have reference to the NICE Guidelines and recommendations [PH50]: (Domestic Violence and abuse: multi-agency working, 2014),which provides different levels and types of training for staff working in different areas of the Health Sector.	Multi-Agency. Led by the 'SCP'.	Review the original two day training content and make relevant amendments to include update awareness training from agreed point in time. Identification of numbers of staff who have received the original two day training and need the additional update awareness training. Identification of LGBT services to provide LGBT awareness training/information. Provision of additional update awareness training/information.	31/03/17 31/12/17	Improved quality of service to victims of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims. Increased understanding of specialist groups regarding domestic violence and abuse.

Recommendation 14	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to ensure that there are multi-agency networks that include direct links between the health services and specialist domestic violence and abuse services providing support to victims and perpetrators. Distinguishing between domestic violence and is complex and should be carried out by specialist domestic violence and abuse experts, rather than clinicians.	**Local**	**Strategic multi-agency work group to develop and implement multi-agency guidance.**	**Multi-Agency. Led by the 'SCP'**	**Working plan and first draft.** **Implementation.** **Evaluation and review.**	**31/03/17** **30/09/17** **31/12/17**	**Improved quality of service to victims and perpetrators of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims and perpetrators.**

Recommendation 15	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Cornwall Local Safeguarding Children's Board, with support from Safer Cornwall Partnership, to consider reviewing the South West Child Protection Procedures, in relation to Domestic Violence and Abuse and Cornwall Local Safeguarding Adult's Board, with support from Safer Cornwall Partnership, to consider reviewing the Cornwall and Isles of Scilly Safeguarding Adults Policy, in relationship to Domestic Violence and Abuse.	**Local**	**LSCB and LSAB with support from the SCP to consider reviewing their relevant policies and procedures in relation to Domestic Violence and Abuse.**	**Multi-Agency. Led by the 'SCP'.**	**LSCB and LSAB Chairs to meet with SCP to identify most appropriate way to conduct the review process.** **Conduct review process.** **Report and Recommendations.**	**31/03/17** **30/09/17** **31/12/17**	**Improve quality of service and response to domestic violence and abuse and standards of safeguarding.**

Recommendation 16	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to develop a multi-agency practitioner's guide/flowchart on how to respond to potential cases of Domestic Abuse and Sexual Violence.	Local	Domestic Abuse and Sexual Violence Strategic Work Group to develop and implement a multi-agency practitioner's guide/flow chart.	Multi-Agency. Led by the 'SCP'.	Working plan and first draft. Implementation/roll out. Evaluation and review.	31/03/17 30/09/17 31/12/17	All practitioners are able to identify and support victims of domestic abuse and sexual violence; clear about their responsibilities to share information and how to access support, treatment etc.

Recommendation 17	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to develop multi-agency guidance for GP's on working with frequent service users who present with the 'Toxic Trio'.	Local	Strategic multi-agency work group to develop and implement multi-agency guidance.	Multi-Agency. Led by the 'SCP'.	Working plan and first draft. Implementation. Evaluation and review.	31/03/17 30/09/17 31/12/17	GP's have clear processes for the management and support of frequent service users who present with the 'Toxic Trio', which includes a standardised care pathway and identified route of expertise/provision of appropriate support, signposting or referral to specialist agencies.

Recommendation 18	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Cornwall Council Domestic Abuse and Sexual Violence Strategic Group to review the findings of the LGBT Organisations [redacted] survey [redacted], to identify any themes.	Local	Domestic Abuse and Sexual Violence Strategic Group to review the findings.	Multi-Agency. Led by the 'SCP'.	Review the findings of the survey. Develop and progress any potential themes and opportunities where identified.	31/03/17 30/09/17	The survey findings may help to identify any themes and potential opportunities across multi-agency organisations in Cornwall. Increased understanding of and quality of service given to LGBT people and communities.

Recommendation 19	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Safer Cornwall Partnership to ensure the Registered Social Landlord Group in Cornwall is part of multi-agency work on domestic violence and abuse and also on Hate Crime.	Local	Domestic Abuse and Sexual Violence Strategic Group to develop policy.	Multi-Agency. Led by the 'SCP'.	Working plan and first draft. Implementation. Evaluation and review	31/03/17 30/09/17 31/12/17	Improved quality of service to victims and perpetrators of domestic violence and abuse. Improved identification of risk and support, signposting or referral to specialist agencies for victims and perpetrators. Improved quality of service for victims of Hate Crime.

Recommendation 20	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The Registered Social Landlord (RSL)Group in Cornwall to consider reviewing their processes for identifying and managing potentially vulnerable customers and those at risk, including consideration of a frequent caller policy.	**Local**	**Safer Cornwall Partnership to provide RSL Group with a covering letter and copy of DHR Overview Report.** **RSL Group to discuss DHR Overview Report and consider review processes.** **Compliance Audit to be completed to ensure relevant processes are in place across the RSL Group in Cornwall.**	**Multi-Agency. Led by the 'SCP'.**	**Covering letter and DHR Overview Report to be delivered once quality assured and approved by Home Office.** **RSL Group meeting to discuss report, findings and way forward.** **Audit to be completed to ensure processes are in place.**	**31/03/17** **30/09/17** **31/12/17**	**RSL Group in Cornwall to have clear processes to be able to identify and support potentially vulnerable customers and those at risk and how best to identify and deal with frequent callers.**

Recommendation 21	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Commissioners for : Cornwall Council (Education, Health and Social Care);Cornwall Community Safety Protection Team; NHS England; NHS Kernow and Dorset, Devon and Cornwall Rehabilitation Company, to develop standard service specifications for providers in relation to: Contributing to Domestic Homicide Reviews; Being able to identify, risk assess and refer(where appropriate) cases of domestic violence and abuse; Guidance for the implementation of Routine Enquiry and for Commissioners to negotiate inclusion in existing contracts and standard text in future tendering opportunities.	**Local**	**Safer Cornwall Partnership to deliver covering letter with DHR Overview Report to Commissioners.** **Commissioners to develop standard service specifications.** **Commissioners to negotiate inclusion in existing contracts and standard text in next round of contract and tendering negotiations.**	**Multi-Agency. Led by the 'SCP'.**	**SCP to prepare letter and deliver Overview Report once quality assured and approved by Home Office.** **Development of standard service specifications.** **Contract negotiations.** **Completed negotiations.** **Contract drawn up and approved.** **Contracts sent out for signing and return.**	**31/03/17** **31/12/17 and will be an ongoing process as contracts come up for tendering and renewal**	**Commissioners are able to ensure providers understand and comply with standard service specifications which will help to contribute to DHR's and identify and support victims of domestic abuse effectively and safely.**

Recommendation 22	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
Where relevant, learning from Domestic Homicide Reviews, is routinely shared with Local Safeguarding Children's Boards and Local Safeguarding Adults Boards, to facilitate an early approach to alter the cyclical nature of some of these events	National	To highlight the issue on submission of the Domestic Homicide Overview Report to the Home Office.	Multi-Agency. Led by the 'SCP'.	Submission of Overview Report to the Home Office.	08/03/16	Overview Report to be submitted to Home Office. Now awaiting response following review of the Overview Report by the DHR Quality Assurance Panel. (Approved 14/04/16).

Recommendation 23	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The Home Office Violent Crime Unit and the Medical Director of the General Medical Council to resolve consent issues, pertaining to engaging and sharing information in a timely way for the purposes of contributing to Domestic Homicide Reviews, so as to minimise any unnecessary disputes or delays.	National	To highlight the issue on submission of the Domestic Homicide Overview Report to the Home Office.	Multi-Agency. Led by the 'SCP'.	Submission of Overview Report to the Home Office.	08/03/16	Overview Report to be submitted to Home Office. Now awaiting response following review of the Overview Report by the DHR Quality Assurance Panel. (Approved 14/04/16).

Recommendation 24	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The Home Office Violent Crime Unit to raise a potential training matter with the Judicial College concerning the Trial Judge's sentencing comments that Mr Smith's murder was not a domestic incident and could not be properly categorised as such.	National	To highlight the issue on submission of the Domestic Homicide Overview Report to the Home Office.	Multi-Agency. Led by the 'SCP'.	Submission of Overview Report to the Home Office.	08/03/16	Overview Report to be submitted to Home Office. Now awaiting response following review of the Overview Report by the DHR Quality Assurance Panel. (Approved 14/04/16).

Recommendation 25	Scope - local or national	Action to be taken (SMART)	Lead Agency	Key milestones and progress (RAG rating)	Target date	Date of completion and outcome
The Home Office Violent Crime Unit to request HMIC to carry out an inspection into the policing of domestic violence and abuse in LGBT relationships.	National	To highlight the issue on submission of the Domestic Homicide Overview Report to the Home Office.	Multi-Agency. Led by the 'SCP'.	Submission of Overview Report to the Home Office.	08/03/16	Overview Report to be submitted to Home Office. Now awaiting response following review of the Overview Report by the DHR Quality Assurance Panel. (Approved 14/04/16).

List of Pseudonyms and Abbreviations

Pseudonyms

Mr Mike Smith ….. Victim

Chloe …….. Victim's daughter

Tony ……... Victim's son

Joyce ……. Victim's former wife

Mr Barnes …… Perpetrator

Mr & Mrs B Barnes. Perpetrator's Parents

Mrs East …….. Perpetrator's Aunt

Mr Newton……. Perpetrator's Uncle

Mr Kay ……... **[Redacted]** of Perpetrator

Mr Hill …… National Homicide Service Caseworker/Victim Support

Abbreviations

ACPO ……..... Association of Chief Police Officers

AMHS ……..... Adult Mental Health Services Organisation

ASB …….. Anti-Social Behaviour

[Redacted] …….. **[Redacted]**

CCA ……... Community Care Assistant

[Redacted] …….. **[Redacted]**

[Redacted] ……... **[Redacted]**

[Redacted] ……... **[Redacted]**

[Redacted] ……... **[Redacted]**

[Redacted] …….. **[Redacted]**

CID ……....Criminal Investigation Department

CMHT ……..…. Community Mental Health Team

CPA …….…. Care Programme Approach

CPN …….…. Community Psychiatric Nurse

CPS …….. Crown Prosecution Service

[Redacted] ……... **[Redacted]**

CSP …….. Community Safety Partnership

CWRT …….. Cornwall Women's Refuge Trust

DAAT ……..... Drugs and Alcohol Action Team

DAISI ……..... Domestic Abuse Intervention and Support Initiative

DASH ……..... Domestic Abuse Stalking and Harassment

DHR ……. Domestic Homicide Review

DPP …….…. Director of Public Prosecutions

DVLA ……..... Driver Vehicle Licensing Authority

GP ……. General Practitioner

HCA …….... Health Care Assistant

[Redacted] ……... **[Redacted]**

HMIC ……..... Her Majesty's Inspector of Constabulary

IMR …….... Individual Management Review

IRIS …… Identification and Referral to Improve Safety

LGBT ……..... Lesbian, Gay, Bisexual and Trans

LGBTQ ……..... Lesbian, Gay, Bisexual and Trans Questioning

MAPPA ……. Multi-Agency Public Protection Arrangements

MARAC ……..…... Multi-Agency Risk Assessment Conference

MDT ……..…….. Multi-Disciplinary Team

[Redacted] ……. **[Redacted]**

MSM ……. Men who have sex with Men

NHS …….…. National Health Service

NHRR ……..... Neighbourhood Harm Reduction Request

NICE ……..……. National Institute for Health and Care Excellence

NPIA …….. National Policing Improvement Agency

NSO ……... Neighbourhood Services Officer

PCSO …… Police Community Support Officer

PIP ……..… Professionalising Investigation Programme

[Redacted] ...…...**[Redacted]**

REACH ……..Risk Evaluation and Co-ordination Hub

[Redacted] ……... **[Redacted]**

RSL ……...…. Registered Social Landlord

SCP …….. Safer Cornwall Partnership

SCR …….. Serious Case Review

SIRI ……... Serious Incidents Requiring Investigations

[Redacted] ……. **[Redacted]**

SODAIT ……..... Sexual Offences and Domestic Abuse Investigation Team

[Redacted] ……. **[Redacted]**

SUI ……..... Serious Untoward Incident