

SOUTHEND COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review The Green Case

Overview Report

Christine Doorly

15/5/2015

Section 1:

Introduction

1.1 Commissioning the Review

This review was commissioned by the Chairperson of the Southend Community Safety Partnership. Mr Green killed his grandfather and assaulted his grandmother on 14th November 2013. The Southend Community Safety Partnership was notified by Essex Police the following day. The Home Office were notified by the Southend Community Safety Partnership of their decision to undertake a Domestic Homicide Review on January 8th 2014. Mr Green was subsequently convicted of murder and attempted murder for the relevant offences. It was deemed that the threshold for a Domestic Homicide Review was met, and that this was to be undertaken under the auspices of the Southend Community Safety Partnership.

1.2 Agency Contact

There was little agency intervention or contact with Mr Green or his family before the homicide, outside of routine employment, housing and other mainstream (largely universal) service contacts. The main exception to this was that Mr Green was using the IAPT first line primary care counselling service at the time of the critical incident, and a domestic abuse incident (which was not related to the subject of this review) had been self-reported by him whilst in the course of using this service.

On 14.11.2013 Mr Green carried out the assault which led to his grandfather's death, and then immediately confessed, stating that his motivation for the act was an allegation (which had apparently been present within the extended family for some years) that his grandfather had sexually assaulted Mr Green's sister when she was a child. From this perspective the attack appeared to come from nowhere.

1.3 Other Processes

Mr Green was convicted of murder of Mr Blue and attempted murder of Mrs Blue in 2014. South Essex Partnership University Foundation NHS Trust (SEPT) conducted an internal investigation which was fed into their respective individual management review. The Domestic Homicide Review was started prior to criminal proceedings and an Interim Overview Report was produced. The recommendations contained within the Individual Management Review's and the Overview Report were proceeded with whilst criminal proceedings were on-going.

1.4 Status and Purpose of the Review

The primary purpose of this review is to determine whether there are any lessons to be learned in terms of how agencies worked together, and to make improvements in services. This review has followed the Home Office Guidance on Domestic Homicide Reviews, as amended in 2013.

Home Office Guidance identifies the following points as the purpose of a Domestic Homicide Review:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a

result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In addition, Home Office Guidance states that:

- Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.
- Domestic Homicide Reviews are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a Domestic Homicide Review indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the Domestic Homicide Review process. Alternatively, some Domestic Homicide Reviews may be conducted concurrently with (but separate to) disciplinary action.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence 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.

The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

In this case, the review proceeded to identify as quickly and effectively as possible any such lessons, and took steps to identify any immediate recommendations for implementation by the Community Safety Partnership.

1.5 Legal framework for the Review

This review has been conducted under Section 9 of the Domestic Violence, Crime and Victims Act 2004, which came into force on 13th April 2011, inter alia:

- A review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by:
- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;

Or

- A member of the same household as himself/herself

1.6 Subjects of the Review

The subjects of this review are the deceased victim, Mr Blue, date of birth 8.11.1929 and the perpetrator, Mr Green, date of birth 3.10.1979.

1.7 Chairperson of the Review

Christine Doorly, an Independent Consultant, was appointed to conduct this review, and to produce the Overview Report. Christine is an experienced professional with a lengthy career in Social Care Management and in the Regulation of Care Services. More recently Christine has been Independent Chair of Southend Local Safeguarding Children Board and Southend Safeguarding Vulnerable Adults Board, as well as holding other such positions elsewhere.

Christine has a degree in Sociology, professional Social Work and Teaching qualifications, and Management qualifications which include a Master of Business Administration (MBA).

Christine has overseen a number of Serious Case Reviews in her capacity as Independent Chair, and has undertaken both the e-learning training modules provided by the Home Office for the purpose of undertaking Domestic Homicide Reviews, and the training previously provided by the Government Office of Eastern England for Overview Report Authors. Christine has previously undertaken a Domestic Homicide Review which was strongly praised by the Home Office in its evaluation of the report.

1.8 The Review Panel

The review commenced with the appointment of a suitable panel to advise and support the process. The panel consisted of the following agencies and their representatives:

Representing agencies involved in the case:

- Southend Borough Council (included Children and Adult Social Care, Housing Services and the Drug and Alcohol Team)
- Essex Police
- South Essex Partnership University NHS Foundation Trust (SEPT) including Atrium Clinical Services; a joint individual management review was agreed.
- South Essex Homes
- Southend University Hospital NHS Foundation Trust (SUFHT)
- NHS England /Southend Clinical Commissioning Group (CCG)

Provision was reserved to co-opt additional experts to the panel if this was felt to be appropriate. However this was not required.

In addition, the following representatives were retained on the panel to support it with professional advice:

- Head of Health Development: Southend Borough Council
- Group Manager Community Safety: Southend Borough Council

1.9 The Terms of Reference for the Review

This panel determined the Terms of Reference for the Review as follows:

Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence, and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim or perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC (Multi Agency Risk Assessment Conference)?

Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments given what was or should have been known at the time?

When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options /choices to make informed decisions? Were they signposted to other agencies?

Was anything known about the perpetrator? For example were they being managed under MAPPA (Multi Agency Public Protection Arrangements, which exist to manage the threat to the public from high risk offenders)?

Had the victim disclosed to anyone, and if so was the response appropriate?

Was this information recorded and shared, where appropriate?

Were procedures sensitive to the ethnic, cultural linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

Were senior managers or other agencies and professionals involved at the appropriate points?

Are there other questions which may be appropriate which could add to the content of the case? For example was the domestic homicide the only one that had been committed in this area for a number of years?

Are there ways of working effectively that could be passed on to other organisations or individuals?

Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses

and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

How accessible were services to the victim and the perpetrator?

To what degree could the homicide have been accurately, predicted and prevented?

The panel also identified the following issues as of particular concerns in this case, and requested that Individual Management Reviews address these areas:

Analysis of each agencies involvement with the victim and alleged perpetrator should be undertaken with particular reference to the agencies policies and procedures and the agency context of their involvement.

When considering the risk (if any) that the alleged perpetrator presented to other partners did the agency consider the potential risk to this victim?

The impact of any substance misuse by the alleged perpetrator, victim, or other significant persons.

1.10 Time Period Covered by the Review

The time line was agreed subject to there being no significant information which would lead to it being reviewed. It was initially considered as follows:

In respect of the victim and perpetrator, all information to be supplied in detail from 8th December 2009. In addition all further significant information prior to this which might relate to vulnerability issues should also be included.

In respect of all other associated persons, agencies are work from December 8th 2009 in detail, but as above to include any previous information which is potentially relevant.

The timeline was set from this point due to a domestic abuse incident occurring on this date at the perpetrators address. Further information on this event showed it to be a low level incident with no involvement of the perpetrator or victim who is the subject of this review. The timeline was then amended to start from the date of the perpetrator accessing of the IAPT service (a local primary care counselling service) which commenced in January 2012. No information subsequently emerged which led to this timeline being changed.

1.11 The Review Process

The process adopted by the panel followed the draft Essex Protocol for the conduct of a Domestic Homicide Review, and the Home Office Statutory Guidance on Domestic Homicide Reviews, on which the above is based.

1.12 Producing the Individual Management Reviews

Following the initial submission of information, the following individual management reviews were commissioned by the panel:

The following individual management reviews were commissioned:

- Southend University Hospital NHS Foundation Trust (SUFHT)

- Essex Police
- South Essex Partnership University NHS Foundation Trust (SEPT) and Atrium Clinical Services agreed to conduct a joint individual management review but actually produced two separate but linked individual management review as their recent affiliation made it too difficult to merge their information. (IAPT is a primary care counselling service of which SEPT is the NHS partner). This was agreed by the chair, and the two reports were generally consistent with each other.
- South Essex Homes
- NHS England/ Southend CCG, individual management review produced by the Valkyrie Surgery in respect of Mr Green
- Southend Borough Council; no individual management review was produced as the Local Authority had no involvement which met the terms of reference.

Each of these individual management review were undertaken with the instruction to use a range of suitable methods, including staff interviews as appropriate, analysis of paperwork and case records, and evaluation of the organisation's policy and procedural documentation and other material factors. They made reference to local and national policy where appropriate. There was very little content to any of the individual management reviews in respect of relevant information and the most significant individual management review in this case was that of SEPT/the IAPT service. All of the individual management reviews were deemed by the Overview Report Writer (and Chairperson of the Panel), to be of an acceptable standard given the very limited nature of agency contact in this case.

In addition to the individual management reviews commissioned, checks were taken to investigate the contact between the local Ambulance Service and the family, and between the Local Authorities where Mr Green's sister had been resident and the child protection services, to identify if she had ever reported sexual abuse by her grandfather, Mr Blue. None of these searches came up with any information.

Chronologies were not produced for this review due to the very limited nature of any information, and all significant incidents have been recorded in the section of this review which deals with the timeline of key events (Section 3).

Essex Police were part of the review panel and all the information is potentially subject to disclosure, therefore suitable arrangements were made to support this process.

1.13 Other inputs to the Review

Information from the family, in particular the victim's perspective, is very important in conducting these reviews. Following a meeting between the Police Senior Investigating Officer and the Review Chairperson, it was not deemed to be appropriate to interview any family members before completion of the criminal trial. However on completion of the trial it was felt by the review chairperson that the perpetrator should be invited to give an interview in order to try and better understand how he came to commit this action, in order to identify if there are any lessons to be learned, albeit from the perpetrators rather than the victim's perspective. Therefore on the completion of criminal justice process and

conviction of Mr Green for murder, the chair wrote to him and requested an interview, to which there was no response. In the absence of an interview from Mr Green it was not deemed to be useful to interview other family members as given the nature of the events which occurred there was no sense in which the victims were the subjects of domestic abuse prior to the attack, or could represent that experience.

Following the initial Home Office evaluation and after discussion with the evaluation panel chair, a second attempt was made to contact the perpetrator and request an interview. Despite a supportive point of contact being offered, this too did not result in a response, so it has proved not possible to interview the perpetrator in this case. However in so far as the perpetrator has communicated any motivation for the attack it has consistently remained the allegation of historic sexual abuse of his sister.

The victims own perspective was impossible to capture since the homicide was essentially carried out by a family member who had not had contact with the victim for many years, until the day of the murder, hence there was no build up to events whereby the victim could be supported or protected.

Section 2:

2.1 Short Summary of What Happened

It would seem that in 2010 Mr Blue, the victim, and his wife, who had been living with their daughter for the past 5 years, suddenly felt they could not do so anymore; describing the reason as being that this was due to a family dispute. They were rehoused and given a tenancy.

It is believed, on the basis of information which has emerged subsequent to Mr Blues' death that the family dispute referred to was an allegation circulating within the family that Mr Blue had sexually assaulted his granddaughter, Mr Green's sister, when she was a child.

Meanwhile Mr Green had no contact with his grandparents during this period, and was not even aware of where they lived. He was living with a long term partner until shortly before the assault occurred. He began attending IAPT for counselling services following a referral by his GP, from July 2013. Here he disclosed suicidal ideation and self-harm and admitted to an incident of domestic violence which he said occurred one and a half years earlier. This incident was not related to the victim who is the subject of this review.

By November of 2013 Mr Green disclosed in counselling that he was leaving his long term partner who he described as controlling, and he also discussed the alleged abuse of his sister and the idea of communicating with his grandfather about this. His mood was identified in records as having improved at this point. At this time he was working as window cleaner, he had other job prospects in line, and he had recently moved in with a new partner whom he had befriended during his window cleaning work. He had also apparently also given up his habitual cannabis usage.

It would seem that on the day of the assault he had sought from other family members the contact details and address of his grandparents and arranged by telephone to visit them. He did not disclose to anyone any information which would alert them to his posing a threat or a danger to his grandparents. His actions on the morning of the assault were not suspicious, and reportedly included getting a tattoo.

He later arrived at his grandparents' home by arrangement. They were initially apparently

pleased to see him. Once in the apartment Mr Green proceeded to tie them up and obtained a knife from the kitchen which he used to attack both his grandfather and grandmother, citing the sexual abuse of his sister as a rationale. He was apparently calm and not especially agitated. They were compliant with his actions as they did not initially perceive there to be any threat. He killed his grandfather and injured his grandmother, but she was able to get away and was assisted by a housing officer who was the first person to arrive on the scene. Mr Green immediately admitted the attacks and again cited to police the alleged historic sexual assault by his grandfather on his sister as his rationale.

Section 3:

3.1 Full Chronology of Key Events, with Overview Writer Commentary

There is very little information to be gleaned from the chronologies and individual management reviews submitted in the review. Extensive searching of records to determine if there had been any reporting of the alleged historic sexual assault on Mr Greens sister, covering all the known addresses of this family, were undertaken without any result. It would appear that the alleged abuse was never reported to the authorities, although given that this would be decades ago, it is not possible to be certain on this point.

A chronology of the key events now follows, complete with comments from the Overview Report Writer where it is felt that there is any particular significance to the event, or it poses a question about inter agency working. The chronology is drawn from the content of the individual management reviews.

18.6.2010

South Essex Homes, in the course of dealing with a housing application by Mr and Mrs Blue, receive a letter from their daughter in law saying that their housing need arises from a situation where Mr and Mrs Blue can no longer reside with their daughter due to a family dispute.

1.7.2010

In respect of the same application, a further letter is received from the daughter of Mr and Mrs Blue, stating the same thing as above.

18.10.2010

Mr and Mrs Blue take up their tenancy and move in to the property offered, within a sheltered housing complex. Their Sheltered Housing Officer, who had regular contact with them, stated in interview subsequent to the attack that Mrs Blue had disclosed to her the fact that the family had made them leave their previous accommodation with them because of something that Mr Blue had allegedly done, but that he had not done it. Also it was reported that the Housing Officer had never seen Mr Green visit his grandparents, except on the day of the attack, this being consistent with the understanding that Mr Green did not know where they resided until the day of his assault.

31.7.2013

SEPT report getting the GP referral for IAPT services (to be delivered by Atrium) for Mr Green. Triage information includes self-harm and suicidal ideation, and an admission that he was violent towards his ex-partner (not the subject of this review) one and half years ago. He reported using marijuana but amounts were not specified. Mr Green was telephoned and made no report of risk of harm to self or others.

ORW comment: this referral does not feature in the GP practice individual management review. The domestic abuse incident which Mr Green self-reported in

counselling was not reported to the Police at the time and was not known to them.

9.8.2013

Mr Green was accepted by Atrium for stress and mood management, a preliminary large group described as focussing on understanding symptoms, psycho education and developing coping skills.

19.8.2013

Mr Green is accepted by Atrium for a Stress and Mood course which starts on August 16th.

19.8.2013

Mr Green is allocated a High Intensity Worker at Atrium

16.9.2013- 21.10.2013

Mr Green attends all six of the weekly sessions of the Stress and Mood course.

11.9.2013

Mr Green attends 1:1 therapy session at Atrium where he raises the issue of his sister's abuse by their grandfather. He also identifies a difficult relationship with his current partner. Counselling records state that: No risk to others was indicated.

26.9.2013

Mr Green discloses in a telephone call to Atrium duty service that he has contemplated suicide but feels it would be selfish. Later he was due to attend for 1:1 appointment but did not attend. Records indicate that the duty call had not been shared with the therapist.

ORW comment- the therapist should have been informed about the telephone call

10.10.2013

Mr Green attends his second 1:1 appointment at Atrium. He describes fleeting suicidal thoughts. Records describe him being directed towards Samaritans, GP, and A&E. Counselling records state that: No risk to others indicated.

ORW writer comment- this highlights the issue of the need for clear processes for escalation either within counselling or towards secondary mental health services, and the use of supervision to address this.

24.10.2013

Mr Green attends 3rd 1:1 appointment at Atrium. He describes difficulties with communication with his partner and fleeting thoughts of death. The session is described as covering assertiveness and communication, and that Mr Green was given contact details of a crisis team. He also mentions his window cleaning business is struggling. Counselling records state that No risk to others indicated.

7.11.2013

Mr Green attends Atrium appointment and discusses the issue of assertion/communication with his grandfather regarding the alleged abuse of his sister. He has a "dramatic drop" in scores (associated with apparent improvement to his mood), which he attributes to his decision to leave his controlling relationship, describing himself as feeling free. He also mentions that he has taken up with a new girlfriend (described as a psychologist), and that

he has handed over his window cleaning business to his ex -girlfriend and is now seeking a job, for which he had an interview arranged.

11.11.2013

Mr Green attends his GP practice for a routine appointment where he discloses that he was suffering hip pain and depression. He reported that his mood had improved in the last three weeks, that his sleep was good and that he had no thoughts of self-harm suicide or harming others. He stated that had stopped using cannabis a week ago. He was issued with anti-depressant medication. His hip pain was noted in the individual management review as unremarkable and not relevant to this matter.

ORW comment: this consultation does not appear in the SEPT/Atrium records

15.11.2013

At around 2.04pm on Thursday 14th November 2013 Police and Ambulance were called to the address of Mr Blue following a report of a stabbing. The incident was reported by the Warden of the sheltered housing complex where they resided. At around 2.09pm on the same day the Police received a call from a male claiming to be Mr Green saying that he had stabbed both of his grandparents. The police attended the incident and found Mrs Blue outside of the wardens office, with the warden treating a serious wound to Mrs Blue's arm. The officers found Mr Green inside the flat, still on the telephone. He was told to drop the telephone which he did, and he walked calmly out of the flat with the officers. Mr Blue was deceased within the flat having been stabbed in the heart, along with other wounds. Subsequent interviews with witnesses determined that Mr Green had tracked down where his grandparents were living and arranged to see them that day. He had arrived at the flat and been welcomed in, and had then proceeded to tie up his grandparents and then attacked them using a knife.

Section 4:

4.1 Analysis of the Individual Management Reviews

Police Individual Management Review

The individual management review for the Police contains no details of any incidents relevant to the review. The individual management review evidences that Essex Police have in place suitable arrangements and procedures for responding to Domestic Abuse, but that these were not relevant to this review in respect of its terms of reference.

Southend University Hospital Foundation Trust Individual Management Review

The Southend University Hospital Trust individual management review has no details relevant to this review. It confirms that the Southend University Hospital Foundation Trust has in place appropriate policies and procedures for responding to Domestic Abuse, but that these were not relevant to this case.

South Essex Homes Individual Management Review

The South Essex Homes individual management review contains information about how Mr and Mrs Blue came to reside at their sheltered Housing complex. There is no information which should have led to any inter agency communication or other action. The housing officer allocated to the complex appears to have made a good relationship with Mr and Mrs Blue and to have acted professionally, including on the day of the attack.

The individual management review writer had identified some actions which could be taken to improve the way in which South Essex Homes could strengthen its approach toward Domestic Abuse. Whilst these would have had no bearing on this case, they

nevertheless would be good practice actions which could protect potential future victims. These include the undertaking of risk assessments for new tenants on an individual (rather than couple) basis in order to improve identification of domestic abuse issues, and the benefits of training Sheltered Housing Support Workers in domestic abuse. Both of these would appear to be appropriate recommendations. Generally it can be seen from the individual management review that South Essex Homes have a comprehensive policy in respect of Domestic Abuse.

NHS England/CCG/ Valkyrie Surgery Individual Management Review

This individual management review does not cross reference with IAPT in respect of referral of Mr Green for counselling, and in respect of his one GP appointment for depression. Otherwise there is no information in respect of GP input which is relevant to this review. The GP individual management review has not analysed whether suitable policies and procedures in respect of Domestic Abuse are in place, and well understood, for GP's working in this medical centre. This matter should be referred to NHS England who commission General Practice in order for them to assess the suitability and comprehensiveness of current arrangements in this respect. This should include policies about information sharing. This would have had no impact on this particular case however.

SEPT/Atrium Individual Management Review

The SEPT/Atrium individual management review contains the majority of the information which this review can draw on to try and understand what was happening in the period leading up to the critical attack. The individual management reviews submitted by both SEPT and Atrium are reflective and have challenged the way that services were delivered in this case. They outline how the IAPT services which Mr Green received are mostly focussed on mild to moderate depression and are relatively high volume primary care services. They are delivered to a set of Regional and National Standards, and in that respect can be seen as somewhat inflexible. They also detail that the risk assessments used by the service focus on the risk of self-harm and there is not a tool in place to assess risk to others. In addition the service is awaiting guidance on the policy for disclosure of domestic abuse incidents reported through counselling. It acknowledges that there were some shortcomings in respect of administrative systems and record keeping.

It should be understood that with hindsight it is possible to see some of the warning signs that Mr Green have posed a danger to himself or to others. These included the disclosure of a violent incident, the fact that his depression scores and mental state did not improve over a significant period of time, his suicidal and self-harming ideation, and the fact that he did not follow the normal path of recovery through the use of this service.

The question which has been examined in the individual management review is whether these matters could have been picked up and responded to during Mr Green's use of the service, and if so, how this would have happened. The analysis provided in the individual management review highlights a number of recommendations which include improvements to the timeliness, recording and sharing of information in the service, a review of policies and procedures to ensure they are sufficiently robust and comprehensive as regards domestic abuse and other allegations, and a better capacity to actuarially assess, and then manage, risk to others as well as self-harm. The individual management review also suggests that the ability of therapists to use supervision effectively, including enabling more serious or complex cases to be escalated to a secondary tier of service when appropriate, by simplifying this pathway, would also be of benefit. It should be noted however that the therapist in this case made consistent use of supervision and the recommendation is not a reflection of that individuals practice, but

about a more structured approach within the service.

The Individual management review therefore makes a number of good recommendations which are endorsed by the Overview Writer. It is not possible to find that the events which occurred could have been predicted or prevented even if these systems had been in place. Nevertheless they will improve practice for the future, including better protection for victims of domestic abuse in so far as when domestic abuse is disclosed through counselling there will be a more strongly supervised and considered response to the information if the recommendations made within the individual management review are in place.

Section 5:

5.1 Analysis of Themes and Issues

Mr Green had very little contact with agencies in the run up to this attack. His main interface was with the primary care counselling service and his GP practice. He was receiving anti-depressants from his GP and was participating in a counselling programme at the time of the attack.

With the benefit of hindsight it can be seen that there were some indicators of risk in the content of Mr Green's disclosure to his counsellor. These included his suicidal ideation, his business worries, and the ending of both a long term relationship and his habitual cannabis use. He did reveal the allegation of the historic abuse by his grandfather, but it would be difficult to see this as a risk factor in advance of the events which occurred. Some exploration and recording of risk factors did take place within the counselling process, but these were more related to the risk of self-harm as opposed to the potential of risk to others. Although Mr Green disclosed a historic incident of domestic abuse whilst in the process of receiving counselling from the IAPT service, this incident had not been reported at the time and hence no DV1 or MARAC referral could have been made at the time. From this perspective there was therefore no opportunity for a multi-disciplinary risk assessment or response to any threat from Mr Green. Furthermore, this incident was in a different context and involving a different victim to Mr Green's grandfather.

IAPT has however accepted that a more structured risk tool should be introduced, one which assesses risk to others, but even if this had been in place it is not evident that Mr Green would necessarily have been seen as posing a significant threat to others. Just prior to the attack his wellbeing scores indicated a strong degree of improvement, although this had not been the case previously.

The Atrium individual management review also identifies that a more structured approach towards onward referral to secondary mental health services should be introduced into IAPT for patients who do not respond to the programme on offer. Whilst as Overview Writer I endorse this recommendation, it is still not clear that this would have been triggered in the case of Mr Green, given the information on record. Mr Greens' counsellor used supervision constructively and frequently, giving her the opportunity to identify and assess risk factors and progress being made, and given the high volume of this primary care service and the threshold for secondary mental health services, it is not clear whether this would have been deemed to have been reached in respect of this case, even if this proposed policy had been in place.

In this respect I conclude that the events which occurred were either predictable or preventable.

5.2 The victim's Perspective, and Victim Support

From the perspective of victim support, there is nothing to learn from this review. Mr Green had no contact with the victim of this review for many years, until the day of the attack. It was not felt to be appropriate to interview family members in advance of speaking to Mr Green, as the best explanation of what had triggered the attack was likely to come from the perpetrator. Mr Green declined to be seen and in the light of this it was felt to be of little or no value to interview other family members.

5.3 Inter Agency Working, including Information Sharing

In respect of the lessons to be learned about how agencies work together, in this case there were some issues about the flows of information between the General Practitioner and the Atrium counselling services, most of which have been addressed in the respective individual management reviews. The Valkyrie Surgery was felt to have insufficient domestic abuse policies and frameworks and this matter is addressed in a recommendation within this overview report. As Overview Writer I feel assured that the recommendation below, combined with the actions in the individual management reports, will address these points.

All other individual management reviews were deemed to be of a good quality and to have suitable action plans. These action plans will be tracked by the respective agencies and progress will be reported back to the Southend Community Safety Partnership.

The Overview Report Writer has added a specific recommendation in respect of the Valkyrie Surgery as follows:

That NHS England reviews the policies and procedures of the Valkyrie Surgery in respect of Domestic Abuse and monitors the implementation of any action plan and recommendations, as appropriate.

The rationale for this recommendation being that this practice did not have sufficiently robust procedures on Domestic Abuse.