WITNESS STATEMENT OF SALLY MIZON, PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, Mrs Sally Mizon **[I/S]** am the ex-wife of the late Mark Tyler (born on 21 June 1975.)

2. I am making this statement from a combination of own my own memory of events, professional knowledge, and from having reviewed Mark's mental health records / other disclosure and the evidence placed before the inquest into my late ex-husband's death, which was held on 27.03.2013.

3. **I have made a point of including relevant extracts from the medical records and reports as I wish the Inquiry to be aware of the inconsistencies / contradictions.**

4. Whilst suffering with psychotic symptoms, Mark shot his mother in her home and then himself with a shotgun in 2012. My ex-husband was failed by multiple agencies. In my view his mental health issues were not formally diagnosed and there was prejudice with regards to the fact that he had a history of substance misuse.

Abbreviations used in this statement:

- Domestic Homicide Review – 'DHR'
- South Essex Partnership University NHS Foundation Trust – 'SEPT'
- BCMHS – 'Basildon Community Mental Health Services'
- IMR – 'Illness Management Recovery'
- MHS – 'Mental Health Services'
- CJMHT – 'Criminal Justice Mental Health Team'
- CDAS – 'Community Drug and Alcohol Service'
- EDAAT – 'Essex Drugs and Alcohol Team'
- CPA – 'Care Programme Approach'
- CMHT – 'Community Mental Health Team'
- MARAC – 'Multi-Agency Risk Assessment Conference'
- MAPPA – 'Multi-Agency Public Protection Arrangements'
- IPCC – 'Independent Police Complaints Commission'

Domestic Homicide Review

5. In this statement, I will be making reference to the Domestic Homicide Review ('DHR') which was published in 2015.

6. You will note that when quoting to relevant sections from the DHR, some parts are in red. These are revisions that the DHR *"…made in response to receipt of the Home Office letter dated 2 April 2014 advising that the Home Office Quality Assurance Panel had judged the*

DHR to be 'inadequate' and further discussions with the Home Office Domestic Violence Policy team."

7. With regards to the establishing of the DHR, the DHR states:

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

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

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

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

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

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

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

9. The DHR speaks in depth with regards to Mark's mother. However, in my statement I have focused on Mark. I refer the Inquiry to the DHR if they would like to consider the further information with regards to Mark's mother.

Family Background

10. In order to fully understand the depth of the failings by South Essex Partnership University NHS Foundation Trust ('SEPT'), it is essential that the Inquiry is fully aware of Mark's upbringing and the trauma he suffered during early childhood.

11. Mark grew up with both of his parents and his brother Lee, who was 14 months older than him. Both boys were extremely close to their mum, but not their father. Mark was also especially close to his paternal grandfather who symbolised a safe space and father figure. Mark grew up as a witness to significant domestic violence as a very young child and his childhood was one of fear and trauma. Living with his father's unpredictable nature and frequent violent outbursts was hard for him and he and his brother felt safer out of the home. Mark would stay out with other children to escape the danger and trauma of his home situation. There was also significant physical domestic abuse from his father directed towards both boys. Mark and his brother both told me that they used to hide under the bed when their father would return home and pretend that they were in a space ship. Mark vividly remembered his mother suffering a broken jaw and being hospitalised when he was around 6 years old. He also shared that his mum would often pack their stuff and tell the boys they were leaving, only to change her mind hours later after driving around and say they were going home. Mark told me of one time that he wet himself in the car due to the fear of returning to the family home.

12. Mark also suffered from a severe dairy allergy which resulted in eczema. His skin would blister and crack. He was often bullied at school and was unable to take part in activities such as swimming due to the severity of his skin condition.

13. At 15 years old Mark went to London with some friends. At the end of the day Mark was mugged by a gang of much older males. He was robbed and beaten up. His friends ran away and left him. Mark told me that was the day he lost trust in everyone. When he returned home his father called him a 'poof' and said he should have fought back. His mother laughed also and appeared to take his father's side. This was a frequent response to his father's behaviour and was most likely a form of protecting herself from further assaults. We would call this survival mode now. In my view, this family would be considered as high-risk domestic abuse, however in the early 80's levels of understanding and safeguarding provisions were almost non-existent. Domestic abuse was also considered the norm and did not cause the social disgrace towards the perpetrator that it does now.

Dual Diagnosis

14. The information in my statement will show that:
    a. Mark had issues of substance misuse,
    b. He had an undiagnosed mental health condition and
    c. As a result, he was not provided with care and treatment under the Dual-Diagnosis Policy

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

16. This statement will show that Mark came into contact with the Criminal Justice Mental Health Team ('CJMHT'), the Community Drugs and Alcohol Service ('CDAS') and A&E Crisis services. Yet none appear to have recognised the severity of Mark's presenting issues and instead appear to blame it on anger management and/or substance misuse. Why is this? Has this changed now?

17. I have worked for Open Road as a complex needs opiate key worker. I have also worked for many years in a statutory organisation, specialising in rough sleepers, who have a range of complexities including substance misuse and mental health concerns. In my experience people suffering from substance misuse, drug induced psychosis and dual diagnosis in general is not acted upon within reasonable time scales or with any sense of professionalism. **The idea currently, is that if a person were to just stop using drugs / substances for three days, then their psychosis will be gone but this is just not the case**. As a consequence, people are left in the community to their own devices, and they are still suffering from psychosis or other trauma induced mental health symptoms. This was sadly the missed opportunity that occurred with Mark – to access early psychosis intervention crisis team or the intense outreach team. It is infuriating that professionals, organisations and services have not improved.

18. Mark's case sadly has shone a light on the importance of dual diagnosis and that it doesn't matter where the psychosis stems from, that people can still die. In my opinion nothing significant has changed in the past 12.5 years within the Essex area and drugs & alcohol services. If someone is prescribed under CDAS they will go to the community team. Basildon with CDAS, Chelmsford with CDATS, comes under the same umbrella. I have spoken at length to the psychiatrist whilst I was working at Open Road, regarding dual diagnosis concerns and the general response to my concerns would be that my clients' issues were drug induced related and that there was nothing that they could do to combat it apart from abstinence. As recently as November last year I had a conversation with a community psychiatric nurse and was told if individuals just stopped smoking crack for three days, they wouldn't have psychosis.

19. You do have section 136 which can be used to assist them. However, the police will take someone under section 136 and the mental health services will simply discharge them, often without even assessing. There are other options such as voluntary section and a section 2 whereby a patient can be hospitalised and assessed for up to 28 days.

20. In my opinion there must be a crisis centre, as they have in Hertfordshire, where those suffering from drug induced psychosis, as well as other high risk mental health symptoms

can go and stay for 72 hours to detoxify and have their mental health symptoms, at the very least monitored.

21. I would also suggest that it is imperative that a mental health assessment takes place in a safe environment. Just because someone is under the influence of alcohol or drugs, doesn't change the symptom. If someone is an alcoholic, they are higher risk than an opioid user because they can die from not drinking. If someone is having psychosis as result of use or withdrawal, they still deserve treatment like anyone else. That person once in withdrawal are in a horrific cycle, withdrawing from drugs/ the numbness drugs create. As a result of this withdrawal, they may hear voices, demonstrate impulsive behaviours such as suicidal ideation, self-harm and more. They also then have to deal with reality i.e. the trauma that has led to the addiction in the first place or underlying mental health symptoms such as personality disorders. They then must deal with their trauma again on a multiplied level and as a result they start using drugs again. They are stuck in a never-ending cycle.

22. I also am of the view it is not necessarily the case that practitioners do not have the skill set to deal with people such as Mark. Instead, I believe that it is their reluctance, dismissal and prejudice against people like Mark who suffer from substance misuse. Essentially a lack of empathy at the core of front-line services and adopting a standard of passing patients off as seen as just heroin or crack users. Is this acceptable?

23. Care is a box ticking exercise which results in less patient care and not only is this happening in Essex, but nationwide. Substance misuse and mental health is an epidemic. Residential rehabilitation doesn't just deal with the physical addiction; it also works with people in undoing years of trauma. This is the service that is required and not simply leaving people in their own home to their own demons. If someone has trauma in their own house and cannot deal with the same, it will be near on impossible for them to get clean within the community.

Diagnosis / Assessments

24. Before I set out key assessments which Mark had, I would like the Inquiry to know my view on these assessments. In my view, the assessments detailed in this statement are predominately a farce. In my view, the referral process appears to be over complicated, and the number of forms required to be completed by staff was excessive and confusing. In addition, I have noted that assessments have sections which have been copied and pasted from earlier assessments – is this reliable information?

25. So many agencies were involved. The DHR includes tables to summarise the agency involvement with Mark (and his mother) during the DHR review period. From my understanding of the table/s, the agencies stated include:
    a. Basildon and Thurrock University Hospitals NHS Foundation Trust
    b. Basildon Borough Council
    c. East of England Ambulance NHS Trust
    d. Essex County Council, Adult Health and Community Wellbeing
    e. Essex County Council, Schools, Children and Families
    f. Essex Police

g. Essex Probation
h. Family Mosaic
i. NHS South East Essex
j. Open Road
k. South Essex Partnership University NHS Foundation Trust (SEPT), Community Drugs and Alcohol Service
l. South Essex Partnership University NHS Foundation Trust (SEPT), Mental Health Services
m. Westminster Drugs Project

26. Did all these agencies talk to each other? Clearly not, which is further discussed below.

27. Was it the case that the agencies (particularly SEPT, A&E and Essex Police) did not adequately assess / diagnose Mark for mental health issues because they simply saw him as a drug addict. For two days, Mark was in psychotic episode in his bedroom, and he had no help from anyone. No one sane would calmly sit down, hold a sawn off shot gun under their chin and pull the trigger. This was the result of Mark's desperate pleas to be helped, to be treated, to be hospitalised by the statutory organisations that should have supported and protected not only him but his mum, me, my children and the wider public. Instead, he was repeatedly ignored. Basic safeguarding processes and multidisciplinary team approaches failed.

28. In order for the Dual Diagnosis policy to have been triggered, he simply needed to be diagnosed. Mark confided he believed he had split personality disorder. However, I believe that he met the criteria for several mental health diagnoses. Why was it so hard for the professionals to not only consider the substance abuse but to also consider the periods of abstinence / symptoms he presented with?

29. For the Inquiry's benefit I have listed below the probable diagnoses that Mark may have had, in my opinion, based on the assessments and reports (which are discussed later in this statement). For ease of reference, I have linked the relevant sections from the NHS website which further expand on the below list possible diagnoses:
    a. Borderline Personality Disorder (BPD)
    https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/
    b. Schizophrenia / schizoaffective disorder
    https://www.nhs.uk/mental-health/conditions/schizophrenia/
    Mark hallucinated, believed he was an alien and that he was the son of God, and that people were constantly out to kill him.
    c. Post-traumatic stress disorder (PTSD)
    https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/
    Mark was brought up a witness to his parents' violent and abusive relationship. His father was frequently intoxicated with alcohol and violent. Mark witnessed this throughout his childhood, and this impacted him in later life.

30. Each time that Mark threatened to hurt himself and/or others this was not given the seriousness it required. He would generally be told that there was **no evidence of formal mental illness**. He received inadequate help and/or inpatient treatment and ultimately

took his and his mother's life. If he had he received the appropriate help that he desperately required, in my view, this tragedy could have been avoided.

31. Given my view on the inadequacy of the assessments, it did not surprise me to read that the DHR stated that none of the drug treatment agencies identified his **mental health concerns** at the time of initial assessments. The DHR also mentions the lack of appreciation of his childhood experiences. It states:

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

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

Mark's involvement in decisions about his treatment

32. In my view:
    a. Mark wasn't involved in decisions regarding his treatment.
    b. He was predominately ignored whenever he self-referred and
    c. was failed by most agencies he encountered.

33. Furthermore, I wasn't involved in decisions about his treatment and/or care. I provided information to agencies involved in Mark's care but none of them gave my concerns the seriousness that it deserved. I do not consider I was listened to.

34. There were occasions where when he presented to mental health services, he should have undergone mental health assessments, for example when he was explaining he was hearing voices, was floridly psychotic, feared he would harm those closest to him / made specific threats to kill me.

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

Date	***Agency***	***Request***

1/2/2011	*Probation*	[Mark] *was aware of referral to CJMHT and was positive about it.*
10/2/2011	*Probation*	[Mark] *acknowledged that he needed help with his mental health.*
22/2/2011	*WDP*	[Mark] *talked about his recent mental health assessment and that he was pleased to be getting help.*
25/2/2011	*Probation*	[Mark] *was concerned that no-one had contacted him from CJMHT. He claimed that he was told that he needed further assessments and welfare checks.*
28/2/2011	*WDP*	[Mark] *asked for help in clarifying progress since his mental health assessment.*
28/2/2011	*CJMHT*	[Mark] *threatened to kill himself, or others, if he did not get help.*
28/2/2011		[Mark] *took an overdose after attending appointments with the CDAS Consultant Psychiatrist and CJMHT practitioners and being told that he did not have a mental health illness.*
3/3/2011	*CDAS*	*Attended CDAS stating that he was "full of anger" and could hurt himself or someone else. CDAS referred* [Mark] *to Basildon Accident and Emergency who referred him to SEPT Duty Psychiatrist who referred him back to G.P. The G.P. referred him to CMHT.*
8/3/2011	*Probation*	[Mark] *made threats to himself or others if he did not get help.*
8/3/2011	*SEPT Contact Centre*	[Mark] *asked to be hospitalised.*
9/3/2011	*CJMHT*	[Mark] *attended appointment with CJMHT. They concluded that there was no evidence of formal mental illness.*
10/3/2011	*Probation*	[Mark] *told his Offender Manager that CJMHT had told him that he had a personality disorder but was not mentally ill.*
15/3/2011	*CDAS*	[Mark] *provided a personal statement as to why he wanted to go into a residential rehabilitation unit.*

17/3/2011	*Probation*	[Mark] *said that CJMHT were not taking his problems seriously.*
23/3/2011	*Probation*	*He told his Offender Manager that he wanted help with his "illness" and that he had lied to mental health practitioners in the past.*
30/3/2011	*G.P.*	[Mark] *was diagnosed with an anxiety disorder.*
7/4/2011	*G.P.*	[Mark] *advised G.P. that he took diazepam due to very bad rage – so bad that he could hurt people or even kill them.*

Date	***Agency***	***Request***
3/5/2011	*CDAS*	[Mark] *started counselling with CDAS, identifying anger and rage as most prominent issues and he wanted to be able to understand these emotions and the relationship with his life.*
16/5/2011	*CDAS*	[Mark] *stated that "he had enough of going round in circles". He said he wanted to change, wanted to stop using and move on with his life.*
17/8/2011	*CDAS*	[Mark] *reported that he had a bad day yesterday and apologised for missing his appointment.*
6/9/2013	*Probation*	[Mark] *reported that he was struggling to come to terms with his father's death.*
15/9/2013	*Family Mosaic Floating Support Service*	[Mark] *self referred and asked for assistance with a mental health referral*
19/9/2011	*CDAS Counsellor*	[Mark] *contacted the counsellor and asked to restart sessions. She advised that she would discuss with his Care Co-ordinator but no further action is recorded.*
26/9/2011	*Family Mosaic Floating Support Service*	*Initial assessment completed.* [Mark] *asked for help with a mental health referral.*
21/12/2011	*Family Mosaic Floating Support Service*	*Initial appointment with Floating Support Officer.* [Mark] *reported that he had a personality disorder.*

25/1/2012	*Family Mosaic Floating Support Service*	*Support meeting mainly focused on financial, benefit and issues relating to* [Mark] *son.*
25/1/2012	*Family Mosaic Floating Support Service*	[Mark] *was aware of his anger issues and agreed a referral be made to the relevant agency.* [Mark] *indicated he wanted more support around his mental health and behaviour issues. No further action was taken.*
18/5/2012	*G.P.*	[Mark] *reported a one month history of depression.*

(emphasis added)

36. Mark was not listened to. Neither was I, as highlighted in the DHR which states:

> "… [Mark's] *ex-wife reported him as a missing person on 2/6/2012 and* ***reported her concerns about his undiagnosed mental health problem.*** *She repeated her concerns to the Police on the 23/6/2012 after* [Mark] *had assaulted her and made threats to kill her.*
>
> *The CPA approach used in both CDAS and CMHT puts the patient at the centre of treatment plans and decisions, but there does not appear to be a mechanism for dealing with clients who report mental health issues but are not formally diagnosed. The G.P. confirmed that his assumption was that once he had referred* [Mark] *to CMHT that they were responsible for that element of his care.*
>
> *The* ***lack of a multi-agency meeting resulted in agencies not sharing the information*** *that was included in their own files. Probation and CDAS have confirmed that there were missed opportunities for them to call a multi-agency meeting or make a referral to MARAC, which may have lead to a sharing of information relating to* [Mark], *although the MARAC is victim focused.* [Mark] *did not meet the criteria for discussion at MAPPA. There does not appear to have been any other mechanism for agencies to share information about a man who was involved with many agencies, taking up considerable time, causing concern for agencies, expressing thoughts of hurting people and asking for help himself…"* (emphasis added)

37. The general behaviour appears to be that the agencies are not sharing information; assume that Mark is someone else's problem.

38. From my understanding, I have concerns regarding the fact that Mark's mum was present at his mental health assessments and asked to provide her insight into his state of mind, in front of Mark. She should have been asked this information in a separate room from Mark, considering his anger issues, threat to her, and others' safety. As a result, I do not believe that Mark's mum was safeguarded. Why involve her in an assessment process in this manner? From a safeguarding perspective, would she have been able to give informed consent to taking responsibility to care for Mark when assessments were done with both of them present? They lived in the middle of a field that was very remote.

Decisions not to admit Mark as an inpatient

39. Mark had been continuously begging for help from Essex mental health services. To my understanding there were occasions where Mark requested to be admitted to hospital. Every time Mark asked to be admitted, was in crisis and begging for help, at the very least the Early Intervention Team should have been in contact with Mark. Not only to support and assess him during the crisis, but also to safeguard his mother, myself and my children. I was at significant risk according to the DHR as Mark thought I was his enemy and trying to have him killed. This put me in danger, and I am aware there were several occasions that Mark stalked me and had planned to kill me in the last year of his life.

40. There were on going failings to recognise that Mark had significant psychosis and I believe he was discriminated against due to his history of substance misuse issues - even though drug tests were often negative. Previous self-reporting of his mental health symptoms was ignored, which put himself and his mother at risk.

41. All the time Mark was asking for help, whether it was CJMHT, probation services, the police, Basildon Hospital, can all be found in the DHR and the Independent Police Complaints Commission report ('IPCC'). I knew Mark was going to kill someone and I did everything in my power to ensure he received the help he needed, in order to try to prevent this.

42. Mark made referrals to Police (CJMHT), SEPT, CDAS and Open Road. He literally made requests to anybody that would listen. The response to his request and the outcome was death. Each failure to admit Mark when there was a clear opportunity to do so, was in my view negligent and culpable homicide.

43. I believe Mark and his mother would still be alive had he been admitted as an inpatient and the many decisions not to admit or treat Mark appropriately within the community would reach the threshold of corporate manslaughter.

44. I implore the Inquiry team to read the DHR in full to understand the breadth of failings and missed opportunities to admit Mark as an inpatient and/or section him for his own safety and that of others.

Alternative mental care/treatment

45. Having looked at all information available to me, including Mark's medical records and the DHR, I did not come across there being any alternative treatment provided to Mark. He was essentially left to his own devices. He was also left in the care of his 79-year-old mother who had no mental health experience. Therefore, when Mark took his life and that of his mother, this came as no surprise to me.

46. In my view, Mark was inappropriately assessed on not one but many occasions. His assessments were not compliant with dual diagnosis policy and there was a clear lack of communication with other statutory agencies about Mark's ongoing mental health issues.

47. In the conclusion section of the DHR it states: *"…the DHR identified information that was available to agencies working with* [Mark] *during the last years of his life and which has led the Independent Chair of the DHR to the conclusion that there was the* ***potential for*** **[Mark's]** ***risk to himself and others to have been identified."*** (emphasis added)

Timeline of events – drug history, mental health problems, domestic abuse

Mark first becoming unwell

48. Mark initially suffered symptoms of a mental health disorder when he was just 13 years of age. Mark began self-harming – cutting his arms at this age. He described that this took the mental pain away and he could watch his anger bleed out. Mark also started smoking cannabis around the same age. By age nineteen he was using heroin and drinking alcohol to excess. He used heroin as a way of self-medicating to cope with his experience of witnessing domestic violence from his father and being bullied during his childhood by his peers.

49. The DHR states: *"…It is understood that* [Mark] *had a long history of using illicit drugs and was self harming at the age of 14. He had tried cannabis when he was 13 years old, started heroin at 19 and was injecting heroin by 23…* [Mark] *reported his alcohol use to be social and not problematic..."*

50. In July 1998 Mark returned home after leaving 4 days prior. He disclosed to me that he was scared. He told me that he had heard voices in his head for most of his life, that ghosts would talk to him and that he had uncontrollable rages so bad that he would black out and lose all recollection of his activities. He told me that was why he boxed, trained at the gym, ran/walked for hours every day and worked for his dad 7 days a week, to keep his mind occupied and to channel all the negative reactions he felt. Mark also mentioned that he was scared that our baby would have the same affliction. He didn't know what to do and was scared of hurting me or someone else. He also told me that his great uncle Charlie had been taken away by horse and cart and remained in hospital until his death.

51. In approximately the year 2000 or 2001, I first became aware of further aspects of Mark's mental health issues. I was only 21 at the time and Mark would be hearing things and saying that ghosts were speaking to him. I just put it down to Mark being Mark and him saying stupid stuff. I remember on occasions our dog would be sitting at the bottom of the stairs in our home and Mark would say that there was a spirit on the top of the stairs. At the time however, I didn't link Mark's behaviour to his mental health issues.

Mark first coming into contact with mental health services and mental health care thereafter

52. From my understanding, Mark first came into contact with mental health services in Essex when he was under the care of SEPT's Community Drug and Alcohol Service ('CDAS') from around 17 May 2002.

53. From my understanding, the medical records identify the following individuals as being involved in Mark's care over the years. It may be that the Inquiry, once they have examined

the medical records in detail, may identify other relevant individuals. I have put in **bold** those individuals who, in my view, were more involved in Mark's care:

a. [I/S] – Consultant Psychiatrist
b. [I/S] – CDAS Care Coordinator
c. [I/S] – CDAS Team Manager
d. [I/S] – CJMHT Community Psychiatric Nurse
e. [I/S] – CDAS Counsellor
f. **[I/S]** – CJMHT Criminal justice Worker
g. [I/S] – CDAS Temporary key worker
h. [I/S] – CDAS Essex Locality Manager
i. [I/S] – Clinical Lead
j. [I/S] – Consultant Psychiatrist
k. [I/S] – Community Psychiatric Nurse
l. [I/S] – A&E Psychiatric Liaison Nurse
m. **[I/S]** – CDAS Counsellor

54. The DHR states:

"… [Mark] *had four drug treatment episodes between 2002 and 2007 and had been an in-patient in two residential drug treatment programmes both in 2006.* [Mark's] *expressed wish was to be abstinent from drugs and he had periods of abstinence but he also had frequent relapses…*

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

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

[Mark] *also self referred to Open Road at the same time. During the DHR review period* [Mark] *had four treatment episodes with Open Road, some were more successful than others. At times he struggled to maintain attendance and his case was closed, in line with their policies. He attended counselling sessions in 2009 and the Structured Day Programme in 2010 and 2011.* [Mark] *accessed some ear acupuncture sessions and contacted the drop-in centre for advice periodically…"*

55. From approximately 2009 onwards until his passing, matters pertaining to Mark's mental health became a lot worse. I remember Mark went back into rehab in approximately 2009 because he was really unwell. He was hearing voices and had extreme paranoia. He was convinced the little old lady living opposite us at the time, was watching him. It was pretty continuous. When he would leave the house, he would walk around in circles rather than

take the obvious direct route to the supermarket. He would do this, because of his paranoia, so he could check if someone was following him. Mark at this time, when he went out, would drive to a dead-end road to see if he was being followed.

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

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

<u>Analysis</u>
[Mark] *received a number of warnings about the use of diazepam from his G.P. and CDAS and he was advised to reduce his dose and not to binge on it.*

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

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

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

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

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

2010 – Drug overdoses

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

October 2010 – Start of Probation / WDP supervision

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

Analysis

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

[Mark] *was breached by Probation in May 2011 following a period of disengagement…"*

57. On 06/01/2011, Mark had come to my house to see our children, whilst I was out. Upon my return to my house, I had found out that he had scared the children by telling them that WIFI is a police tracking device and telling our children that I was trying to have him killed. Our children were in bed when I came back and therefore, I agreed to take Mark home. Whilst we were driving toward Mark's house, he began behaving weirdly toward me. When we approached his driveway, Mark dragged me out from the driver side by my throat to the passenger side. He then dragged me out of the car headfirst onto the driveway where he proceeded to strangle me with both hands while kneeling over me. At this time, I weighed approximately 7.5 stone, Mark was around 14 stone and had trained as a body builder, boxer and Maui Thai. I managed to fight back and stop him and pushed him back whilst screaming to attract attention.

58. Mark walked off as I bent down to find my glasses, as I would have been unable to drive home without them. Mark then stood on the other side of the fence to his house and was asking me why I was crying and what had happened. He called me 'babe' and appeared genuinely concerned at why I was on the floor and crying. His eyes appeared different and glassy, and he could not comprehend what had just transpired. Literally thirty seconds after the assault, it was as though Mark was a totally different person and had moved into a different state of mind.

59. The following day, on 07/01/2011, the children told me about the things that Mark had been saying which made me concerned for this mental health and I went to the police to report what Mark had done to me. As a result of this, on 11/01/2011, Mark was served with a non-

molestation order which he breached that day. Mark was then arrested and taken to court where he pleaded guilty to the breach of the non-molestation order and not guilty to the assault charges. Mark was convicted of the breach in May 2011, but the CPS dropped the assault charges.

60. Did Mark undergo a mental health assessment because of the assault against me in January 2011? As far as I am aware, the only response to this incident was that he was arrested by the police. A mental health assessment did take place in February 2011, but it wasn't because of my police call. I do recall saying at the time that I had wished that Mark would get a prison sentence for this assault, so that he could get the help he needed with his deteriorating mental health, as that was the only way I could think of to get him help. Despite this, Mark did undergo a mental health assessment because of an assault that had taken place on 02/11/10. Why did a mental health assessment take place in 2010, and not because of the assault in 2011?

61. I understand that in early 2011 Mark had several assessments. From my understanding these were mainly done because of the excellent work that Mark's offender manager at Basildon Probation did. She repeatedly made referrals due to her recognising the significant decline in his mental health. Disappointingly, in my view, the mental health services did not show the same concerns or professionalism.

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

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

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

<u>31.1.2011</u>

65. The DHR states: *"…Probation referred* [Mark] *to the Criminal Justice Mental Health Team (CJMHT) on 31/1/2011..."*

66. Mark's medical records contain a CPA form 1 which states:

"…Date of First Contact: 31/01/2011…* **[I/S]** *…Basildon Probation…Date of Referral: 31/01/2011 Time:11:30*

…Following discussion with staff from CJMHT on 27.01.2011 they advised that a referral was needed…

He was very happy but when asked about this explained that he feels he is being contacted by outside agencies through his mind. He believes that everyone is an actor sent to pass messages to him. Mark states that he has been visited by an agency before but they wanted to kill him this time he believes that they want to study him because they find him interesting. Mark states that he hears the voice of [redacted] *talking to him in his had telling him not to worry…Attends CDAS for drug testing and prescriptions.*

…Urgent as it is unknown whether he should be looking after his children whilst expressing these views.

…Risk to self through drug use Has previous convictions for violence. Most recently against a [redacted]

Due in Grays Magistrates Court on the 23rd Feb for assault [redacted] *and breach of non-molestation order…√ Urgent next available Clinical Assessment Service appointment…"*

16.02.11

67. On 16/02/2011, Mark attended a mental health assessment, which was completed by **[I/S]** **[I/S]** (Community Psychiatric Nurse) of the CJMHT. Forms documenting the mental health assessment on 16.02.2011, which is detailed further below, note that firstly Mark had a *"…history of self neglect/self harm/suicidal ideation and attempts…"* and *"…indicates risk of impulsive suicide attempts…"*. It also noted that Mark had described *"…feeling if things carry on as present he may seriously harm someone…"*. Mark reported feeling very angry and believed that he was constantly being watched by the police. He described experiences of people he believed were actors walking in front of him and mimicking his mannerisms. He described his mind like a *'tornado'*. They also note that **the CPN's** conclusion of the assessment and diagnosis of Mark was that he *"…appeared floridly psychotic and needs urgent review by a psychiatrist… and would consider admission or medication…"* but did *"…not feel a mental health act assessment was appropriate at this time…"* **The CPN** confirmed that on the same day *"…discussed in Team meeting agreed to Mr Tyler being seen by Dr* **[I/S]** *at Southend Court on Monday 21.2.11…"*.

68. A CPA Form 14 in the medical records states:

Date & Time of Event: 16.2.2011 12.30Hrs (Signature Designation & Date Record is Made: **[I/S]** Community Psychiatric Nurse 22.2.11)

"Mr Tyler attended appointment at Basildon Probation office albeit 30 minutes late. Mr Tyler was co-operative and pleasant in manner throughout interview, core assessment completed see file for details. Conclusion of assessment was that Mr Tyler appeared floridly psychotic and needs urgent review by a psychiatrist; however as he states he would be willing to see a psychiatrist and would consider admission or medication I did not feel a mental act assessment was appropriate at this time.

I informed Mr Tyler I would discuss with our team meeting as to how to get a psychiatrists assessment as soon as possible and get back to him as soon as possible.

Discussed case with [I/S] *probation officer for Mr Tyler and informed her of what action I am proposing.*

16.45Hrs

Discussed in Team meeting agreed to Mr Tyler being seen by Dr [I/S] *at Southend Court on Monday 21.2.11 as Dr* [I/S] *already had a full diary this week."*

69. A CAS Form 1 in the medical records states:

"…Name of Assessor: CPN *Date of Assessment: 16.2.11*

…From Referrer concerns over mental state feels he is being contacted by outside agencies through his mind.

From Client He feels he is very angry and a danger to others because of what is happening to him, feels he is constantly being watched by armed police because of his ex-wife.

Describes experiencing people who believes to be actors walking in front of him and mimicking his mannerisms, he feels they are trying to help him.

Describes overactive thought pattern "states his mind is like a tornado"

…Currently lives on his own, feels his neighbours were moved away to protect them from hi but now have returned. Denies any intent to harm them at present…

Vulnerable people/dependants in the home: None but has had access to his children…

…Significant life events: as a child witnessed violence from Father to Mother

Bullied at school, eventually snapped and became violent to others

Age 20 Committed Arson

2006 Marriage split up…2008 Divorced

…No previous contacts with secondary mental health services apart from CDAS since 2002. Describes anger problems and drugs since adolescence.

Medical history: None known only medication prescribed at present is Methadone 30ml

…Probation Officer [I/S] *feels he is a possible risk to others and is concerned about his current mental state as well as a risk to his children if he has access too them*

…Summary of needs: …Urgent assessment of mental state

Arrangements made for Mark to see Dr [I/S] *on 21.2.11 at Southend Magistrates Court…"*

70. The medical records contain a CPA Form 6, dated 16.2.11, completed by CPN, which states:

1. Clinical Symptoms Indicative of Risk

Risk History

- 'Early Warning Signs of relapse', 'Ideas of harming others', 'Ideas of self-harm / suicide ideation' and 'Delusions' are all indicated with a '√'
- 'Impulsivity / lack of impulse control' and 'Other' are indicated with a '?'

Current Warning Signs

- 'Impulsivity / lack of impulse control' is indicated with a '?'

2. Behaviour Indicative of Risk

Risk History

- 'Physical harm to others', 'Preparation to harm others inc. carrying weapons', 'Evidence of targeting children / females / males', 'Suicide attempts', 'Deliberate self-harm' and 'Drug / alcohol abuse' are indicated with a '√'
- 'Threats / intimidation' and 'Child protection issues' are indicated with a '?'

Current Warning Signs

- 'Drug / alcohol abuse' is indicated with a '√'
- 'Threats / intimidation', 'Preparation to harm others inc. carrying weapons', 'Evidence of targeting children / females / males', 'Child protection issues' and 'Suicide attempts' are indicated with a '?'

4. Forensic History

Risk History

- 'Conviction for violent or sexual offences' and 'Other involvement suggestive of risk (e.g. stalking, injunctions)' are indicated with a '√'

Current Warning Signs

- 'Other involvement suggestive of risk (e.g. stalking, injunctions) is indicated with a '√' and states 'restraining order'
- 'Conviction for violent or sexual offences' is indicated with a '?'

5. Personal Circumstances Indicative of Risk

Risk History

- 'Recent severe distress', 'Abuse/ victimisation by others' and 'Social isolation' are indicated with a '?'

Current Warning Signs

- 'Recent severe distress' and 'Concern expressed by others (relatives, carers)' are indicated with a '√'
- 'Abuse/ victimisation by others' is indicated with a '?'

71. The form continues to state:

"Persons Potentially at Risk"… "Partner/spouse" and "*Other"* boxes are indicated with a 'X'.

"…Detail of Risk to Self or Others: Recent history of violence against others currently facing charges of violence on ex wife

Appears to have paranoid and other delusions as well as possible distortion of perceptions

Current Warning Signs of Risk: See above appear to be currently psychotic and deluded

Summary and Management of Risks Identified Urgent review by consultant psychiatrist.

Further action recommended/required: …Discussion with multi disciplinary team members…" box is indicated with a 'X'.

"…Assessed by: [I/S] Date of Assessment: 16.2.11…Community Psychiatric Nurse…"

72. The medical records also contain a version of a CPA Form 6, assessment by [I/S] (Community Psychiatric Nurse) on 16.2.11. There is a counter signature handwritten by what appears to be an [I/S] dated 05/04/2011. The form states:

"…convictions for Assault and possession of offensive weapon

Currently under probation for assault…Currently facing charges of assault [redated] and breach of restraining order both of which he denies.

…Recent history of violence against others currently facing charges of violence…

Appears to have paranoid and other delusions as well as possible distortion of perceptions

…Urgent review by consultant psychiatrist…"

73. The medical records also contain an Information Summary Sheet completed by Ken Stevens dated 16/02/2011 From my understanding the form states:

Under the Type of Assessment: *"TA1 X Core Assessment"*

Under Assessment Outcome: *"OA5 X Pending further assessment."*

Under Diagnosis and Conditions:

- "DF11 X Disorders due to drug use"
- "DF20 X Schizophrenia"

74. Essentially it appears to me that CPN has detailed a schizophrenia disorder – if so, why was this not followed up?

75. A CPA Form 14 in the medical records states:

Date & Time of Event: 17.2.11 10.00Hrs (Signature Designation & Date Record is Made: [I/S] Community Psychiatric Nurse 22.2.11)

"Telephone call to [I/S] Basildon Probation to inform her of arrangements with Dr [I/S]. I have asked that she inform Mark and arrange for a travel warrant if required.

12.00Hrs

Several attempts made to ring Mr Tyler on his mobile phone no but no answer checked no he gave me with [I/S] *I Basildon probation but I keep getting message call rejected."*

Date & Time of Event: 21.2.11 11.30hrs (Signature Designation & Date Record is Made: **[I/S]** Community Psychiatric Nurse 22.2.11)

"Mr Tyler attended to see Dr [I/S] *at Southend Magistrates Court. Dr* [I/S] *felt Mr Tyler was clearly unwell, paranoid and probably psychotic, he felt the court would require a full psychiatric report and that he should be* ***seen by Dr*** [I/S] ***consultant Psychiatrist for CDAS team. He also felt a low dose of antipsychotic medication*** *would be beneficial and that either Dr* [I/S] *or clients GP could prescribe this."*

76. The DHR states: *"…The outcome of the mental health assessment completed on 16/2/2011 was that* [Mark] *was floridly psychotic and expressing bizarre ideas. It was noted on the assessment that his history indicated "impulsive suicide attempts" but that he denied thoughts of suicide at that time.*

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

It was concluded that [Mark] *required an urgent review by a CJMHT Consultant Psychiatrist, which was conducted on 21/2/2011. The doctor concluded that* [Mark] *was "clearly mentally unwell, paranoid and probably psychotic". He told* [Mark] *that he needed a low dose of antipsychotic medication and that either the CDAS Consultant Psychiatrist or the G.P. could prescribe it for him. The MHS IMR does not outline whether* [Mark] *was advised of the process for the prescription to be provided to him, or how long he was told he would need to wait.*

No contact was made with [Mark] *for one week, although discussions were on-going between CDAS and CJMHT as to which agency would provide a prescription to* [Mark]*…"*

77. A CPA Form 14 in the medical records states:

Date & Time of Event: 22.12.11 15.40hrs (Signature Designation & Date Record is Made: **[I/S]** Community Psychiatric Nurse 23.2.11)

"…Discussion with [I/S] *, coordinator for Mark, at Basildon CDAS. I explained mine and Dr* [I/S] *opinion and requested that he ask Dr* [I/S] *to review Mark,* ***he declined stating that CDAS and Dr*** [I/S] ***do not have any involvement with mental illness symptoms.*** *To discuss case with* [I/S] *Team Manager at next team meeting…"* (emphasis added)

Date & Time of event: 23.2.12 17.00Hrs (Signature Designation & Date Record is Made: [I/S] Community Psychiatric Nurse 23.2.11)

"…E Mail sent to Dr [I/S] *requesting that he refer this gentleman to be seen by Dr* [I/S] *(see files for details)…"*

Date & Time of Event: 28/2/11 11.20 (Signature Designation & Date Record is Made: [I/S] Team Manager, 28/2/11)

"…Telephone call received from [I/S] *stating that Mark had rang this morning saying he was going to kill himself if he did not get the help he needed. Informed* [I/S] *that I will contact Mark who is open to CDAS…."*

11.50: "…*Spoke to* [I/S] *(manager CDAS), she stated that* ***CDAS do not carry cases that require mental health input*** *but would ask Dr* [I/S] *to see Mark this afternoon at 3pm. Jane spoke to both Mark and his mother. His mother expressed concerns for her son and stated that she felt that as he was not having access to his children has impacted on his mental health. Mark again reiterated to* [I/S] *that he felt angry and would kill himself or hurt someone if he did not receive help. He said that* CPN *and Dr* [I/S] *had said he would be getting help but that nobody had helped him…"* (emphasis added)

12.10 "…*Telephone call to* [I/S] *(Crisis Team) who agreed to find a bed on the assessment unit and if it was felt he required admission when seen this afternoon could be admitted…"*

15.00 "…*Seen by Dr* [I/S] *and* [I/S] *from CDAS. There was no evidence of psychosis on assessment and Dr* [I/S] *has prescribed him 10mg Diazepam for this evening and will be seen again tomorrow by CDAS…"*

16.10 "…*I saw Mark after the assessment and he denied symptoms of psychosis, He did state that people follow him around and mimic him but denies any other symptom that is highlighted by* CPN *on assessment. Mark feels he needs help with his anger. I discussed the differing forms of treatment with him and* ***the responsibility he would need to take if he hurt others. I stated that he needed to control his anger*** *and seek help with anger management through IAPT. I advised him that* CPN *had been seeking to get him help and that there was no quick treatment that can be received. I advised him that if he felt like harming himself or others that he should take himself to the A&E department for help. It was agreed that* CPN *would contact him tomorrow afternoon for follow up…"* (emphasis added)

Date & Time of Event: 1.3.11 11.30Hrs (Signature Designation & Date Record is Made appears to be: [I/S] Community Psychiatric Nurse 2.3.11)

"…Telephone call from [I/S] *Team manager I have agreed to check calendars and arrange joint meeting with mark and myself as well as* [I/S] *to attempt to resolve discrepancies in presentation.*

Appointment arranged for 12.30 Hrs on 2.3.2011 at Sankey House. Telephone call to Mark's mobile after ringing it eventually diverted to ansaphone so message left on answerphone giving appointment details. Three other attempts made to ring Mark again call was diverted to answerphone…"

16.00 Hrs (Signature Designation & Date Record is Made: [I/S] Team Manager, 28/2/11)

"…Two more attempts made to ring Mark but still going to answerphone, further message left detailing appointment and requesting ring me to confirm he received message…."

Date & Time of Event: 3.3.11 10.40 (Signature Designation & Date Record is Made: [I/S] [I/S] Team Manager, 28/2/11)

"…Mark attended CDAS to pick up his script, informed reception that he had an appt with the CJMHT. I informed them that his appt was for 1.3.11 and that I would be unable to see him now. He is due to come back to CDAS today at 2pm to pick up his methadone script…"

13.20 "…*Telephone call received from* [I/S] *(O.M) Basildon probation. She informed me that she had seen Mark today and he was threatening to either hurt himself or others if he did not receive help. I informed* [I/S] *of recent events and that he had been seen and prescribed Valium this week but that* CPN *will ring him Tuesday on his return to offer an appt…"*

13.50 "…*Spoke to* [I/S] *(CDAS) who will be seeing Mark this afternoon, updated her on the information received from probation…"*

Date & Time of Event: 8.3.11 11.30Hrs (Signature Designation & Date Record is Made appears to be: [I/S] Community Psychiatric Nurse 9.3.2011)

"...Message received from [I/S] *Team Manager that Mark has been contacting his probation officer making threats to himself and others if he doesn't get help. Also telephone message via contact centre saying Mark now wished to be admitted…"*

11.45Hrs "…*Telephone call to Mark asking him to see me at Sankey House 9.3.2011 @ 10.30hrs. Mark has agreed to attend this. Email sent to* [I/S] *at Basildon probation…"*

Date & Time of Event: 9.3.2011 10.30hrs (Signature Designation & Date Record is Made appears to be: [I/S] Community Psychiatric Nurse 9.3.2011)

"…Seen at Sankey house this morning with [I/S] *Team manager. Mr Tyler presented as having predominantly anger problems and substance issues. He did not present with psychotic symptoms and appeared pre occupied with obtaining medication. Advised that his medication would be prescribed by Dr* [I/S] *and that these teams' actions will be limited to asking his GP to refer him for counselling psychological treatment.*

Discussed case with [I/S] *Team manager and agreed that case to be closed to CJMHT as there was no evidence of a formal mental illness and that I would inform probation officer of this decision and write to GP.*

Brief court report completed and kept on file in view of outstanding court cases. Case to be closed to CJMHT…"

<u>28.02.2011 -9.3.11</u>

78. The DHR states: *"…On 28/2/2011* [Mark] *contacted CJMHT and threatened to hurt himself or others if he did not get the help that he needed. CJMHT contacted CDAS as* [Mark] *was open to them and an emergency medical review was scheduled in CDAS for that afternoon.*

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

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

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

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

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

The SEPT Duty Psychiatrist diagnosed anger and depression and recommended that [Mark] *make an appointment to see his G.P. for treatment…"* (emphasis added)

79. The medical records include a letter to Dipple Medical Practice, Dr [I/S] from SEPT, Providing Partnership Services in Bedfordshire, Essex and Luton, A&E Liaison Service Mental Health Unit, Basildon Hospital, [I/S] A&E Psychiatric Liaison Nurse dated 08/03/201. It states:

"A&E Date: 3rd March 2011 *…I was requested to see the above named patient of yours in Basildon Hospital A&E Department for psychiatric assessment on 3rd March 2011 presenting with suicidal thoughts, feels like exploding because there is a lot happening to him and says he may hurts someone and says he took overdose of amitriptyline and heroin on Monday.*

History of presenting complaint: Mark said he has not been able to control his rages since he was 15 years old, and does not want to hurt anybody. Mark said he had a breakdown 18 months ago [redacted] *Mark said one minute he is crying, gets angry and then feels*

numb afterwards. Mark said he has flashbacks of his [redacted] *physically abusing his [redacted], being bullied as a child, his experience of being beaten up in prison, and stabbing people. Mark said he started taking cannabis, acid and alcohol when he was 13 years old, and was always causing trouble…Initial Management Plan:*

1. Discharge to GP

2. Refer to CAS for referral for psychotherapy and anger management

3. Mark to go back to CDAS…"

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

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

CJMHT completed a second mental health assessment on [Mark] *on 9/3/2011…"*

80. The medical records contain a CAS Form1 which states:

"Name of Assessor: CPN *Date of Assessment: 9.3.11 Place of Assessment: Sankey House*

…Reassessment because of differing presentations

…Preoccupied with his anger problems and the need for medication to calm him down

Denies beliefs of conspiracies although states that the police are very aware of him and do keep him under observation at times…"

"…None known only medication prescribed at present is Methadone 30ml

Prescribed Diazepam by CDAS on 28.2.11…States he has no close friends as he doesn't trust others…History of self neglect/self harm/suicidal ideation and attempts:

Client states 7 years ago took accidental overdose of heroin by injection

During 2010 took 2 overdoses but details not given Denies current suicidal ideation but History indicates risk of impulsive suicide attempts

…Previous conviction for Arson, Assault, and offensive weapon.

Last conviction was for assault... Denies any current intent to harm others

…Long history of Drug Misuse Mainly Heroin occasional use in past of crack cocaine

States currently he is maintained well on Methadone but when under stress does take occasional heroin to supplement this.

From CDAS regular tests show mainly negative but occasional positives would seem to confirm this statement.

…Uses heroin in addition to methadone when under stress (self medicates)

…difficulty in getting to sleep also early wakening, describes overactive thought pattern

…Concentration Appears good

…No clear cycle of variation of mood changes in mood appear to be related to circumstances

…History of violent offences. Still admits to anger issues

Substance Misuse issues May have presented psychotic symptoms due drug induced factors

…Summary of needs: …

Does not present as currently psychotic.

Anger management Substance misuse issues…"

81. With regards to an assessment dated 9.3.11, a CPA Form 6 in the medical record states:

1. Clinical symptoms indicative of risk

Risk History

- 'Early warning signs of relapse', 'Ideas of harming others', 'Ideas of self-harm / suicide ideation' and 'Delusions' are all indicated with a '√'
- 'Impulsivity / lack of impulse control' and 'Other' are indicated with a '?'

Current Warning Signs

- 'Impulsivity / lack of impulse control' is also indicated with a '?'

2. Behaviour indicative of risk

Risk History

- 'Physical harm to others', 'Preparation to harm others inc carrying weapons', 'Evidence of targeting children / females / males', 'Suicide attempts', 'Deliberate self-harm' and 'drug / alcohol abuse' are all indicated with a '√'
- 'Threats / intimidation' and 'Child protection issues' are indicated with a '?'

Current Warning Signs

- 'Drug / alcohol abuse' is indicated with a '√'
- 'Threats / intimidation', 'Preparation to harm others inc. carrying weapons', 'Evidence of targeting children / females / males', 'Child protection issues' and 'Suicide attempts' are all indicated with a '?'

4. Forensic history

Risk History

- 'Conviction for violent or sexual offences' and 'Other involvement suggestive of risk (e.g. stalking, injunctions)' are both indicated with a '√'

Current Warning Signs

- 'Other involvement suggestive of risk (e.g. stalking, injunctions)' is indicated with a '√' and states 'restraining order'
- 'Conviction for violent or sexual offences' is indicated with a '?'

5. Personal circumstances indicative of risk

Risk History

- 'Recent severe stress', 'Abuse / victimisation by others' and 'Social isolation' are all indicated with a '?'

Current Warning Signs

- 'Recent severe stress' and 'Concern expressed by others (relatives, carers)' are both indicated with a '√'
- 'Abuse / victimisation by others' is indicated with a '?'

82. The form continues to state:

"…Recent history of violence against others currently facing charges of violence [redacted]… appeared to have paranoid and other delusions as well as possible distortion of perceptions…

…Anger management problems Frustration over not seeing his child

…May have had psychotic symptoms triggered by illicit substances.

…Currently risks appear to be related to poor anger management and to substance issues .

Case to be closed to CJMHT and will remain open to CDAS…Assessed by: [I/S] *…Designation: Community Psychiatric Nurse…"*

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

The MHS IMR reports that the psychotic symptoms described at the initial assessment could have been induced by illicit substances (drug induced psychosis). They state "It is the case that whilst under the influence of illicit drugs a person can experience similar psychotic symptoms to those who suffer from a formal mental illness like schizophrenia. The psychotic effect only lasts until they cease the drugs and the chemical substance is out of their system. The person will then often present with normal behaviours. However if

they were to use the drugs again there is a possibility the symptoms will re-occur." No diagnosis of drug-induced psychosis was recorded at the time.

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

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

84. The medical records contain a letter to Clerk to the Magistrates from SEPT, Providing Partnership Services in Bedfordshire, Essex and Luton, Criminal Justice Mental Health Team, Sankey House, [I/S] (Community Psychiatric Nurse) dated 17/03/2011. It states:

"…Mr Tyler is currently under the care of secondary mental Health services and he has a consultant Psychiatrist Dr [I/S] *of Community Drug and alcohol services, Sankey House, Pitsea.*

I can confirm that he is under the care programme approach with his coordinator being [I/S] *also based at CDAS Sankey House.*

In addition to his substance issues I have recently completed a core assessment on this gentleman and can confirm that in my opinion he has symptoms that would suggest an emotionally unstable personality disorder.

In view of this I would recommend that should he at some stage be convicted of the offence then the court would benefit from requesting a full psychiatric report by Dr [I/S] *.."*

85. The DHR states: *"…*[Mark] *had completed a self assessment form for Therapy for You, which the G.P, had given him on 4/3/2011, and which was received by the IAPT service on 14/3/2011. An assessment was carried out by a High Intensity Therapist on 22/3/2011 and* [Mark] *was accepted into the service.*

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

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

It is clear from the G.P.'s IMR that [Mark's] *G.P. Considered that once* [Mark] *was being seen by the mental health team and CDAS, that it was their responsibility to deal with this aspect of his care. It would appear that the G.P. was not advised of the outcome of the referral he made to CMHT, and he assumed that* [Mark] *had been accepted for treatment.*

The DHR Is unaware of any further actions taken by the G.P. When [Mark] *repeated his claim that he may hurt someone or even kill them one month after this referral was made.*

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

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

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

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

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

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

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

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

Analysis

The CDAS and MHS IMRs ***recognise that the Dual Diagnosis Policy should have been triggered in*** **[Mark's]** ***case. In addition a multiagency meeting could have been***

arranged under the CPA approach. *There appears to have been ineffective communication between CDAS and CJMHT relating to the provision of care for* [Mark].

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

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

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

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

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

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

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

The gap between the G.P.'s referral to IAPT and the first appointment was longer than expected due to the demand on the service at the time. [Mark] *had started counselling with CDAS before the first appointment had been scheduled. CDAS have confirmed that a recent review of the pathway between CDAS and IAPT has resulted in IAPT now offering*

sessions on CDAS sites, and referrals being discussed for suitability between teams in advance.

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

CDAS, CJMHT, WDP and Probation were all aware of concerns for [Mark's] *mental health in early 2011…"* (emphasis added)

86. With regards to Mark's father who died in July 2011 from cancer, I would like to state that as a result of this bereavement, in my view, Mark's mental health deteriorated. He laid with his dad as his dad was dying and said you never told me you love me. The knock-on effects on his mental health caused the resumption of illegal drug use. I think that it is reasonable to believe that the loss of his father and associated grief caused Mark's fragile mental health to become exacerbated / suffer from paranoia and delusions, where he heard noises and would get into rages seeing the colour red.

87. The DHR goes on to state:

"…<u>26th July 2011- Death of</u> [Mark] *<u>father</u>*
[Mark] *father died on 26/7/2011.* [Mark] *reported his death to CDAS on 3/8/2011.*

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

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

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

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

On 19/9/2011 [Mark] *contacted the CDAS counsellor and asked to restart the counselling sessions. She advised that she would discuss this request with his CDAS Care*

Coordinator but there is no information in the IMR reporting additional sessions, the result of the discussion, or the reasons for that decision.

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

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

Analysis
There is no evidence that the counselling sessions restarted after [Mark's] *request in mid September.*

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

CDAS were aware that [Mark] *had self referred to the Family Mosaic Floating Support Service.*

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

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

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

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

23.12.11

88. A CPA form 14 in medical records states:

Date & Time of Event 23.12.11 11.00 Signature Designation & Date Record Made [I/S] [I/S] CJMHT 23.12.11

"…I assessed Mr Tyler at Basildon police station following his arrest after an incident involving a knife where both he and the other person in custody suffered significant wounds. Concerns were expressed from the police regarding his presentation. Prior to assessment I discussed his current presentation with CDAS worker, [I/S] *who informed me that Mark regularly attends his appointments, and is compliant with his methadone. A CDAS worker had met with Mark during the week and no concerns were expressed regarding his presentation or mental state. When asked of his previous involvement with mental health services he stated this was due to the stress of legal matters at that time.*

During interview mark was orientated to time, person and place there was no evidence of though disorder, or any psychotic illness or than a odd idea of being investigated by the police. He denied any thoughts of self harm, stating that he had not done this since the age of 13. He stated that he has a "split personality", when asked to describe this he stated that he becomes very angry. When asked if this is what occurred in this incident he stated that the neighbour had been a police informant and was passing information regarding him to the police. He stated that he walked out of his house, the neighbour then came out and made comments to him and had a carving knife on his person. At this point Mark fought with the neighbour, managed to get the knife off him and then used the knife to attack the other person. Throughout the interview Mark presented as very emotionless, when describing the knife incident he very calmly told us of the wound that he inflicted on the other person. He stated that he had no remorse for this incident and never does following. When asked to describe his personality he stated that he is calm unless some one physically challenges him and then he retaliates, he stated that he has waited 8 years in the past for revenge.

Mark is currently prescribed citalopram 40mg and diazepam 10mg, which he states that he is compliant with, prescribed by his GP. He denies any drug use, and states that he does not drink alcohol. Mark was fully compliant with the assessment and stated that he feels he needs help as he has a "split personality", but feels the support that he has from CDAS is important to him.

Following discussion with the police sergeant a brief court report was prepared, recommending that there was no apparent need for admission under the mental health act.

Should he be remanded into custody then the receiving prison to be aware of his medication and level of violence. Should the court require it a full psychiatric report may be requested to ascertain if Mark is suffering from a personality disorder.

…23.12.11 15.40

Report faxed to police, I have requested that the report is attached to his PER form if he should be remanded into custody the In Reach team can follow up his mental health issues…"

89. The medical records also include a letter to Clerk of the Magistrates from SEPT, Providing Partnership Services in Bedfordshire, Essex and Luton, Criminal Justice Mental Health Team, [I/S] (Criminal Justice Worker), dated 23/12/11. It states:

"…I assessed Mr Tyler at Basildon police Station on 23/12/11 following his arrest for Affray whereby he reports he was involved in a fight with a knife.

Mr Tyler is known to the community drug and alcohol team who report that he is fully compliant and engages with services.

There is no evidence to suggest that Mr Tyler is detainable under the mental health act, however he is known to services previously where he was treated for a psychotic illness and did describe odd thoughts at assessment that could be somatic of psychosis.

IDENTIFIED RISK FACTORS:

- *Risk of violence to others*
- *Poor anger management skills.*

…I would recommend the courts seek a full psychiatric report and if remanded into custody, would request this report is attached to his PER form where the accepting establishment can refer him to the mental health services for further mental health follow up.

Mr Tyler is at present on a methadone programme and prescribed Methadone 50mg. he is also prescribed 40mg Citalipram and 10mg Diazepam by his GP…"

90. The medical records also contain a letter to Dipple Medical Practice, Dr [I/S] from SEPT, Providing Partnership Services in Bedfordshire, Essex and Luton, Criminal Justice Mental Health Team, [I/S] (Criminal Justice Worker) Dated 12/01/12. It states:

"…I am writing to inform you that the above mentioned person was assessed by the CJMHT on the 23rd December 2011 at Basildon Police station. Please find enclosed the core assessment.

Mr Tyler was present following his arrest after an incident involving a knife, from which he sustained a number of wounds to his face and to his abdomen.

On assessment, Mr Tyler was orientated to time, person and place and not exhibiting any symptoms of a psychotic nature, other than having an idea that the he was being investigated by the police. He denied any auditory or visual hallucinations. Mr Tyler reports that he has a split personality and that his anger problems relate directly to this. He states that he acts out violently when he is physically challenged.

Mr Tyler remains open to CDAS services and I confirmed with his worker that he was fully compliant with his treatment and they had no concerns regarding his current mental state. There was no evidence to suggest that Mr Tyler was detainable under the Mental Health Act 1983, however he is previously known to mental health services where he was treated for a psychotic illness and he did, at assessment, describe thoughts that maybe somatic of psychosis.

…At present there is no further input for the criminal justice mental health team and I am therefore closing the case.

Should you require any further information regarding Mr Tyler then please contact the team using the above details…"

91. A CPA form 6, completed by CJW dated 23/12/2011 states:

Under Risk Profile

1. Clinical symptoms indicative of risk

Risk History

- 'Ideas of harming others' and 'ideas of self-harm / suicide ideation' are both indicated with a '√'
- 'Impulsivity / lack of impulse control' and 'Other' are indicated with a '?'

Current Warning Signs

- 'Early warning signs of relapse', 'Ideas of harming others', 'Delusions' and 'Impulsivity / lack of impulse control' are all indicated with a '√'

2. Behaviour indicative of risk

Risk History

- 'Physical harm to others', 'Preparation to harm others inc. carrying weapons', 'Evidence of targeting children / females / males', 'Suicide attempts', 'Deliberate self-harm' and 'Drug / alcohol abuse' are all indicated with a '√'
- 'Threats / intimidation' and 'Child protection issues' are both indicated with a '?'

Current Warning Signs

- 'Physical harm to others', 'Threats / intimidation' and 'Drugs / alcohol abuse' are indicated with a '√'
- 'Preparation to harm other inc. carrying weapons' and 'Evidence of targeting children / females / males' are both indicated with a '?'

4. Forensic history

Risk History

- 'Conviction for violent or sexual offences' and 'Other involvement suggestive of risk (e.g. stalking, injunctions) are both indicated with a '√'

Current Warning Signs

- 'Other involvement suggestive of risk (e.g. stalking, injunctions)' is indicated with a '√' and states 'restraining order'
- 'Conviction for violent or sexual offences' is indicated with a '?'

5. Personal circumstances indicative of risk

Risk History

- 'Recent severe stress', 'Abuse / victimisation by others' and 'Social isolation' are indicated with a '?'

Current Warning Signs

- 'Abuse / victimisation by others' is indicated with a '?'

92. I am surprised to note that despite what is written in her report, there is no detail recorded for either historic or current warning signs regarding the sections 'Recent severe stress' or 'Social isolation'.

93. The medical records contain a CAS Form 1 that states:

"…Name of Assessor: **CJW** *Date of Assessment: 23.12.11*

Place of Assessment: Basildon Police Station

…Requested to assess mental state following concerns raised by the police following arrest. When returned to the police station after receiving medical intervention for wound received, clothing collected for evidence and due to blood on clothing, Mr Tyler was noticed to have a stab wound to his abdomen which he had not reported.

From Client Mr Tyler states that he suffers from split personality and that this presents itself as anger when he feels that he is physically challenged. He states that his neighbour is a police informer and that this is the reason for this arrest.

…Currently lives with son **[I/S]** *who is now at his mother's following the arrest. Next door neighbour –* **[I/S]** *was involved in this current incident, whom he states is working with the police as an informant.*

…No known family history of mental illness, Mark describes his father as a violent Alcoholic, and describes frequently witnessing his father being violent to his mother. Mark reports that his father died in July 2011. Following this he was assessed by a mental health team and prescribed anti-psychotic medication though he did not take this.

…As a child witnessed violence from Father to Mother

Bullied at school, eventually snapped and became violent to others. Reported that he self-harmed at the age of 13 / 14 making cuts and burns to his arms stated that this was to control the pain. This then stopped when he started going to the gym.

Age 20 Committed Arson

2006 Marriage split up …

2008 Divorced

2011 – July Father died

…No previous contacts with secondary mental health services apart from CDAS since 2002. Describes anger problems and drugs since adolescence.

Appointments offered with IAPT though client records detail that he cancelled the appointment.

Stated that he received counselling through open road with regards to relapse prevention.

…Was working with his father until his death in July 2011, Mark reports that he has not worked since.

…Bullied at school but then eventually became aggressive to others.

…Mark states that he has support from his family

…States he has no close friends as he doesn't trust others.

…Current Medication: Methadone 50mls Citalopram 40mg Diazepam 10mg

Forensic history:

1995 Arson

Since then Criminal Damage.

Assault and possession of offence weapon.

Community order and DRR for assault conviction

Charges of assault on ex wife to which he intends to plead not guilty.

Current arrest for affray following fight with neighbour. Mark reports he left his home and the neighbour came out with a knife and made comment about his kids, he states that the got the knife off the neighbour and then stabbed him a number of times. He held the knife under the neighbour's eye and made him say thank you and then let him go…

…Client states 7 years ago took accidental overdose of heroin by injection

During 2010 took 2 overdoses but details not given

Denies current thoughts of self-harming or suicidal ideation but states that when he was 13/ 14 he self-harmed to 'control the pain' he stopped this when he started going to the gym and has stated that he has not self-harmed since.

…Previous conviction for Arson, Assault and offensive weapon…

States that he has a 'split personality and that this causes his anger. Reports that he acts out violently when he feels that he is physically challenged and that he has waited 8 years in the past for revenge.

…Long history of Drug Misuse. Mainly Heroin occasional use in past of crack cocaine

States currently he is maintained well on Methadone and that he last used in July 2011 following the death of his father. He reports that he finds the support he receives from his CDAS worker beneficial.

CDAS report that he is compliant with his methadone (currently on 3 day collection)

Mark states that he does not smoke or drink alcohol

…Used heroin in addition to methadone when under stress (self-medicates) though states that he has not used since July 2011.

…States that he has had trouble sleeping since he has not been working.

…Was able to concentrate throughout the assessment and fully engaged.

He states that he has no concerns and is able to relax and concentrate at home when watching TV.

…No clear cycle of variation of mood changes, he reports that his 'split personality' causes his anger outbursts and that this is when he feels physically challenged or threatened and this has been since he was 15 years old.

…Historical reported risk to others especially ex wife and her contacts,… Risk to his neighbour as feels he is an informant of the police.

…Discussed with CDAS worker [I/S] *who stated that he has no concerns for his mental health at the present, he is compliant on his Methadone regime and appeared calm and lucid at last meeting. Was seen by member of CDAS team on the 20.12.11 and no concerns raised.*

…At assessment Mr Tyler presented as orientated to time, place and person and was not exhibiting any symptoms of a psychotic nature other than having an idea of being investigated by the police (which we were unable to confirm).

He denies auditory or visual hallucinations or self-harm 'suicidal ideations.

Mr Tyler has received counselling in relation to his drug use from 'open road' last saw 4 months previously. He is currently prescribed Methadone 50mg. His GP has prescribed anti-depressant medication, which he states has a good effect. There were no symptoms present of a depressive nature.

Mr Tyler reports that he has anger problems and links this to his 'split personality'. Mr Tyler was able to describe his view of his anger issues rationally.

There is no evidence to suggest that Mr Tyler is detainable under the mental health act, however he is known to services previously where he was treated for a psychotic illness and did describe odd thoughts at assessment that could be somatic of psychosis.

… **CPN** *Date: 29.12.11"*

94. The medical records also contain a Contingency & Crisis Plan dated 28/12/11, completed by [I/S] which I have several issues with. The plan states:

"CONTINGENCY PLANNING PREVNTS CRISES DEVELOPING BY DETAILING THE ARRANGEMENTS TO BE USED AT KEY POINTS IN THE CARE PROGRAMME.

…INCREASING USE OF ILLICIT OPIATES

NON ATTENDANCE,NON COMPLIANCE WITH TREATMENT

HGH RISK ACTIVITY REVERTING TO I.V USE AND I.V IN HIGH RISK AREAS I.E GROIN,NECK AS MOST VEINS ARE COLLAPSED

IN TIME OF CRISIS TO RING ABOVE NUMBERS OR GO TO A and E FOR BOTH MEDICAL AND PSYCHIATRIC ISSUES THAT CANT WAIT AND CAUSING SERIOUS CONCERN

… CLIENT STATED THAT SHE CAN BE CONTACTED THROUGH HER SISTER…"

95. My issues with this plan are as follows:

a. The crisis plan does not highlight Mark's self-reporting of his mental health symptoms, instead it focuses on his addiction, in my opinion in a dismissive manner. It also states

that he can be contacted through his sister. Mark had a half sister much older than him who lived abroad and was blissfully unaware of the situation at home. In my view there is no way that Mark would ever have said this. In addition no contact number is provided for this half-sister.

b. The completed plan does not reflect Mark's mental health at the time, is not completed to a satisfactory professional level and there is no evidence that any referrals were made.

c. Finally the plan is not signed or dated by Mark and no patient comment has been completed. In my view this indicates that this was purely a paper exercise and was not completed with Mark or have the relevant risks included.

96. The medical records contain a Risk Assessment / Substance Misuse. It states:

"Assessed by: [I/S] *Date of Assessment: 28/12/2011…Designation CPN…"*

1. Suicide, self-harm & vulnerability

- 'x' has been stated in the sections historic and current risk next to "Previous suicide attempt"
- 'x' has been stated in the sections historic and current risk next to "Suicidal intent / ideation"
- 'y' has been stated in the section historic risk next to "Recent significant life events". However, 'x' has been stated in the section current risk. This is despite the fact that Mark had just been stabbed outside his home and his father had died five months earlier.

2. Aggression / violence

Historic Risk

- 'Previous history of violence' is indicated with 'yes'

Current Risk

- 'Previous history of violence' and 'Uninhibited behaviour' are indicated with 'yes'

"…MARK HAS BEEN INVOLVED WITH CRIMINAL JUSTICE SYSTEM WAS TAKEN TO COURT AT THE BEGINNING OF THE ATTRIBUTE IT TO STANDING FOR [redacted] WHEN HE FOUND OUT THEY WERE BULLIED AND WAS ON PROBATION. WE WERE INFORMED THAT HE WAS IN THE POLICE CELLS FOR AFFRAY AND KNIFE INVOLVED ON 23/12/2011 AND CJMT WENT TO ASSESS HIM. MARK CAME TO THE OFFICE TODAY AND INFORMED ME THAT HE WAS SET UPON BY [redacted] CAME AT HIM WITH A KNIFE AND SUSTAINED A 6CM SLASH OVER (L) FOREHEAD AND EEDED 9 STITCHES AND A 3 CM SLASH WOUND ON HIS EPIGASTRIC REGION NEEDING 3 STITCHES AND HAS TO WRESTLE THE PERP CONCERNED AS HE WOULD NOT LET GO OF THE KNIFE AND DID INFLICT WOUNDS ON THE OTHER PERSON BUT HE STATED THAT HE WAS ONLY DEFENDING HIMSELF FROM SERIOUS INJURY. HE SATED POLICE WERE

CALLED AND LATER WAS IN THE CELLS AND HE ALSO STATED CPS DID NOT FEEL THERE WERE SUFFICIENT GOUND TO CHARGE HIM AND WAS RELEASED ON THE SAME DAY AND HAS TO REPORT TO THE POLICE ON 28/01/2012…

3. Child protection/safeguarding children and young people

    - 'Y' has been stated in the section historic risk next to "Child Protection Issues". However, 'N' has been stated under current risk despite the fact that my 16-year old son was living in the property at the time.

"…CRIMINAL JUSTICE

… MARK HAS PREVIOUS FOR ASSAULTING SOMEBODY HE FELT WAS BULLYING [redacted] *AND WAS PUT ON PROBATION AND BASED ON THIS RECENT EVENT WHERE A KNIFE WAS INVOLVED AND WHERE HE HIMSELF SUSTAINED INJURIES WHICH HE STATED WHILST DEFENDING HIMSELF AND WHETHER CHARGES ARE IN THE OFFING IT HAS TO BE BORNE IN MIND OF MARKS PROPENSITY FOR VIOLENCE BUT HE HAS ALWAYS BEHAVED IMPECIBLY WITH STAFF BUT ACCEPT THAT HE DOES SEE HIS PEERS WHILST ATTENDING CDAS AND ONE HAS TO BE MINDFUL OF ISSUES WITH THERS AND TO MINIMISE RISKS BY LIAISING WITH OTHER WORKERS CLIENTS FOR APP NOT TO COINCIDE WITH PEOPLE THAT MARK HAS ISSUES WITH…"*

Under the section "Persons Potentially at Risk", the following boxes have been crossed: Self, Child/young person, General public.

97. As a consequence, I would like to understand whether safeguarding was put in place.

98. It continues to state:

"…Comments: MARK HAS BEEN IN CONTACT WITH MH SERVICES PRIOR TO ATTENDING COURT EARLIER IN THE YEAR AND PRIMARY CARE RX CITALOPRAM AND DIAZEPAM

Expand MARK WAS ASSESSED BY CJMHT ON 23/12/11AND DID NOT FEEL THERE WERE MH CONCERNS AND IDENTIFY ISSUESOF THREAT TO OTHERS AND ANGER MANAGEMENT …*

Detail of Risk to Self or Others:

WHEN THREATEN MARK WILL FIGHT BACK BUT HE STATED BUT HE HAS STABILISED HIS DRUG USE,NOT USING ILLICIT CLASS A DRUGS AND NO ACQUISITIVE CRIMES

Current Warning Signs of Risk:

LOW AS MARK STATED HES VERY KEEN TO BE DRUG FREE, MOVE ON AND HOPEFULLY FIND HIMSELF A JOB

Summary and Management of Risks Identified

ROUTINE / RANDOM URINE SCREENING

DISPENSING MODE IS NOW WEEKLY AD MARK IS VERY KEEN TO START REDUCING 1:1 KEYWORKER SESSIONS TO ADDRESS ON GOING ISSUES, MANAGES LAPSES, DEVELOP BETTER COPING SKILLS…"

99. I am of the opinion that the content of the above section "Summary and Management of Risks Identified" is irrelevant and, in any event, the correct risks have not been identified.

2012

100. With regards to events in 2012, the DHR states:

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

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

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

101. In early February 2012, I reported Mark for harassment actions to the police but also to my solicitor [I/S] due to the concerns for my safety and continued breaches in the non-molestation order. As far as I am aware, nothing significant came of me reporting Mark for harassment on this occasion and he did not undergo any mental health assessment following this incident. I would like the Inquiry to find out if this is the case and if so why.

102. The medical records contain a Care Plan 07/02/2012 stating:

Under section "*Identified need / difficulty*":

> *"…Was recently involved in an altercation where by a knife was involved and sustain injuries, which he stated whilst defending himself and as well as inflicting injuries to the other person.*

Under the adjacent section "*Objective to meet need / difficulty*":

> *"…Incident to be recorded in Datix,information to be shared internally and externally and to await outcome of Mark reporting back to Police at the end of Jan 2012. In the interim for appointments to be on site and other staff to be aware of Mark's attendance, mindful of the propensity of violence and also being aware of no known antecedents of any violence to staff".*

103. The medical records contain a D&A Form 7 dated 07/02/2012, completed by [I/S] [I/S] which states:

"…Date of this review: 07/02/2012

…MARK HAS DESPITE COMPLIANCE WITH APPS HAD A CHAOTIC BRIEF PERIOD WITH OTHER ILLICIT CLASS A DRUGS.HE IS NOW MORE STABLE AND HAS DECIDED TO A GRADUAL REDUCTION AND HOPE TO BE DRUG FREE SOON. .HE HAS RECENTLY BEEN TO COURT FOR ASSAULT AFTER FINDING OUT [redacted] *WERE BEING BULLIED.*

HE HAS TO APPEAR IN COURT ON JAN 07/2011 FOR SENTENCINGAND HE FEELS EVEN A CUSTODIAL SENTENCE WILL BE HELPFUL AS HE FEELS DETOXING IN PRISON HAS ADDED ADVANTAGE

HE REMAINSCOMPLIANT WITH RX MEDS AND HASN'T SUPPLEMENTED FOR MONTHS WITH ILLICIT CLASS A DRUGS AND DISPENSING MODE IS NOW WEEKLY PICK UP. OTHER TREATMENT OPTIONS HAVE BEEN EXPLORED BUT HE FEELS THAH SUBSTITUTE RX IS THE BEST OPTIONN AND CARE PLAN REVISITED…

… [I/S] *…Designation:CPN D/A Date:07/02/2012…"*

104. The DHR further states:

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

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

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

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

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

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

By this time [Mark] *had disengaged from all agencies.*

<u>May 2012 – Depression</u>
On 18/5/2012 [Mark] *attended his G.P. and reported a one month history of depression.*

Analysis

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

2nd June 2012 – Missing Person report

[Sally] *reported* [Mark] *as a missing person on 2/6/2012. She informed Police that he had undiagnosed mental health problems.* [Mark] *had missed a child contact visit which was very unusual and* [Sally] *was very concerned.* [Mark] *returned to his mother's home later that night. He was seen by a Police officer the next morning.*

Analysis

The Police followed their procedures, and attended [Maureen's] *home on 3/6/2011 to check on the welfare of* [Mark]. *No other agency was aware of this incident."*

105. On 23/06/2012, I called 999, after Mark had approached me at his mum's house, after I had gone to collect our 2 youngest children. Due to Mark's behaviour I insisted that contact was in a safe environment with his mother and it was led by the children, if they wanted to see him I would facilitate it, if they didn't want to see him then I would not enforce contact. As I pulled up to the house in my car, Mark had come running out with a machete and was shouting at me and threatening to kill me and smash my car up. My driver's door window was slightly open and Mark put both hands into the window and tried prising my door open using his foot against the wing of my car as leverage. I was terrified and felt in imminent danger, so I put the car between the children and Mark. Mark's mum then came running out of her house and put herself between Mark and me. I was also on the phone to 999 as the events unfolded.

106. Mark looked up after a while and his eyes changed from the manic way in which they were to bursting into tears. He then left through the gate and ran away. I realised that Mark had been having a psychotic episode. It was a visible change. He was in absolute confusion; the colour of his eyes and his pupils had changed. With everyone screaming around him, he just ran.

107. Following my call to 999, in which I was crying and explaining that Mark had threatened to kill me and smash my car up. Despite the seriousness of what had just occurred, no officer called at my home that evening and nobody contacted me to explain the delay.

108. On 24/06/2012, two officers, PC [I/S] and PC [I/S] attended my home. I explained that Mark, the day before had threatened to kill me and had damaged my car. I was told by the officers that they could not arrest Mark as he had not done anything wrong. I repeated to the officers that Mark had threatened to kill me and asked the officers why Mark could not be arrested. They responded that it would be his word against mine and there was insufficient evidence, with PC [I/S] specifically saying sarcastically that they 'couldn't go running around after disgruntled ex-wives'. I explained to the officers my concerns about Mark's mental health, and I believed that he had access to guns. PC [I/S] then filled out a DV1 form and said I did not need to make a statement. I also recall mentioning to PC [I/S] about a domestic murder that had occurred in Braintree and his response was that I was being a 'drama queen'. The police laughed at me.

109. Two days later, as I was fearful Mark would return to kill me, a friend contacted the police. Two officers turned up to her house and one of them was PC [I/S] with PC [I/S] PC [I/S] attitude was immediately wrong and he said to me "*what's wrong now*". I tried to explain my fear that Mark would return to harm me, as my ex-boyfriend had returned to his army barracks and I was on my own. To this PC [I/S] responded "*why are you so concerned now, you weren't that bothered the other day*". The officers left without completing any paperwork of my complaint. As Mark was not arrested for threats to kill and damaging my car, he was not assessed for his mental health.

110. On the second occasion in June 2012, when Mark threatened to kill me, I contacted Open Road and spoke to [I/S], the duty worker there, so that Mark could be referred to CDAS for an assessment for his mental health, as he was a patient of theirs. Open Road correctly documented the concerns. I knew [I/S] personally and said although I knew they could not discuss his care with me that they could note down and act upon information I gave them. Thereafter, Open Road advised me to contact the duty worker for CDAS, which I did. My contact with CDAS however, either wasn't recorded correctly and/or my concerns to assess Mark were not acted upon. I request that the Inquiry team enquire as to the outcome of any assessment with CDAS. Because if there was an assessment, then CDAS should have documented the outcome of the assessment. It is my understanding that Mark would only be advised in a multi-disciplinary meeting (MDT) and/or case review with their Approved Mental Health Professional (AMHP), as this is their medical mental health side of substance issues.

111. The DHR states:

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

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

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

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

CDAS have confirmed that with effect from 1/4/2012 patients are no longer discharged from treatment when their CDAS interventions finish as they remain under the care of

Open Road or WDP (if they are Class A drug users and criminal justice clients) as those agencies now have responsibility for care coordination. Their identification of high risk clients disengaging from services will be one factor in reducing the risk of similar tragedies in the future…" (emphasis added)

112. When Mark went missing for 2 days in June 2012, I felt he was clearly unwell and scared that he was at risk, so I contacted the police to report Mark as a missing person because had gone out on Friday to a shop fully clothed and had not returned. The police on Sunday, came out and went to investigate at his mum's house and reported that he was found at 5am by his mum in her field, with nothing but a pair of Calvin Klein boxer shorts screaming and singing to the angels. However, despite the concerning behaviour and our concerns with his mental health, the police did not deem that the incident warranted contacting mental health services for Mark to be assessed and because, in my opinion, in their eyes he was a drug addict and they felt that he was no longer missing, and that their part was done.

113. The DHR states:

"…14th July 2012 - Hoax call to the Police

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

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

28 July 2012 – MHA assessment

114. From my understanding in July 2012 [27/28 July 2012]:

a. Mark was arrested for being drunk and disorderly.

b. At the police station, he claimed to be the son of God and half intergalactic being, and admitted to consuming 10 cans of lager, crack cocaine, heroin, and 40mg of diazepam.

c. He was deemed medically fit for detention and monitored overnight by the police and not by medical professionals.

d. During his time in custody, it took 19 hours for the AMHP to come, who were not prepared with Mark's case history to provide suitable care and treatment.

e. A Mental Health Act assessment found no diagnosable mental illness, attributing his behaviour to drug use. The team advised him to seek help for substance abuse but found no risk to himself or others, concluding hospital admission was unnecessary.

f. Although the incident was referred to Basildon Community Mental Health Team (CMHT), an administrative error meant no follow-up was requested, which just shows that paperwork is more important than patient's mental health. As there was no mental health diagnosis, CMHT did not initiate contact, and no further action was taken

115. In my view the police should have put Mark under a section 136, rather than arrest him. Had Mark been offered voluntary inpatient care and/or detained under section 2 of the MHA for a period of 28 days, as I believe it is mandated, it is my very strong believe that he wouldn't have died on 3rd September 2012. Another missed opportunity for community-based support such as early intervention referrals to see Mark for follow-up with the crisis team.

116. He was seen by three mental health professionals, and it was not considered that Mark should be sectioned and/or treated for his mental health condition. Was Mark assessed under Mental Capacity Act 2005 and Mental Health Act 1983? If not why not as if he had been, he may have been able to access community-based care such as Home Treatment Team, Intensive Outreach Team and the Crisis Team as well as admission.

117. With regards to this, the DHR states:

"… [Mark] *was arrested on 27/7/2012, the day after the first anniversary of his father's death, for being drunk and disorderly.* [Mark] *was taken to a Police station where he told the Custody Sergeant that he was the son of God and he believed that he was half human and half intergalactic being. When asked what he had consumed in the last 24 hours he said 10 cans of lager, crack cocaine and heroin.*

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

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

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

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

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

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

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

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

No carer's assessment was provided to [Maureen] *and due to the mistake on the report sent to CMHT no follow up care was actioned. EDS confirmed that they assumed that CMHT would provide a carers' assessment but this did not happen."* (emphasis added)

Domestic Abuse

118. I am of the view that more should have been done to address the impact that Mark's childhood trauma could have had on his mental health.

119. The DHR states:

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

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

120. Has anything been done to address children witnessing events as Mark did as a child?

121. The DHR goes onto state:

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

122. As the Inquiry will note, I have stated in various places in this statement the domestic abuse which I suffered. I think it is important for the Inquiry to also see information that the DHR has stated re the same:

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

[Sally] *reported an incident of suspected harassment in early February 2012. This was assessed as standard risk.*

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

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

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

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

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

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

Criminal history, violence, use of weapons and management of offenders

123. I have included below what the DHR also states with regards to criminal history, violence, use of weapons and management of offenders as it is important for the Inquiry to carefully note the failings in addressing Mark's history due to the potential impact of the same.

Criminal History / Activities

"…[Mark] *had a criminal record which included:*

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

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

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

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

Analysis

[Mark's] *criminal record, or at least elements of it, were known by a number of agencies,*

if [Mark] *self reported the offences to them.* ***Only*** *the Police and Probation knew his full criminal record. Only the Police were aware of the intelligence they had recorded…"*

Violence

"..During the period of this review [Mark] *was arrested and charged with several violent offences, including the domestic abuse offences.*

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

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

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

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

Analysis
As above, most agencies were ***only*** *aware of* [Mark] *self reporting. The Police were aware of* ***all*** *the incidents, as were Probation while* [Mark] *was under their supervision.*

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

Weapons

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

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

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

[Mark's] *home address was searched on 8/3/2012 after intelligence was received that he was in possession of a sawn off shotgun. No firearms were found and no further action was taken. Since the murder,* [Mark's] *ex-wife and his brother have both*

reported knowledge of [Mark's] *illegal firearms, while other members of the family knew about his interest in guns but were unaware that he owned any firearms.*

Analysis

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

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

124. With regards to the management of offenders, the DHR states:

"…The Essex Multi-Agency Public Protection Arrangements team have confirmed that [Mark] *was never referred into the MAPPA process. MAPPA criteria are as follows:*

Category 1 offenders: All registered sex offenders

Category 2 offenders: All violent and sexual offenders sentenced to imprisonment of 12 months or more or detained under a s37 hospital order.

Category 3 offenders: Any other offender considered to pose a significant risk of serious harm to the public.

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

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

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

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

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

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

Although policy exists for PDP it is not something that as being utilised at the relevant time and there were no persons categorised as PDP by Essex Police at that time. Essex Police have now rewritten their PDP Policy. The new policy, which is to be the subject of extensive internal communication, encourages all staff to identify persons who pose a risk to the public who are then formally assessed. Once adopted as a PDP, the individual will have a nominated manager responsible for proactive work to minimise the risk that they pose…"

125. I am of the view that it is *essential* for the Inquiry to address how financial and housing troubles can impact a person's mental health. I have stated below section from the DHR which address this in relation to Mark:

*"…**Financial and Housing Difficulties***

[Mark] *moved into his home in November 2007 with one of his children.*

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

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

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

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

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

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

On 25/6/2012 [Mark] *also contacted the Family Mosaic Customer Care Line (CCL) and asked for a transfer from his property because it had a lot of bad memories for him. He stated that his child used to live with him there and he had a heroin relapse and his child*

was taken away. His neighbour tried to stab him. The officer tried to call him back but could not contact him.

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

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

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

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

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

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

Analysis

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

Basildon Council was aware that [Mark's] *benefits had been stopped.*

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

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

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

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

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

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

Concerns and Complaints

Quality, Timeliness, Openness and Adequacy of Responses

126. Mark did not understand why all the mental health professionals who he had been seeing were not doing anything to help him, even when he was pleading and clearly expressing, he would hurt himself and others, if not treated. Mark felt he was going around in circles. The DHR clearly states the occasions when Mark raised concerns and sought help for his mental health issues. An example being on 28th February 2011, where the DHR states Mark "…threatened to kill himself, or others, if he did not get help" and on the same day "…took an overdose after attending appointments with the CDAS Consultant Psychiatrist and CJMHT practitioners and being told that he did not have a mental health illness", which was an obvious cry for help.

127. Any concerns and complaints Mark raised himself generally followed the pattern of a lack of appropriate response from the Trust and other agencies. There was an absolute lack of empathy, care and understanding. In addition, I am of the view there are serious concerns over the quality of the forms which are completed by staff. They are lacking in appropriate detail and accuracy. There were delays in between Mark's assessments and a lack of follow up.

128. Whilst writing this report, I have been astounded at the comments made by so called professionals. For [I/S] to tell Mark (on 28.2.11) that he needed to control his anger and take responsibility if he hurt anyone was, in my view, not only unprofessional and patronising but shows the culture that the professionals involved with CDAS adopted. Where was the understanding of the fact that this was the exact reason why Mark was asking for help? After reading through what I have, it really is no wonder that Mark took his own life. From his perspective, what alternative was there?

After Mark's death

129. On 3rd September 2012 at 9.07pm, I recall I was in my house, with my two oldest children who were watching TV downstairs. There was a knock at the door whom I initially

thought was our neighbour. I went downstairs and opened the front door. A man and a lady were stood at my doorsteps and introduced themselves as police and asked to come in. I said in response "it's Mark, isn't it" and took a step back.

130. Before I allowed them into the house, I asked them if he was dead, to which they told me to go and sit down. I sent my children to go upstairs. I was told early in the evening that a man had been found at Mark's mums address, with gunshot wounds to the head. They explained that they believed this person to be Mark as he was laying facedown and the tattoo on the back of his neck with my name was visible following their observations.

131. I was later told that a female in her 70s was also found dead at the scene with gunshot wounds. Thereafter, I was told that they, the police, were not looking for anybody else in connection to the deaths, as they had found Mark's finger still on the trigger.

132. After being told that Mark had passed, I was told by family liaison officer that there would not be a murder investigation, and that avenue of investigation would be closed. We were also told that there will be an inquest, and I was informed that there will be a DHR. They told me that the Home Office would looking into everything concerning Mark and his mum's death to eventually prepare a DHR.

Support

133. We did not receive any support. I would like it to be known that, from my understanding, our GP at the time tried to get my children psychological support to deal with the effects of losing their father and grandmother in such a fashion but was told no by SEPT, CAMHS. CAMHS's response was that my children hadn't been present or witnessed Mark and their grandmother's death and as a result, they did not fall within the criteria. I couldn't get them help and got absolutely nothing. This makes me still angry. Social services were wanting to find out if I was safeguarding my children correctly.

134. I had to plan a funeral for my children's father with no funds or assets. Who expects to have to bury their 37-yr old physically healthy ex-husband. Again, there was no support. It was only because of the kind actions of the funeral directors and the church who reached out to me through the family liaison officer that I was able to bury him. I called the DWP asking about a loan or grant to pay for the funeral and was told he had other relatives so they should pay for it. Those other relatives were his siblings that had just lost their mother.

135. CAMHS, Children Social Care frustrated me at every step of the way and didn't provide the support that we desperately needed, even up until this day.

136. The DHR acknowledged the family's grief and noted that support for surviving family members, including specialist services, is strongly recommended to aid in long-term recovery.

137. The DHR states:

"…The DHR Chair would like to highlight the need for all members of the families affected by domestic homicide to receive support, which may require long or short term provision,

or specialist services for children or adults. The surviving members of this family will have to live with the consequences of the events in 2012 for the rest of their lives. Specialist support and care provided now may help the healing process and provide tools that will guide them through their grief…"

Observations

138. I promised my children that I will clear Mark's name, as he wasn't violent, which is how he had been portrayed in the press. Andy Brogan, the senior nurse at **SEPT** said what happened to Mark wasn't SEPT's fault. I asked for Mark's health records, approximately 8 copies - some were redacted, some not, and some partially redacted. In Mark's records they tried to victim blame and they were not prepared to accept any responsibility and in doing so refused any strategic learning.

139. I would like the Inquiry to note that the Chair of the DHR, provided contact details for AAFDA (Advocacy of the Fatal Domestic Abuse, Frank Mullane CEO) to whom I self-referred. They were the ones that offered support. They did a referral to Winston's Wish for kids whose parents died by suicide. AAFDA was the one that provided a support worker for me for the inquest. They are the ones that offered practical support as well as emotional. I took up everything that they could offer.

Quality of Investigations Undertaken or Commissioned by Healthcare Provider

140. I would like the Inquiry to look into, and provide me, with all investigations (including any internal emails, witness statements) and reports prepared with the purpose of looking to the care which Mark received.

With regards to the DHR and the IPCC reports

141. The DHR report outlined multiple missed opportunities to assess and treat Mark's mental health and substance misuse issues effectively. It saddens me that this was despite repeated attempts by Mark to seek help for his complex needs, including a likely undiagnosed mental illness which was never formally recognised. The DHR acknowledged that Mark's childhood trauma, anger issues, substance misuse, and his chaotic lifestyle were poorly addressed by services.

142. From my understanding the DHR concluded that although Mark disclosed using drugs to manage his rage and admitted fears of harming others, no substantial interventions were made to manage these risks.

143. The DHR states:

"…*It would appear that opportunities were missed to assess* [Mark] *and to provide him with the care and treatment he required. His initial assessments, completed at the start of every treatment episode did not identify the mental health symptoms that have been reported to the DHR by his ex-wife. Although* [Mark's] *childhood experiences were recorded, there does not appear to have been specific work undertaken to address those issues or the long term implications of those experiences.* [Mark] *reported his reasons for self medicating with both illicit drugs and prescriptions drugs over the years, stating that he used them to calm him down and control his rages.* [Mark] *was aware that he had a*

problem with anger and he described being fearful that he would hurt himself or someone else. He stated that he would rather kill someone than hurt them if they wound him up but very few, if any, actions were reported to the DHR to address his rage…"

144. Mental health assessments were inconsistent; one professional would acknowledge his needs and then another would minimise them. After being told he was not mentally ill, Mark took an overdose.

145. From my understanding the DHR also noted that if diagnosed, Mark would have qualified for care under the Dual Diagnosis Policy and been recognised as a vulnerable adult, factors that might have prompted better inter-agency coordination. However, a lack of shared information, inconsistent record-keeping, and over-reliance on Mark's self-reporting resulted in disjointed care. Agencies often failed to act on critical signs or to coordinate care, particularly following life events like the death of his father.

146. In 2012 there were multiple incidents which raised concerns about Mark's wellbeing, police interventions and a (in my view, failed) Mental Health Act assessment. Mark disengaged from services during this period, while his emotional and financial stability deteriorated. In my view the agencies failed to identify the escalation in his risk factors, such as mental health decline, substance misuse, loss of contact with his children, and housing instability.

147. Was Mark's suicide risk ever taken seriously, give his history of depression, trauma, and drug misuse? If not, why not? He self-disclosed overdoses to CDAS and other professionals assessing his mental health, whom had a duty of care to safeguard him. Nor was he referred to MARAC as a perpetrator following domestic violence incidents involving me. Probation and other services missed opportunities to convene a multi-agency meeting that might have offered a clearer picture of his escalating risk.

148. The DHR also states in conclusion:

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

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

At Christmas 2010 [Mark's] *father became ill, and he subsequently was diagnosed with a terminal illness and died in July 2011. The first presentation of bizarre symptoms from* [Mark] *was recorded by two agencies, Essex Probation and WDP on 27/1/2011.* [Mark]

was referred to the Criminal Justice Mental Health Team (CJMHT), part of Basildon Mental Health Services (BMHS), who are part of South Essex Partnership University NHS Foundation Trust (SEPT). [Mark] *was subject to twice-weekly drug tests at the time, the majority of which were recorded as negative.*

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

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

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

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

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

Evidence submitted to the DHR suggests that if [Mark] *had been diagnosed with a formal mental health illness or a personality disorder, then he should have been treated under the Dual Diagnosis Policy. This might have ensured a level of care and treatment that would have supported him, rather than the lack of care and treatment that resulted in him*

repeatedly asking agencies for help with his mental health during the last 18 months of his life, as has been outlined previously in this report.

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

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

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

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

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

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

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

In addition many agencies appeared to rely on [Mark's] *self reporting without verification of the facts and it would appear that* [Mark] *would often report contact with another agency when he was not engaged at all. It is unlikely that* [Mark's] *CDAS Care Coordinator was*

able to monitor [Mark's] *treatment effectively as there is little recorded liaison between him and the other agencies.*

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

The UK Government invested in this evidence based treatment approach to drug dependency and the report highlights the success of this approach.

There was evidence submitted to the DHR showing [Mark] *participation in some psychosocial interventions, for example, the Open Road Structured Day Programme.*

There is little evidence that these interventions were planned as part of [Mark's] *treatment plan and little evidence to suggest that interventions were put in place in response to the life events that occurred during the DHR review period, particularly in 2011 - 12.*

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

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

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

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

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

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

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

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

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

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

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

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

There appeared to be many occasions in [Mark's] *life when he was referred on to another agency. On 3/3/2011, for example,* [Mark] *attended CDAS and was referred to Basildon Hospital Accident and Emergency, in order to be referred to the SEPT Duty Psychiatrist,*

who referred [Mark] *back to his G.P. who referred* [Mark] *for counselling and assessment to BCMHS. This would appear to be a costly exercise for a range of agencies in order that a client already referred to BCMHS should be re-referred to the same service. Current research shows that a high percentage of people who are in drug treatment also have mental health issues and will at times require mental health services.*

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

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

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

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

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

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

[Mark] *killed his mother and then he killed himself, but that certainly is not the whole story. Shortly after this review commenced it became evident that this was a complex family, with*

a complicated web of contributing factors which escalated over the last few months and resulted in a family tragedy…"

149. It is my view that:

a. The quality of the assessment process for those who are in desperate need for mental health assistance, is inhumane and impersonal.

b. The amount of time it took to get Mark to receive mental health assessment/s and take his concerns seriously is extremely concerning.

c. The out of hours process is not fit for purpose, because my understanding is that when Mark was assessed in custody, they did not have access to his medical records. Not having access to Mark's medical records highlights a major concern and flaw in the system. If someone has mental health symptoms, the mental health professionals should not be solely relying on their word when they state they are fine. The reason being that they may be masking the issues they're facing.

150. In my view:

a. CJMHT and CDAS didn't act appropriately.

b. When Mark went to the hospital in March 2011 and July 2012, he was seen by the crisis mental health team, and they discharged him back to CDAS.

c. CDAS failed in their capacity as his care provider.

151. I also have concerns regarding lack of communication with Mark's GP (Dr [I/S] at Dipple Medical Centre). The GP wasn't informed that Mark had been referred to CDAS in March 2011. I believe, Diazepam just carried on being prescribed, even though Mark had been reporting to health professionals that he was misusing it.

152. Dr [I/S] did not understand the process and to be frank, who can blame him. CDAS had a psychiatrist and Community Psychiatric Nurses, yet according to my understanding of [I/S] account, [I/S] stated that *"…CDAS and Dr [I/S] do not have any involvement with mental illness symptoms…".* Common sense would lead you to question why a psychiatric team would not have involvement with mental health.

153. In my view:

a. Mark did not receive any appropriate mental health treatment.

b. The decision made at assessment and referrals were not adequate.

c. Because of prejudice and discrimination due to Mark's drug habits, Mark's mental health symptoms were not given seriousness it deserved.

d. Had prejudice not been at the heart of Mark's care, he would have received adequate treatment for his mental health.

154. Many of Mark's drug tests returned negative results. However, if Mark had been appropriately diagnosed and treated under dual diagnosis policy, then it would not have mattered if it was drug induced psychosis or not i.e. they still would have treated him. I believe that psychosis should be treated regardless of whether it is organic or non-organic.

155. In any event, it is with regards to drugs testing, it is worrying that the DHR states:

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

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

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

IPCC Assessment of Investigation Appeal dated 19th September 2013

156. I made complaints to the police about my contact with them. These are detailed in the IPCC report as follows:

"…

1. *The length of time taken by Essex Police to see Ms Tyler after her call to them on 23rd June 2013*

2. *The failure of PC* [I/S] *and PC* [I/S] *to arrest Mark Tyler for making threats to kill.*

3. *The attitude displayed towards Ms Tyler by PC* [I/S]

In her complaint she also states that the police did not take her seriously despite her telling them that Mark Tyler had guns and mental health issues.…"

157. The IPCC reached the below conclusion and learning objectives in relation to Mark's history and possession of firearms. The IPCC report states:

"…

- *Essex Police should ensure all operational officers are aware of the new Home Office Firearms Guidance.*

- *Any information provided by victims in relation to their knowledge of weapons, the offender may have access to, should be documented in sufficient detail.*

- *Essex Police should ensure they investigate credible allegations of possessions of firearms, in particular where these are linked to allegations of domestic abuse or previous violence involving weapons…"*

158. With regards to whether the findings of the police investigation were appropriate / proportionate to the complaint, the IPCC report concluded:

"… Overall a thorough investigation has been conducted into Ms Tyler's complaints. However, I do not concur with the findings in respect of complaints 2 and 3, given the evidence available. This aspect of the appeal is upheld.

In light of the history of Domestic Violence cases in Essex Police, this complaint should have been referred to the IPCC. This incident occurred, at a time when Essex Police were taking steps to improve how they deal with Domestic Violence Incidents. It is of significant concern that this incident should occur during that period and we were not informed of it. The force should also have considered whether article 2 was engaged.

Essex Police need to put together an action plan to respond to this incident which should include a way in which they will continually monitor their response to Domestic Incidents. It should also ensure that all operational officers fully understand police powers and harassment and intimidation laws and how these should be used.

Essex Police and its entire staff must learn from the historic, high profile Domestic Violence cases…"

159. With regards to whether the decisions that the police had made about whether the officers had a case to answer for misconduct / gross misconduct were appropriate, the IPCC report states the following:

"… In Part.

I agree that PC [I/S] CO [I/S], CO [I/S] and PC [I/S] have a Case to Answer.

The complaint against PC [I/S] in respect of his attitudes towards Ms Tyler should also be upheld. I am of the view that this conduct also amounts to a case to answer.

Summary Appeal Assessment Upheld…"

160. With regards to whether the force's proposed actions following the investigation were adequate, the report states:

"… No.

The investigating officer (IO) recommended that PC [I/S] receive Management Action for her failings to record the incident correctly.

In respect of CO [I/S] and CO [I/S] she recommended they receive Management Action for failings to appropriately allocate a police unit, when the incident was first transferred them.

In respect of PC [I/S] the IO recommended he receive Management Action for his failure, on his second visit to Ms Tyler, to act on the information he received. She also recommended a day's attachment to DAST.

I share the concerns Ms Tyler raises in her appeal about the lack of training recommendations following this investigation…"

161. The Management Action proposed for all four officers was considered necessary but insufficient on its own. The report states the following:

"In respect of PC [I/S] Management Action is appropriate because she was on a three month secondment to FIR to cover staff shortages. However, she is a front line officer and in some ways you would expect her to know what information is important for officers to be in possession of when dealing with DV incidents. Equally important is that, in cases where staff are seconded to another role, in particular FIR, that they are provided with appropriate training. Whilst Ms Tyler did not initially wish to make a complaint against PC [I/S] the issues in respect of the call need to be addressed and Ms Tyler has made further comments in her appeal in this regard.

In respect of the failures by CO [I/S] and CO [I/S] to adequately deal with the 999 call. I recommend that in addition to Management Action the force consider the Unsatisfactory Performance Procedure (UPP) so that there is a long term monitoring performance plan in place. This will ensure lessons are learned by seeing it in practice and will better address the issues that have come out of this investigation. As part of that plan for FIR staff, I would recommend that calls and subsequent actions are monitored randomly over a set period to ensure there is no reoccurrence of these mistakes.

With regards to PC [I/S] whilst I agree that a day's attachment to DAST is appropriate, I recommend that he also is subject to UPP to ensure lessons are learned and by way of monitoring his performance. The way in which he records information on domestic incident should also be reviewed for a set period. Whilst it is accepted that we are only human and we make mistakes, mistakes of this nature, have catastrophic effects and everything possible should be done to ensure we are not just identifying lessons but learning from them.

Whilst the appeal is upheld in respect of PC [I/S] attitude towards Ms Tyler, I have concluded that an adequate and sufficient outcome would be for the officer to be subject to Management Action. It should be made clear that a clinical and unsympathetic approach is not appropriate when a person is in fear of another person and that the comments he made were unprofessional.

All the learning to come from this case should be shared with officers throughout Essex Police…

Summary Appeal Assessment Upheld…"

162. Concerns were raised about the lack of training and wider organisational learning following the investigation, which I echoed in my appeal. The IPCC report demonstrated

the clear need for ongoing performance oversight and structured learning, rather than one-off remedial actions.

163. The IPCC report concludes with the following summary:

"… ACTIONS REQUIRED OF THE FORCE / AUTHORITY

- *The complaint against PC [I/S] in respect of his manner should be recorded as upheld.*

- *The Management Action proposed in section 3, for all four staff, should be progressed and the force should formally respond to the UPP recommendations.*

- *The force should assure the IPCC that the learning from the [I/S] and [I/S] cases have been shared with all staff. The force should also consider obtaining an acknowledgement from staff that they have read and understood the lessons from those cases and this one."*

My views / reflections

164. In my view Mark never received the treatment for his mental health which he deserved in order to get well. In the last phone call I had with Mark, we talked for hours about how he needed help. Mark told me that he tried to get help but was repeatedly sent away by Essex mental health services and other agencies he came into contact with.

165. I believe that Mark's mental health would have improved if only he was given the right treatment which he so desperately needed. When Mark begged for help, he was repeatedly refused and turned away by the very people employed by the NHS who should have been helping him.

166. In my view, the main reason why Mark failed to get help for his mental health was because of the stigma, prejudice and discrimination against his substance misuse. I believe that this prejudice is pervasive in the healthcare sector. Tragically, I feel that it was this failure to failure to treat Mark's mental health that eventually led to his death.

167. I would like to have sight of the psychiatric assessment report completed by the Criminal Justice Mental Health Team (CJMHT) on 16th February 2011. I would also like to access the mental health assessment report completed by the Community Drug and Alcohol Service (CDAS) Consultant Psychiatrist after they assessed Mark on 28th February 2011. Finally, I want to have access to the records pertaining to Mark's attendance at Accident and Emergency at Basildon Hospital and the subsequent assessment carried out by the SEPT Duty Psychiatrist on 3rd March 2011. I want to know the rationale behind their decisions not to treat Mark.

Recommendations for Change

168. In addition to the recommendations mentioned above by myself and that are stated in the DHR, I would like to add the following:

169. Currently, in my view:

a. The dual diagnosis pathway is nothing but a paper exercise.

b. Constant public sector cuts means that there are no resources to help people who are simultaneously suffering from mental health conditions and substance addiction.

c. Healthcare staff, clinicians and the various other agencies involved with Mark's care and treatment, lacked the necessary knowledge to recognise Mark's mental health symptoms as being genuine. They dismissed Mark's plea for help on the basis of his drug use. No one showed curiosity or diligence to try and understand the complex relationship between Mark's drug use and his desperate need to manage his psychosis.

d. In the future, a multidisciplinary approach where the agencies clearly communicate with each other should be used in treating people with dual diagnosis. People involved with Mark, including the Police, adult social care, and mental health services, could have benefited from shared information about Mark.

e. The agencies should have used trauma informed practices to peel back the layers of Mark's problems in order to discover the core of all of Mark's issues, which was years of untreated trauma.

f. I also feel very strongly that there should be a board of people with lived experience of dual diagnosis, (i.e. mental health difficulties and substance abuse).

g. There should be a peer-led approach to hold the professionals to account and to ensure that basic human rights are being met.

h. The culture of 'once a junkie, always a junkie' still thrives in EPUT, and the various other associated agencies.

i. It is a disgrace that accessing appropriate mental health services is so complicated, including making referrals from one mental health team to another or refusals by services to accept someone onto their case load.

j. The NHS is still a public body and is funded by taxpayers' money.

k. Referrals and services need to be simplified to ensure that cases like Mark's never happen again.

l. Psychiatrists such as Dr [I/S] should have their cases reviewed by a peer review process to ensure they are still working within the guidelines.

m. CPN's who work within substance misuse should have clear and defined training in this specific area of mental health care.

n. I would like to remind the Inquiry team that from my understanding, these people took an oath; an oath to not cause harm. EPUT have failed in this Oath on numerous occasions hence the need for this inquiry into over 2000 deaths in Essex alone has arisen.

170. With regards to recommendations, it is important that the Inquiry considers the recommendations made by the DHR in their report of 2015. This is important for two reasons, namely for the Inquiry to consider whether these recommendations:

a. were put in place by the Trust and other agencies involved

b. need to be updated / added to in any way

171. The DHR states:

*"…**Recommendations***

Basildon and Thurrock University Hospitals NHS Foundation Trust

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

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

Basildon Borough Council

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

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

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

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

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

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

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

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

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

East of England Ambulance NHS Trust

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

Essex County Council, Adult Health and Community Wellbeing

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

The other area previously identified is a more joined-up approach to Domestic Abuse training for AMHP's. These actions would need to be led by the Mental Health Service and discussed in a multi-agency forum, there would need to be evidence provided as to the advantages or disadvantages of adopting this approach to Domestic Abuse and Mental Health Assessments.

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

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

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

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

Essex County Council, Schools, Children and Families

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

Essex Police

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

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

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

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

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

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

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

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

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

Essex Probation Service

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

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

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

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

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

Family Mosaic

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

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

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

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

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

NHS South Essex PCT Cluster (G.P.)

No recommendations were included in the IMR.

The DHR Chair recommends that the Clinical Commissioning Group conduct a review into how care and support can be provided to vulnerable adults in the community (those adults who are vulnerable due to their life circumstances rather than the definition as per the legislation); and to the risk factors that might create vulnerability (including living alone, adult children with serious complex needs, financial difficulties etc.).

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

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

Open Road

1. External communications

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

2. Internal communications

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

3. Domestic Violence

- *Open Road to pursue whether it is appropriate to develop a greater and deeper understanding and knowledge of Domestic Violence, particularly in relation to safeguarding victims and assessing and managing the risks posed by perpetrators, and decide by end of March 2013 the level of future involvement.*

- *Open Road to consider possible involvement in all Community Safety Partnerships Domestic Violence Forums across Essex by February 2013 with a view to having new arrangements in place by April 2013.*

- *Open Road to look at Domestic Violence training opportunities for managers, staff and volunteers by March 2013 for possible inclusion in Open Road's Training Plan for 2013/4.*

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

No recommendations relating to CDAS were included in the IMR.

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

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

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

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

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

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

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

- *The delay between* [Mark's] *first referral and first appointment*

- *The lack of timely follow-up after* [Mark's] *appointment with the Consultant Psychiatrist*

- *The possible discrepancies in diagnoses provided to* [Mark], *including the diagnosis of a personality disorder.*

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

- *The lack of a joint treatment plan with CDAS.*

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

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

- *Actions to address* [Mark's] *risk of suicide*

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

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

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

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

Westminster Drugs Project

- *Reinforce restrictions on children being brought to services*

- *That risk assessment training is provided*

- *That risk assessment documentation is reviewed and its implementation is clarified through specific training*

- *That DASH tools and processes are introduced into the standard working practices and is supported by training provided following a clear analysis of need*

- *That partnership working between the Inside Out team and MARAC is explored and defined*

- *That a schedule of audits across the project is planned and includes an examination of the case notes*

- *That the quality of case management and record keeping is more effectively monitored and managed through clarified expectations of the supervision process*

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

Recommendations from the DHR Chair

1. *That the appropriate Essex-wide partnership / board monitors;*
   - *the number of patients in drug treatment services in south Essex who are also being treated for a personality disorder and / or a diagnosed mental health illness; and*

- *the number of patients in drug treatment and who have an identified personality disorder and are receiving an appropriate treatment.*

2. *That the Essex Health and Wellbeing Board consider the issues raised in this DHR and in particular the vulnerability of those people who have not received a formal mental health diagnosis, but may be suffering from a personality disorder or a mental health illness as a result of known childhood trauma.*

3. *That in light of the findings of this DHR, the Essex Safeguarding Board considers reviewing and broadening the definition of a "vulnerable adult" to include adults with complex needs.*

4. *That consideration be given to the establishment of a national database which records all incidents related to mental health concerns. This might include reports of concern to the Police (hoax calls, victims of domestic abuse expressing concern), mental health assessments undertaken by CMHS or agencies working out of hours, diagnoses of mental health issues including anxiety and depression. This database would allow local CMHS to identify residents where the frequency of incidents was increasing or the severity and risk was increasing above established thresholds and triggering an automatic welfare check or care response to the patient and potentially also the carer.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

172. The knock on effects from the failures continued following Mark's death.

173. Mark's brother, Lee, ended up dying from a heart attack as a rough sleeper because he had nowhere to live after his mother died. Lee was left homeless and grieving. He lost his brother, mum and dad all within a year. Lee was in prison when Mark and Maureen died, and I had to inform Lee of the deaths whilst he was in prison.

174. I have enclosed below a list of disclosure which is in my possession which I can provide the Inquiry with:

a. Mark's medical records – GP records and EPUT records
b. Inquest Transcript
c. Serious Incident SI521 Action plan
d. Root Cause Analysis report
e. Domestic Homicide Review
f. IPCC Report

175. I have also stated above the disclosure which I am of the opinion that the Inquiry should obtain. In addition:

a. From my review of the medical records, I do not appear to have any CPA form 14 after 2010 written by [I/S] - the notes I do have in my possession are ineligible hand written notes. I ask the Inquiry team to obtain all records written by [I/S] [I/S] Mark's care coordinator.

b. Dr [I/S] - Psychiatrist for Mark: I do not appear to have any substantial records pertaining to Dr [I/S] involvement with Mark. I strongly request the Inquiry team to obtain these records as they will be crucial in determining why Mark:
   i. was not formally diagnosed,
   ii. was not admitted when necessary on a voluntary basis (as Mark had requested)
   iii. was not prescribed an adequate care package for example, anti psychotic medication or holistic therapy

Statement of Truth

I believe that the facts stated in this Rule 9 Witness Statement are true.

SIGNED [I/S]

SALLY MIZON

DATED 12/09/2025