FACEREMELIUS

INDEPENDENT REVIEW

of the care and treatment received by JW prior to an incident of homicide in December 2020

Case no: 2020-23751

Summary Report

July 2023

Section 1: Contents

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Summary Report

Overview of the incident of homicide

1.1 In the early hours of the morning of 9 December 2020, JW violently attacked and killed an employee at the accommodation where he was staying. The emergency services were called, and the victim was pronounced dead at the scene. Later that morning JW (anonymised initials) went to the local police station and admitted to the killing.

1.2 In the previous July 2020 JW was remanded to a category B prison in the south of England after being arrested and charged with sexual offences. While in prison, he was treated for a psychotic episode with antipsychotic medication, a supply of which was given to him on his release.

1.3 At a magistrates' court hearing on 27 October 2020, JW was given three custodial sentences of three months, each suspended for twelve months. He was placed on the Sexual Offenders Register and made the subject of a Sexual Harm Prevention Order. Later that same day, he was released from prison to no fixed abode. He struggled to function on his release and was initially homeless.

1.4 A few days after his release, and as part of the response to the Covid-19 pandemic to reduce the number of homeless people on the streets, the local authority placed him in local accommodation. In December he got into a fight with two other residents and was arrested. This resulted in him having to leave the accommodation and he was once again potentially homeless. He sought help from his family. They funded a stay in different local accommodation. By this time, he had run out of his antipsychotic medication and had been unable to obtain further supplies.

Investigation process

1.5 In May 2021, National Health Service (NHS) England formally commissioned Facere Melius, a healthcare consultancy, to undertake an independent investigation to review the care, treatment and management JW received from 2017 until the incident in December 2020. This is in line with NHS England's Serious Incident Framework, published in March 2015.

1.6 The main purpose of an independent investigation is to ensure that mental health-related homicides are investigated in such a way that lessons can be learnt effectively to prevent recurrence and improve patient safety. The investigation process may also identify areas where improvements to services might help prevent similar incidents and mitigate risk to mental health care service users and the people with whom they come into contact.

1.7 This was a complex investigation involving the local community mental health services, the healthcare provider in the prison, primary care, and other statutory agencies: adult social care, the police service, prison service, and police and probation service.

1.8 Terms of reference for the investigation were agreed in April 2021 with NHS England, Facere Melius and those agencies involved in JW's care treatment and management. They were shared with the victim's immediate family, who were able to add comments and raise questions that they wanted answers for. These were considered and addressed throughout the investigation process, and were reflected in the full report. This report was shared privately with the family. The terms of reference for this investigation can be found in appendix one.

1.9 The approach taken by the investigation team was to use a range of qualitative and quantitative techniques and methodology. The team reviewed all the available records relating to JW's contact with public sector and other support services, and interviewed a range of staff who had come into contact with JW. Meetings also took place with individuals who were in leadership or strategic positions in the police service, the healthcare provider in the prison, local adult social care service, and NHS England Health and Justice, to better understand the context and expectations of the roles and responsibilities of those who had worked directly with JW.

1.10 The investigation team also spoke to a member of JW's family to provide insight into JW's upbringing and his behaviour during his early years. This discussion also included their views on JW's state of mind and behaviour during the time leading up to the incident.

1.11 JW was given the opportunity to contribute to the investigation, but he declined to participate. Instead, a set of questions was given to those involved in his care, who elicited his answers to them. These have been received by the investigation team and were reflected in the investigation and its full report. This report has been shared with JW's family.

1.12 The prison service where JW was remanded contributed to the investigation at a late stage; their staff were not interviewed by the investigation team.

1.13 Following the document reviews and interviews, the team verified the accuracy of the chronology of events, identifying key themes. These were fact-checked, analysed and assimilated, wherever possible, and the information triangulated. Prior to drafting of the report, a team of independent advisers provided the

investigators with additional support, guidance, analysis, and expert opinion.

Childhood and early adult background

1.14 As a child JW had behaviour problems and his parents sought help from their GP. At the age of six he was seen by a child psychiatrist, who identified that he had some indicators consistent with attention deficit hyperactivity disorder (ADHD). There was no evidence of any further investigation to identify which of the possible neurodevelopmental conditions JW might have had. This would have been the first opportunity to provide him and his family with support to manage his condition.

1.15 As a young adult he was prone to severe anxiety and had difficulty with interpersonal relationships. In 2008 at the age of twenty he sought help from his GP concerning his mental wellbeing. This is the first indication that he was struggling with his mental health, and may have been seeking help. Although he was referred for counselling, there is no evidence that he attended, or that he received any help or benefit from this.

Relevant mental health and forensic history: 2017 – July 2020

1.16 JW first came to the attention of the police in 2017 when he was cautioned for assaulting a police officer. In 2018 he was charged with assault of a family member, for which he was given a conditional discharge for a period of nine months. While in custody he was referred to the Criminal Justice Liaison and Diversion Service (CJLDS) for an assessment, as there was a concern that he might have a learning difficulty. JW chose not to engage with the assessment. His risk of harm to himself could not be assessed, but his risk of harm to others was categorised as high.

1.17 In November 2018 he was arrested and charged with criminal damage and breaching his conditional discharge. He was given a two-year restraining order with regard to the location of the offence.

1.18 From November 2018 and through much of 2019, JW was homeless, apart from a short spell in bed and breakfast accommodation. Two police Public Protection Notices (PPNs) were issued in February and May about his vulnerability and deteriorating mental and physical health. These were shared with the relevant agencies, but no further action was taken, nor was a safeguarding alert raised.

1.19 His GP referred JW for a detailed psychological assessment for possible Asperger's syndrome (a form of autism spectrum disorder). The referral form included completion of a screening tool which records, in the patient's own words, their thoughts feelings, beliefs, and so on. The Community Adult Asperger's Service (CAAS) were unable to accept the referral because the screening tool section of the form was not completed.

1.20 JW's housing officer made numerous attempts to help him with his housing and mental health needs, as did his GP. Because JW was generally reluctant to interact with those trying to help him, these needs were not met, and another consequence was that he was not referred to the Asperger's service. He was not, therefore, receiving the help and treatment that he needed at that time.

1.21 After Covid restrictions came into force on 23 March 2020, JW was offered accommodation in a local bed and breakfast. This was as part of the government's response to the pandemic to ensure all people who were homeless and rough sleeping were provided with safe accommodation.

1.22 JW changed GP practices, and his new GP made him another referral to the Asperger's service, CAAS. The pandemic and lockdown restrictions meant that no face-to-face appointments were permissible. In April and June 2020 JW was offered two separate telephone screening appointments with CAAS. He declined both, and was discharged from the service, but with the understanding he could be referred again once face-to-face appointments were reinstated. On 5 June 2020 the CAAS wrote to his GP to update them on the situation, and recommended JW be referred for a social care assessment. No referral was made.

1.23 A family member contacted CAAS to explain that JW would not accept a telephone appointment. They expressed their concern about his vulnerability and homelessness, but were advised to contact social services themselves.

1.24 In June 2020 JW was arrested and detained for a sexual offence. While in custody he was referred again to the Criminal Justice Liaison and Diversion Service (CJLDS). Because of the Covid restrictions, they could not see JW in person. They recommended that JW had an appropriate adult assigned to support him through the process, as there were concerns about whether he had an undiagnosed neurodevelopmental condition.

1.25 JW was charged and released, with the requirement to attend magistrates' court on 14 July 2020 for sentencing. A Public Protection Notice (PPN) was also submitted regarding his escalating pattern of sexual behaviours, and his deteriorating mental health. These factors were suggestive of an undiagnosed mental health disorder. It was also recorded in the PPN that JW should be assessed in an all-male environment.

1.26 Although several different agencies were involved with JW over this period, no decisive and co-ordinated action was taken to provide a definitive assessment of the state of his mental health.

1.27 In June 2020 JW was arrested for several sexual offences, and arrested again on 4 July for further sexual offences. While in police custody his behaviour and mental health were causing concern. He was again referred to the CJLDS, but was difficult to engage with. However, his risk of harm to others based on his arrest details and history was assessed as high. JW was released from police custody on bail on 5 July 2020, to appear in court a few days later.

1.28 At this stage, given his history of sexual offending, the risks he posed to the public, and the likelihood that he would repeat the offence, there would have been a strong case for JW being remanded in custody in order to face charges in court, rather than released on 5 July, only to offend again and be re-arrested two days later. A referral to MAPPA (multi-agency public protection arrangement) would not have been appropriate at this time as an individual would need to be convicted of (or cautioned for) a relevant offence. JW did not fit the MAPPA criteria at this point. The decision making was in line with national guidance at that time.

1.29 He was arrested again on 7 July 2020 for sexual offences. He was denied bail, and was to attend a virtual court hearing on 9 July. His police custody record on 7 July notes that JW had come to the notice of the police ten times in the past year following a series of sexual offences, and he was demonstrating a pattern of escalating behaviour that was causing concern. His history of violence was also noted as a further concern.

1.30 At the virtual court hearing on 9 July, he was charged with three counts of sexual offences. His application for bail was refused by the court because there was a 'substantial risk of further offending'. He was remanded in custody and sent to a category B prison in the south of England.

Relevant mental health history while remanded in prison: 9 July – 27 October 2020

1.31 During his first days in prison, JW struggled to adjust, and he was closely monitored by the prison staff. His mental health was deteriorating: he had displayed the first signs of delusional thinking, but no mental health care plan was established other than the Assessment Care in Custody Teamwork (ACCT), which is a process specifically to mitigate the risk of self-harm or suicide. It is not intended to be a clinical care plan.

1.32 On 21 July 2020 the ACCT was closed as JW was no longer considered to be at risk of self-harming or suicide. He was assessed by the mental healthcare

team on 24 July, but did not fully engage in the process, and made further delusional claims.

1.33 On 28 July JW was moved from the single cell, where vulnerable prisoners are located, to the main wing. During the following nine days JW assaulted and injured other prisoners in two unprovoked attacks. As a punishment he was confined to a cell in the segregation unit.

1.34 JW's mental health continued to deteriorate and he was moved to the healthcare wing on 12 or 13 August, where he remained until 9 October 2020.

1.35 Initially he was relatively settled with occasions of poor behaviour: he would bang on his cell door for long periods of time. His nursing records on SystmOne (the electronic prison healthcare record system) were not always comprehensively completed. There is no record of an initial assessment to develop a care plan, and no care co-ordinator was allocated to him.

1.36 There followed a number of violent door-banging episodes, and JW was reviewed by the prison psychiatrist. Because of the risk of assault JW had been assessed as posing, this was conducted through the cell hatch.

1.37 The psychiatrist noted that JW appeared to be displaying symptoms of autism spectrum disorder – a developmental condition that affects communication and behaviour. He was to stay on the healthcare wing because of his perceived vulnerability and to enable observations to continue. Transfer to a hospital that specialises in acute mental health disorders and assessments was also considered.

1.38 JW was judged to be too unwell to appear at the next scheduled remote court hearing on 25 August 2020. The court was made aware that he had experienced a serious mental health episode, and asked for a full psychiatric assessment to be undertaken. His case was adjourned until 15 September 2020.

1.39 Over the next few weeks, JW's mental health deteriorated further. His behaviour was erratic, abusive and unsettled, and he was heard shouting threats to others. On 27 August he violently attacked two prison officers, one of whom was female and required hospitalisation for her injuries. The incident was reported to the local police, but their investigation was delayed, and was not completed before he was released from prison. The prison's review of the incident indicated this was a planned assault, with the prime target being the female officer.

1.40 A management plan was put in place requiring a three-person team in personal protective equipment, and the presence of a supervising officer, to be present whenever JW's cell door was unlocked.

1.41 On 3 September 2020 JW was reviewed by the prison psychiatrist, and on 7 September by the court-appointed psychiatrist. Both reviews had to be conducted at his cell door for security reasons. JW displayed disturbed and delusional behaviour on both occasions. After the first of these reviews the psychiatrist recorded that JW was suffering from a psychotic episode, and he was prescribed an antipsychotic medication. The two psychiatrists agreed that JW would benefit from assessment in a psychiatric intensive care unit (PICU).

1.42 JW's erratic behaviour in September was causing increasing concern among the prison and healthcare staff, and he was refusing to engage with his ACCT review, which had been reopened on 4 September. He was assessed at the highest level of risk of violence in prison.

1.43 The prison psychiatrist conducted another review of JW on 14 September 2020. Although JW's mental health had slightly improved, he remained unwell, with periods of agitation and distress. The antipsychotic medication dosage was increased.

1.44 A court hearing on 15 September was carried out in JW's absence – he was assessed as too unwell to attend. The court agreed to move to an interim hospital order, and requested a second psychiatric opinion. This order would allow for JW to be detained in hospital for assessment and treatment before sentencing. The court was informed of the three violent incidents in which JW had been involved while in prison.

1.45 JW was assessed by clinical staff from a mental health hospital on 22 September 2020. They concluded that he was a risk to others, and it was thought possible that he had been psychotic for some time. A transfer to a specialist hospital for further assessment and treatment was felt to be the best option. On 29 September, however, the hospital informed the healthcare team at the prison that they were unable to offer JW a place for a number of constraining circumstances. The hospital advised them to increase JW's antipsychotic medication dosage to the maximum recommended.

1.46 The prison psychiatrist reviewed JW again on 5 and 8 October 2020 (again through the cell door for security reasons) and concluded that his mental health and behaviour had improved, but that his symptoms were consistent with schizophrenia. They requested an assessment for autism spectrum disorder (ASD), as this was still considered another possible diagnosis. The

referral for this assessment was never formally recorded. They also consulted the court-appointed psychiatrist, who it was agreed would inform JW's solicitor that on release, JW would also require a mental health follow-up. There is no formal referral pathway to the Community Adult Asperger's service (CAAS) from prison for an assessment of ASD. The plan would be to inform the prisoner's GP on their release that this assessment was needed.

1.47 The prison psychiatrist also recorded a requirement for the healthcare team to write to JW's GP with a request for JW to be followed up on his release, and referred to the CMHT. This task was not completed. If it had been, his GP would have been aware of the medication JW had been prescribed, of the need to refer him to the local mental health team, and that he required an assessment for ASD with the Asperger's service (CAAS).

1.48 JW was transferred to the main wing on 9 October 2020. His nursing records provided no rationale for this transfer, or details about the care and treatment he should receive there. He adjusted well, and on 20 October his ACCT was closed.

1.49 On 27 October 2020 JW attended magistrates' court via video link. The court had received a report from the court-appointed psychiatrist stating that JW was responding to his antipsychotic medication, but his diagnosis remained uncertain. The report also noted that he would need follow-up with a community mental health team to ensure compliance with his medication, and an ASD assessment should take place. It further stated that he was mentally fit to be released into the community. The interim hospital order was no longer viable, and he was fit to be sentenced.

1.50 JW was sentenced to three custodial sentences of three months (one for each of the offences), each one suspended for twelve months. A Sexual Harm Prevention Order was imposed, which contained various restrictions which were to run for five years. He was also placed on the Sex Offenders Register for a period of ten years. As a result of this conviction, JW became the subject of multi-agency public protection arrangements (MAPPA) level one supervision, with the lead agency being local police. He was assigned to the case load of a police offender manager, a civilian police employee.

1.51 JW was released from prison later that day to no fixed above and provided with 28 days' supply of his antipsychotic medication.

Relevant mental health and forensic history following JW's release back into the community: 27 0ctober - 8 December 2020

1.52 On 29 October 2020 JW attended the local police station to complete his initial registration (in accordance with his release conditions). He informed the police that he was homeless.

1.53 On the same day the police violent and sex offender register (ViSOR) unit undertook a risk management (RM 2000) assessment of JW. He was assessed as being at high risk of sexual reoffending. He was to be placed on a regime of three-monthly visits as a minimum requirement. This assessment did not identify JW's potential risk to lone females, or his potential for violent behaviour. This basic assessment was not shared with any of the other statutory bodies involved with JW, such as the council's housing service or his GP. JW's housing officer located suitable temporary accommodation for him.

1.54 On 3 November 2020 the offender manager assigned to work with JW was informed that all outstanding high-risk visits were to be concluded in the next few days, before the forthcoming national lockdown in response the pandemic. In response to this order, he arranged to meet JW at the local police station on 4 November. The offender manager was not made aware of JW's violent assaults or of his mental health issues whilst in prison.

1.55 At this meeting the offender manager did not complete the active risk management system (ARMS). This is a dynamic and sophisticated risk assessment. It assesses areas such as sexual preoccupation, whether there are high levels of hostility/aggression, socialisation, opportunities to reoffend, mental health illness, and employment.

1.56 If JW had been regularly taking his prescribed antipsychotic medication, the 28-day supply provided for him on release from prison on 27 October would have run out on 24 November.

1.57 On 4 December 2020, by which time JW had probably gone ten days without taking his medication, he was arrested following an apparently unprovoked assault on two men in the accommodation where he was staying. While JW was in custody, the police were informed by the street triage service (via email as they were working remotely because of Covid restrictions) that JW was not under the care of the local mental health services, but that concerns had been raised about his mental health while he was in prison, and he had been prescribed antipsychotic medication.

1.58 The street triage information was not added to the police record system on the

night of JW's arrest (4 December); this is a task normally undertaken by the police. He was not 'marked up' for CJLDS attention on the police handover notes, and was released (on 5 December in the early hours) before that team came on duty. This may have been a missed opportunity for JW to have been given a face-to-face assessment with the CJLDS. If all the relevant information about him had been made available by other agencies, then JW may have been placed before the court and an application for a remand in custody made, rather than released on 5 December.

1.59 JW was charged with using threatening behaviour and actual bodily harm and released on bail at 01.20 on 5 December to appear in court on 5 February 2021. He was not allowed to return to his temporary accommodation.

1.60 JW was once again homeless and his family booked him temporary local accommodation. During the evening a family member contacted NHS 111 as they were concerned that JW was not taking his medication. Paramedics attended the accommodation where JW was staying. They completed their mental health assessment, which indicated that he had no suicidal intent and/or plans to self-harm, and identified an adult safeguarding concern. They gave him advice on what to do if his condition worsened, and they would make a referral to the out-of-hours GP service to discuss his concerns about his lack of medication.

1.61 JW telephoned the 111 service as soon as the paramedics left (01:00 on 6 December 2020) asking for help to obtain further supplies of his prescribed medication. After a number of exchanges with clinical staff, he said he did not want to discuss matters further.

1.62 JW's family remained concerned about his deteriorating mental health and on 7 December contacted his GP to enquire about how to obtain further supplies of his medication. An appointment was made for JW to see his GP the following day (8 December).

1.63 That afternoon (7 December) the offender manager met with JW at his accommodation. He went alone, although he was aware of the violent incident on the previous Friday, because he did not consider himself at risk. He reminded JW of his responsibilities under the Sex Offenders Register to report to the police station within three days of changing addresses.

1.64 The offender manager then attempted to help JW find alternative accommodation. The offender manager realised that the situation was deteriorating and considered JW's behaviour represented a potential threat to his safety, and withdrew.

1.65 The offender manager spoke with the accommodation duty manager and asked him to contact him when JW checked out. He then returned to the police

station, and completed a visit log to record the incident at the accommodation on ViSOR, the violent and sex offenders register database. His plan was to complete the ARMS risk assessment the following morning.

1.66 Later that afternoon JW's family continued to voice their concerns to the offender manager, particularly about JW not taking his medication. The offender manager appears to have believed that JW was being supported by his family and therefore any concerns he had were allayed. The family funded a further stay for JW at the accommodation.

1.67 On 8 December the offender manager began the ARMS risk assessment. He spoke to a senior officer about referring JW for multi-agency public protection arrangements (MAPPA) at level 2, as he felt it necessary to involve other agencies in his risk management plans.

1.68 On the afternoon of 8 December JW attended the appointment with his GP to request a prescription for his medication. The GP explained that the medication needed to be prescribed under supervision, with a structure or plan of treatment in place. The GP offered to refer JW to the CMHT, but he declined. The GP noted that they would contact social services and the safeguarding team for advice. JW left the surgery without any medication or prescription and returned to his accommodation.

1.69 It is clear that JW's family were trying to support him, while struggling to understand where and how to access help in the various complex systems.

9 December – the homicide

1.70 In the early hours of Wednesday 9 December 2020, JW attacked and killed the victim in the accommodation where he was staying. JW surrendered himself to the police that morning; he was arrested on suspicion of murder, charged, and remanded in custody. A consultant psychiatrist conducted a mental health review of him. On 10 December he was detained under section 2 of the Mental Health Act 1983 and taken to a secure mental health facility.

Court outcome

1.71 On 1 June 2021 he was convicted of manslaughter on the grounds of diminished responsibility, and was detained indefinitely in a secure mental health hospital under section 41 of the Mental Health Act.

Key themes

1.69 Summary of the most significant themes identified in this investigation.

Vulnerability/adults at risk

1.72 The Care Act 2014 (the Act) places a general duty on local authorities to promote the well-being of people in need of care and support when carrying out community care functions. In JW's case there were many examples over the period of the investigation, particularly in the two years (2019-20) before he was remanded to prison, when he was displaying vulnerability and self-neglecting behaviour.

1.73 The local authority Adult Access Team (AAT) were notified via a police Public Protection Notice (PPN) of JW's vulnerability and his deteriorating mental and physical health. They made two safeguarding referrals as a result of the PPN and reached out to his GP, and liaised with the Adult Access Team (AAT) and the learning disabilities team. Other agencies involved with JW during this period had at various times also identified him as being potentially 'at risk' and having significant difficulties managing his daily life.

1.74 The Community Adult Asperger's Service (CAAS) was contacted by a member of JW's family about his need for a face-to-face assessment for his possible Asperger's. They also expressed concerns about his living conditions and wider vulnerability, but were advised to contact social services themselves. CAAS did not consider whether they had a duty of care to act more decisively and to have made a safeguarding referral themselves. They did write twice to JW's GP suggesting the GP made a referral for a social care needs assessment, but only if they 'deemed it appropriate'. There is no evidence that the GP took this action.

1.75 The key aims of adult safeguarding are to prevent harm and to reduce the risk of abuse or neglect to adults with care and support needs. It is also about safeguarding them in a way that supports them in making choices and managing their lives. This is a statutory duty for the local authorities under the Act. There were a number of missed opportunities for the agencies that had contact with JW during the period under review to proactively safeguard JW, who clearly met the criteria for an 'adult at risk', by making a formal safeguarding referral.

Information sharing

1.76 Information sharing is an essential component of multi-agency partnership working and enabling local authorities to discharge their statutory obligation under the Care Act. Proactive, appropriate and lawful information sharing arrangements/agreements between the agencies that form this key strategic partnership need to be in place in order that their services can function effectively. Availability of relevant information to those working with service users is essential for robust and safe decision making, risk management and clinical assessment.

1.77 In JW's case there were numerous occasions when those working with him either did not have or seek access to all relevant information about him, or did not proactively share critical information about him with other key agencies.

1.78 The mental healthcare team at the prison should have ensured that mechanisms were in place to support timely and appropriate access to a range of health services for JW when he was released into the community. Discharge planning for his release from prison should have started at an early stage. The effectiveness of continuity of care depends on seamless case management and the relevant information being shared with the right people at the right time so that treatment and support can be targeted and continue to be delivered effectively. This is particularly important for people with specific mental health needs, whose continuation of prescribed medication needs to be managed.

1.79 The healthcare team at the prison should therefore have ensured that JW's GP, the local CMHT and social services all had the relevant information about his health needs, the medication he was taking, and his social needs, as he was released from prison to no fixed abode and was once again in a vulnerable position and homeless. This lack of information sharing had a direct impact on JW's inability to continue with the medication regime that had been started in prison and had appeared to be helping him manage his mental health needs. He also needed further assessment and support so that he could obtain a diagnosis for his mental health condition, along with an assessment to determine whether he had a neurodevelopmental condition such as ADHD or Asperger's, and the support or treatment that would be required to manage these conditions.

1.80 Because JW was a registered sex offender and therefore a MAPPA level 1 nominal when he was released from prison, he was subject to single agency supervision with the police as the responsible authority. The prison had a duty under the MAPPA guidance to share information with the police offender manager to ensure that any risk JW posed to the public was effectively managed, and that he was able to return safely to the community.

1.81 It would have been reasonable to conclude that the prison where JW was remanded had a duty under the MAPPA guidance to proactively share information held regarding JW with the responsible authority – the local police – when JW was released, if not before. There is no evidence to suggest that this took place.

1.82 The police had a duty under the MAPPA guidance proactively to seek relevant information from partner agencies, and in particular the prison, to enable them to carry out effective risk assessments and to develop risk mitigation strategies to protect the public and members of the agencies who came into contact with him after his release from prison from risk of harm from JW. This did not take place.

1.83 It is important therefore that all organisations involved in multi-agency practice in cases like this one are proactive in sharing, seeking and providing key information to allow for effective decision making.

1.84 Appropriate governance systems and processes should be in place to support safe prisoner release planning.

Leadership and accountability

1.85 When a case like JW's comes to the attention of multiple agencies as a result of an individual's unusual or transgressive behaviour, it is vital that there is a dynamic level of co-ordination and leadership in handling such complex cases, in which a pattern of offending and disruptive or abnormal behaviour becomes increasingly serious and/or starts to escalate or deteriorate.

1.86 From January to June 2020 JW's pattern of sexual offending behaviour continued to escalate, yet he was repeatedly released from custody. No individual agency which became involved with JW appeared to take ownership of his case or showed awareness that, although these were relatively low-level offences, he was beginning to pose an increasing risk to the community. The need for clear risk management planning and/or assessment and diagnosis of his mental health state was increasingly apparent, but not decisively acted upon.

1.87 Several local agencies were aware during this period of JW's history, but none took a decisive lead in in seeking to establish a clear understanding of the factors relating to his behaviour, and therefore to intervene to mitigate the risk of his pattern of offending behaviour worsening.

1.88 This did not even happen when he was released from prison at the end of October 2020, or in early December when he was arrested for actual bodily harm and public disorder following his apparently unprovoked assault on two men in the accommodation in which he was staying. The local police should have acted more proactively in seeking relevant information, especially from the prison service. This lack of information impacted on decision making during this critical period. If this information had been available, and given JW's potential homelessness on release, active consideration should have been given to remanding him in custody rather than releasing him on bail.

1.89 None of the agencies reporting on JW's mental health concerns put a clear plan in place to ensure he continued to have access to and management of the antipsychotic medication that was keeping his behaviour relatively stable at the time he was released from prison.

1.90 A structure or plan is needed whereby the kind of proactive risk assessment and management in multi-agency practice outlined above prevents an individual with complex, escalating needs and risks from falling through the net, as in JW's case.

Policies, protocols and guidance

1.91 Systems should be in place to ensure that national guidelines and policies are appropriately applied and followed, and any deviation from mandatory policy, guidelines or procedure should be challenged to ensure that standard practice is being followed and that the quality and safety of the services are being monitored and maintained. The rationale for any decision not to follow policy or guidelines should always be properly recorded.

1.92 When JW was first remanded in prison his mental health was identified on several occasions by the prison staff and mental health provider's team as in need of assessment and diagnosis, but no clear diagnosis was made for JW during his time in prison.

1.93 There was no evidence of joint mental healthcare planning for when he would leave prison. Opportunities for him to receive assessment, treatment and a diagnosis for his mental health condition in a specialist hospital when he needed them did not materialise. His symptoms were managed by antipsychotic medication which was appropriate for his presentation; the therapeutic interventions or treatment that should be offered to someone presenting with psychosis (and possible schizophrenia and ADHD) were not available in the prison environment. If he had received this inpatient care, he would have been likely to receive a formal diagnosis for his mental health with a care and treatment plan, and a plan to support him on release from prison.

1.94 The care planning approach, which is a framework for assessing secondary mental health needs and coordinating care was not used in JW's case. Instead, there was an over-reliance on the use of the prison ACCT process to record information and ensure that JW's behaviour remained stable and compliant.

1.95 The risk management and discharge planning for JW was not completed with the rigour or detail required by national guidelines for care after his release from prison. If it had been followed properly by the health care team in the prison, this might have ensured that JW had the access to the medication and the support and care that he needed in the community when he was released.

1.96 The guidance governing the police's lead role in supervising a released prisoner (who was a registered sex offender and thus a MAPPA level 1 nominal) on

discharge into the community should also have been followed more rigorously and comprehensively.

Provision of services

1.97 Prisons are highly complex organisations, operating within a framework of rules and regulations to ensure the safety of those working in them and the prisoners who are serving time. Many of those entering the prison as inmates have health issues. The Institute of Psychiatry estimates that over half of prisoners have poor mental health. It also estimates that around 15% of prisoners have specialist mental health needs (Mental Health Foundation, 2019).

1.98 The ability of the healthcare provider operating in the prison where JW was detained to provide high quality, safe health and mental health care to the prisoners was impacted by the broader issues across the prison service, such as loss of experienced staff, inconsistent training (especially in dealing with mental health issues among prisoners), staff shortages, and difficulties in recruitment and retention, further exacerbated by the Covid-19 pandemic.

1.99 NHS England Health and Justice team has responsibility for commissioning prison health care, and in April 2020 recommissioned prison health services at the prison where JW was detained, in line with the NHS England *Service Specification* (2018). A new independent healthcare provider was awarded the contract to provide these services from 1 July 2020; JW was remanded there on 9 July the same year.

1.100 When a new provider is commissioned in this way, as part of the mobilisation of the new contract, the commissioners, the incumbent provider and the new provider should carry out a risk assessment and any mitigation put in place to ensure a smooth and safe transition of service. This new independent healthcare provider experienced considerable workforce shortfalls from the start of the contract. They had an overall vacancy rate of 67%, as only 29 out of 79.5 whole time equivalent staff had transferred over to them from the previous provider. It is estimated that 47% of the prison population would require mental health interventions.

1.101 Key tasks were missed by a member of the healthcare staff working in the prison, and consequently the release plan for JW was never completed. He was released without having undergone the required preparation, briefing, liaison, or sharing of vital information with health, care and support services in the community (such as provision for the continuance of and access to his medication) through the electronic record systems available, including the summary care record.

1.102 NHS England Health and Justice are responsible for monitoring prison healthcare contracts, and for ensuring that services are being provided in a safe and effective way. They stated that they were provided with a workforce strategy by the independent healthcare provider in the prison, and had regular monitoring meetings with them.

1.103 NHS England undertook a quality assurance visit to the prison on 22 October, five days before JW's release. A summary report should be completed within thirty days of the visit, and recommendations made by the review team would form the basis of the healthcare improvement action plan, which would be monitored via the contract review meetings with the commissioner (Health and Justice). No detailed report of this visit was published, but there was a quality improvement action plan arising from it. This makes no detailed reference to clinical processes or service delivery, but relates largely to matters of the prison environment and cleanliness/infection prevention and control.

1.104 The independent healthcare provider in the prison have acknowledged that JW was not released into the community in line with the required guidelines that should have provided him with continuity of care, treatment and support when he returned to the community. They stated that they have improved their performance management and governance systems, and are in the process of introducing a care programme approach for prisoners with mental health needs.

Other factors to consider

1.105 In this summary and analysis of the care, treatment and management of JW, it is important to acknowledge that there were a number of other factors that might have had an impact on the way various agencies managed his case.

1.106 One of these was the restrictions imposed at times within the period of this investigation by the regulations concerning the Covid-19 pandemic. Organisations had to change the ways they worked, and this curtailed some of their most effective working practices. Many had to delay any but essential work, and had to prioritise what they could do, for example in reducing or removing their capacity for assessing individuals face-to-face. The report indicates occasions when JW was not able to be seen by agencies in person because of these restrictions; this may have delayed his being given the support he needed.

1.107 All of the agencies involved had heavy workloads, including during the time of pandemic restrictions, and some, like the healthcare team working in the prison, did not have their full complement of staff. They would also be dealing with high numbers of cases which presented multiple, complex issues, and it is not always possible in the day-to-day process of working to

recognise readily which individual cases represent high risk, or when escalation of intervention might be required, when so many individuals could potentially fall into such categories, or do not always present with indicative warning symptoms or behaviour.

2. Conclusion

2.1 This was a particularly brutal crime, and the victim's family will have been traumatised by their untimely death. This was a young person in the prime of their life, with so much to look forward to, and this potential has been violently taken away from them and their family.

2.2 This report has identified a number of omissions and gaps in the quality of the care, treatment and management of JW prior to the incident of homicide in December 2020. There was no consistently decisive leadership and ownership among the various agencies that dealt with JW, and they did not always adhere to national guidelines and policies. This included the release into the community of JW from prison in October 2020 without the health care provider having put in place an appropriate care, support and treatment plan that should have continued to manage and monitor his mental health condition and behaviour.

2.3 The omission of the proactive information seeking and sharing, particularly by the police, the prison service, the independent healthcare provider in the prison, and JW's GP practice, resulted in the risk JW posed to the community being underestimated and therefore not effectively managed. These omissions and gaps also resulted in his mental health condition deteriorating rapidly as a consequence of his inability to access and continue taking the medication that was largely successful in stabilising his behaviour.

3.1 Recommendations

3.1 The commissioners of this investigation, NHS England, will ensure that each of the individual and statutory agencies involved in the care and treatment of JW will develop (a) robust action plan(s) to address the recommendations outlined below.

Vulnerability/adults at risk

R1 All agencies involved in this investigation should ensure that they have an appropriate plan in place to identify an individual's serious escalating behaviour at an early stage to enable effective multi-agency oversight and co-ordination. The Safeguarding Adult Board, who have responsibility for holding statutory partners to account, should ensure that this is in place and

satisfy themselves that relevant partners understand that perpetrators who pose a risk to the public may have care and support needs themselves.

R2 Statutory organisations who receive public protection notices (PPN) need to undertake a review of how they effectively consider the information contained within PPNs so that they take appropriate steps in respect of the person who is the subject of the report.

Information sharing

R3 The local criminal justice board (LCJB) should satisfy itself that all statutory agencies understand the information sharing agreements that are in place with partner agencies, and that a culture of proactive, lawful information sharing is developed to address both the needs of the service user and to minimise risk to the wider public.

R4 Consideration should be given to developing an information sharing process that could establish multi-agency meetings where an offender in prison is on short-term remand and considered to be considered at significant risk to the public but are not currently a MAPPA subject.

R5 The healthcare provider in the prison should ensure that it has robust systems and processes in place to ensure that timely and appropriate information is shared with known relevant health services for a prisoner due to be released, so that the right treatment and support can continue to be delivered effectively.

R6 To enable offenders to be managed safely in the community, the criminal justice system should review release planning arrangements for those remand prisoners released suddenly from court to enable offenders to be managed safely in the community.

R7 Where local police are acting as the lead agency for a MAPPA subject, they should ensure that police offender managers understand the need proactively to take reasonable steps to seek relevant information from known agencies to inform the risk assessment process and subsequent risk management plan.

R8 Operational staff and supervisors within Sexual or Violent Offender Manager (MOSOVO) units should understand the College of Policing guidance on third-party disclosure, recognise when it is required, and be confident in using it appropriately.

Leadership and accountability

R9 The local police should ensure that the risk management process for persons

under MAPPA is conducted at the earliest opportunity in order to identify the risks to the public, staff and the nominal themselves.

R10 The local police should encourage and support the use of the dynamic ARMS risk assessment, particularly where mental health issues, violence and escalating behaviours are identified.

Policies, protocols and guidance

R11 Recognising the complexities involved in arranging care and support for vulnerable prisoners released suddenly from custody, the Ministry of Justice should consider convening a multi-agency group comprising senior representatives from all relevant agencies to undertake a review to improve safeguarding and safety planning within national release pathways. This should include, but not be limited to, the specific consideration of the needs of those with mental health, or neuro-diverse issues and those who are to be released to no fixed abode.

R12 NHS England Health and Justice must ensure their monitoring arrangements identify any lapses in compliance with standards and plans to rectify them are put in place.

R13 The healthcare service in the prison should actively implement the care programme approach (CPA) or the Community Framework for all prisoners who present with complex mental health needs. This will provide a well-established framework to ensure continuity of care, joint working and effective information sharing takes place.

R14 The healthcare service in the prison should ensure that their clinical staff understand their responsibilities under their respective codes of practice, and that systems are in place for compliance with their codes to be monitored through clinical supervision and managerial challenge.

Provision of service

R15 NHS England need to ensure their quality assurance visits to prisons provide clear recommendations and when relevant are shared with the relevant Integrated Care System. Also, sharing relevant information with health and justice commissioners to enable them to monitor and ensure the healthcare service in the prison deliver high quality and safe care and that any emerging risks are identified and acted upon.

R16 NHS England's Health and Justice team need to gain robust assurance from the healthcare service in the prison that it has the governance, performance systems

and processes in place to ensure it is delivering high quality and safe care.

R17 NHS England's Health and Justice Team should work with all healthcare provider agencies to ensure that SystmOne functionality is maximised to promote appropriately accessible sharing of important information between prisons and community services when a patient transfers in and out of secure and detained settings. It must be ensured that within this due consideration is given to NHS England plans for Accelerating Citizen Access to GP Data (1 November 2022).

3.2 Having set out these recommendations, it is important to acknowledge that the local police have taken steps to address identified areas for improvement. The investigation team have not had the opportunity to evaluate this work, but have seen two action plans, one arising specifically from JW's case, and the second from a peer review of the local police MOSOVO unit carried out in July 2021. Actions identified within the plans include:

- Additional training for MOSOVO staff on the use of ARMS, risk management planning and mental health.
- A review of all current cases for escalating behaviour issues and for consideration of third-party disclosure.
- Development of a performance framework for the MOSOVO unit that will include resourcing against demand, and supervisory quality assurance of ARMS assessments.
- Improved supervision of ViSOR records

Appendix One – Terms of Reference

Independent Review of the Care and Treatment received by JW prior to an incident of homicide in December 2020

Purpose of the Review

- To independently assess the quality of the care and treatment and the management of JW against best practice, national guidance and relevant organisational policy.

- To identify further opportunities for learning that may be applicable on a local, regional or national basis.

The outcome of this review will be managed through corporate governance structures in NHS England, the Clinical Commissioning Group, NHSE Specialist Commissioning and the provider's/other statutory agencies formal Board sub-committees.

1. Terms of Reference

NB: The following Terms of Reference remain in draft format, until they have been reviewed at the formal initiation meeting and agreed with the families concerned.

1.1 Produce a full chronology (from 2017) of JWs contact with Mental Health, Primary Health Care, other statutory services (Police, Social Care etc) and third sector services to determine if his healthcare needs and risks were fully understood.

1.2 Determine if there were any incidents or events prior to 2017 that may have indicated a deterioration in JW mental state or an escalation of risk behaviours'.

1.3 Consider whether there was a shared understanding across agencies, of the risks (violence, aggression and sexual offending) and vulnerabilities presented by JW in

- The home environment
- The community (pre custodial sentence)
- Prison
- The community (post custodial sentence)

1.4 Review the Forensic assessment completed in September 2020 and determine how that contributed to risk management plans within the prison and community.

1.5 Given the apparent escalation in behaviours between February 2018 and remand should a MAPPA referral been considered prior to detention in prison?

1.6 Identify any factors that hindered the risk assessment and management processes across agencies.

1.7 Were the Court made aware of JWs vulnerabilities at the hearing on 27/10/2020

1.8 Review the referral process/pathway for Adult ASD assessment between primary care and the CAAS team against best practice/local policy.

1.9 Determine what steps were taken following the recommendation for community based ASD assessment whilst in prison and whether a referral pathway exists between prison and local services.

1.10 Review the quality of interagency and inter-service liaison, communication, decision making and planning at the time of JWs release from prison with particular reference to support for mental health and housing needs.

1.11 Determine whether there were any missed opportunities to engage other services and/or agencies to support JW following his release in October 2020.

1.12 Identify any missed opportunities for intervention by mental health services with particular reference to JWs detention on 5th December 2020 and that thresholds/criteria for referral pathways between agencies are understood and responsive.

1.13 Determine if there were there any missed opportunities to make disclosures regarding risks that would have safeguarded the public

1.14 Determine whether there were any missed opportunities to engage other services and/or agencies to support JW's Family.

1.15 Having assessed the above, comment on relevant issues that may warrant further investigation

1.16 Make recommendations for the Provider, CCG and/or NHS England and other relevant agencies as appropriate.

2. Family Questions:

2.1 What were the conditions and elements of control and supervision that the judge's sentence of October 27th 2020 (which releases JW) established, what was their purpose, who was entrusted to comply with and implement those measures and what competencies did they have to ensure its observance.

3. Timescale

3.1 The review process starts when the investigator receives the Provider documents and the review should be completed within 3 months thereafter.

4. Initial steps and stages

NHS England will:

4.1 Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.

4.2 Arrange an initiation meeting between the Provider, commissioners, Investigator and other agencies willing to participate in this review.

5. Outputs

5.1 We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

5.2 A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proofread and shared and agreed with participating organisations and families (NHS England style guide to be followed).

5.3 At the end of the review, to share the report with the Provider and meet the victim and perpetrator families to explain the findings of the review and engage the Clinical Commissioning Group with these meetings where appropriate.

5.4 A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

5.5 A briefing document of key learning points that can be shared with the Regions, CCGs and Providers.

5.6 The investigator will deliver learning events/workshops for the Provider, staff and commissioners if appropriate.

6. Other

6.1 Should the families formally identify any further areas of concern or complaint about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

Appendix Two – Public services involved

A2.0 The local **HealthCare University NHS Foundation Trust** is responsible for all mental health services and many physical health services in the local county, delivering both hospital and community-based care. This includes specialist learning disability, addiction, and community brain injury services. They serve a population of almost 700,000 people across the local county. Mental health inpatient services are provided at a local Mental Health Hospital. The trust is also responsible for providing the Community Adult Asperger's Service and the Criminal Justice Liaison Diversion Service, among many other community and inpatient services.

A2.1 A local hospital run by **HealthCare University NHS Foundation Trust** provides assessment and treatment for a wide range of mental health illnesses, supporting people aged 18 and over who are in an acute phase of their illness and working towards recovery. Inpatient services include a specialist, low secure forensic ward for male offenders with mental health problems, and a specialist psychiatric intensive care unit (PICU) for patients who are in extreme crisis.

A2.2 The **Community Mental Health Team (CMHT)** is an integrated team which includes social workers, it is hosted by the local HealthCare University NHS Foundation Trust provides care, advice and information for people over 18 with significant mental health problems, including:

- schizophrenia and psychotic or delusional disorders
- affective disorders such as mania, manic depression and moderate/severe depression
- eating disorders
- organic mental disorder
- significant mental health problems following childbirth
- phobias, anxiety disorder, post-traumatic stress disorder and obsessive-compulsive disorder
- personality disorders that cause significant distress or risk to the individual or others

A2.3 Their goal is to help people manage or recover from their conditions and lead healthy, fulfilling lives.

A2.4 **Community Adult Asperger's Service (CAAS**) provided by the local HealthCare University NHS Foundation Trust offers a wide range of services to people diagnosed with an autism spectrum condition

(Asperger's Syndrome or High Functioning Autism). They work with people over 18 who do not have a learning disability, providing a range of person-centred care and support. This includes:

- diagnostic assessment, including second opinions
- group work, including post-diagnostic and sensory groups specialist occupational therapy assessments and interventions, alongside consultation by occupational therapists and psychologists
- advice and signposting to other relevant agencies, services, and groups
- advice on seeking an assessment of social care needs
- support to professionals in different teams and agencies to improve their understanding of the condition

A2.5 The team includes clinical psychologists, a consultant psychiatrist, occupational therapists, assistant psychologists, and team assistants. The referral pathway to Community Adult Asperger's Service is via the person's GP.

A2.6 The **Criminal Justice Liaison and Diversion Service** (CJLDS) is provided by the Healthcare University NHS Foundation Trust and works alongside the police to support people with mental health and other needs (including learning disabilities/difficulties) in police custody, courts, and the community. They identify vulnerable people in the justice system and provide the specialist assistance they and their families may need.

A2.7 These are the main roles within the service:

- mental health practitioners, who carry out assessments of people in police custody identified as having a vulnerability.
- support time recovery staff, who work with people with specific, unmet needs. They work with people for up to four weeks, providing help, where appropriate, with accessing services around mental health and drug or alcohol dependency, as well as issues such as housing, debt problems and benefits.

A2.8 The aim of the service is to divert people, wherever possible, out of the youth and criminal justice systems into health, social care or other supportive services, and reduce re-offending.

A2.9 The **Street Triage Service** is a multidisciplinary team of experienced mental health nurses, social workers and occupational therapists,

support workers and peer specialists. Working largely via telephone, the qualified practitioners are experts in de-escalating crisis and coaching people in distress tolerance and emotional regulation strategies. As well as telephone-based work, the role also entails completing face-to-face urgent assessments. Working from 07:00 to 03:00, they provide the police with details about arrested suspects' mental health status to help manage them while they are in custody.

A2.10 **An independent healthcare provider** delivers round-the-clock healthcare to more than 40,000 patients at over 45 prisons of all categories. Prisons are treated as a community and have access to the same kinds of health services as anyone within the wider community. These include reception health checks on arrival and regular GP services to help with substance misuse, mental health, chronic or long-term conditions, podiatry, physiotherapy, and optometry.

A2.11 **The Local Authority (Housing Department)** has various statutory duties under the housing legislation to help those who are, or are at risk of becoming, homeless. This includes helping homeless people in their area to find accommodation. To achieve this, they have a team of staff who will engage with homeless people and, with their cooperation, enable them to seek and secure housing.

A2.12 During the Covid-19 pandemic councils were required to reduce the number of people who sleep in the open or on the streets. As hotels were closed to the general public, they were used to house those people in the council geographical area who were sleeping outdoors without a home or shelter.

A2.13 The **Local Authority Adult Access Team (AAT)** provides a single point of access for adult social care support.

A2.14 The role of **general practitioners** (GPs) is to treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the whole person's health, combining physical, psychological, and social aspects of care. The GP is the main conduit of a person's care.

A2.15 The **NHS 111 telephone health assessment service** is a free-to-call medical helpline. It is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues. It helps people access advice, support and treatment when they urgently need it; various clinicians are employed to provide this.

A2.16 In many cases NHS 111 clinicians and call advisers can give patients advice using set algorithms without using another service such as their GP or accident and emergency (A&E) services. If needed, NHS 111 can book patients in to be seen at their local A&E or an urgent treatment centre. They can also refer to emergency dental services, pharmacy, or other more appropriate local services and send an ambulance should a patient's condition be serious or life-threatening.

A2.17 **NHS England Health and Justice** is responsible for commissioning healthcare for children, young people and adults across secure and detained settings. This includes prisons, secure facilities for children and young people, police and court liaison and diversion services and immigration removal centres. It is responsible for commissioning £503 million of services to meet a wide range of health and care needs across detained and secure settings, and also sexual abuse/assault services. The ambition is to narrow the health inequalities gap between those in the criminal justice system and the rest of the population and improve their outcomes. They aim to support a reduction in the number of people who are detained as a result of undiagnosed and untreated mental health issues and also support continuity of care after release.

A2.18 The local **County Police** core responsibilities are: to protect life and property; to preserve order; to prevent the commission of offences; to bring offenders to justice. They are also one of the core agencies responsible for safeguarding children and vulnerable adults.

A2.19 **Her [now His] Majesty's Prison and Probation Service (HMPPS**), previously known as the National Offender Management Service, work with partners to carry out the sentences given by the courts, either in custody or within the community. They seek to reduce offending by rehabilitating the people in their care through education and employment, as well as ensuring that the appropriate support is in place, particularly for those leaving prison.

A2.20 The prison service keeps those sentenced to imprisonment in custody, helping them to lead law-abiding and useful lives, while they are in prison and upon release. They should assess the level of risk of harm presented by offenders, managing that risk while the offender remains in custody, and then share information with partners to inform the risk management process and to enable released offenders to be managed safely in the community.

A2.21 Although the police would be responsible for serious crimes committed within a prison establishment, lower-level offences, including assaults on other prisoners, can be legally dealt with by the prison governor under the adjudication process without referral to the police.

A2.22 The **Probation Service** supervises offenders sentenced by the courts who are either released into the community on license, or subject to a community sentence. The probation service works with relevant partners to ensure such offenders are safely and effectively managed. They have responsibility for assessing offenders in prison to prepare them for release, and where they are released under probation supervision.

A2.23 The Criminal Justice Act 2003 provides for the establishment **of multi-agency public protection arrangements (MAPPA)** in each of the 42 criminal justice areas in England and Wales. They are designed to protect the public from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies to work together in partnership to manage these offenders. MAPPA is not a statutory body in its own right, but a process through which relevant agencies can better discharge their statutory responsibilities and better protect the public in a co-ordinated manner.

A2.23 **Partnership Co-ordination Groups (PCGs)** were established in 2015 and are held in each former district or borough area of the local authority. They are multi-agency meetings established to be intelligence-led and outcome-orientated. The aim of the meetings is to reduce and prevent crime, disorder and anti-social behaviour and safeguard identified individuals. PCGs are chaired by the borough police chief inspector for community safety. The local PCG provides information to the county Community Safety Partnership, which is accountable for all statutory duties placed on community safety partnerships.