BWRDD LLEOL DIOGELU PLANT GWYNEDD & YNYS MŌN

LOCAL SAFEGUARDING CHILDREN'S BOARD

ADOLYGIAD ACHOS DIFRIFOL

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY REPORT

CHILD J

SERIOUS CASE REVIEW
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EXECUTIVE SUMMARY
9 MAY 2014
NON DAVIES, BAAF CYMRU

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INTRODUCTION

Child J, the subject of this Serious Case Review was born on 6 June 2009, the third child to his birth parents.

On the 30 March 2012 J, then aged 2 years and 9 months was found deceased along with his mother at their home which they shared with J's father and two older siblings.

J's father was arrested at the scene and on the 1 April 2012 he was charged with the murder of Child J and Child J's mother. He was initially remanded in prison, however, following a psychiatric assessment he was moved to a secure mental health unit.

On the 31 July 2012 Child J's father pleaded guilty to the manslaughter of Child J and Child J's mother and not guilty to their murders on the defence of diminished responsibility. He was sentenced on the 24 August and was detained for an indefinite period under the provisions of the Mental Health Act 1983.

The Gwynedd & Ynys Môn Local Safeguarding Children's Board agreed that Child J's case fell within the criteria for undertaking a Serious Case Review in accordance with Regulation 4 of The Local Safeguarding Children Board (Wales) Regulations 2006.

As the Gwynedd Community Safety Partnership had a statutory requirement to conduct a Domestic Homicide Review in relation to the death of Child J's mother, it was agreed that there would be a Joint Serious Case Review / Domestic Homicide Review Panel to address the requirements of both processes.

Due to a combination of factors there has been a significant period of delay in this process.

THE SERIOUS CASE REVIEW

Terms of Reference

Purpose of the Serious Case Review:

- To establish whether there are any lessons to be learned from this case about the way in which professionals and agencies work together to safeguard children.
- To identify clearly what the lessons are, how they will be acted upon, and what is expected to change as a result.
- To identify good practice.
- To consider whether the actions of each agency were in accordance with the relevant legislation, regulations, statutory guidance, All Wales Child Protection Procedures and agency policies and procedures.

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Scope of the Serious Case review:

- The responsibility for overseeing, convening and chairing the Serious Case Review will remain with Gwynedd & Ynys Môn Local Safeguarding Children Board's Serious Case Review Panel.
- The Independent Chair of the Serious Case Review Panel is an Assistant Director of Children's Services Barnardos.
- The Independent Author will be recommended by the Serious Case Review Panel and commissioned by the Local Safeguarding Children's Board
- The period covered by the Serious Case Review was 4 November 2008 – 30 March 2012.
- Health Inspectorate Wales have not as yet conducted an external Mental Health Review.
- Relevant information regarding the wider family will be included and relevant members of the extended birth family will have an opportunity to be included in, and contribute to the review.

The Joint Serious Case Review and Domestic Homicide Review Panel:

The membership of the Panel is made up of representatives from the agencies and organisations as follows, Public Health Wales, Betsi Cadwaladr University Health Board, North Wales Police, Gwynedd County Council, Gwynedd Community Safety Partnership, Hafal and the South Gwynedd Domestic Abuse Services.

The Joint Panel met on nine occasions and the SCR Independent Overview Author met with the authors of the Internal Management Reports separately on one occasion.

The SCR Independent Overview Author worked closely with the Chair of the Joint Panel and the author of the Domestic Homicide Review throughout this process.

Timescale of the Review

The initial timescale for completion was six months from the date of commission, May 2012. Due to a combination of factors this timescale was not attainable. Welsh Government has been closely informed as to progress throughout this process.

Basis of the Report

- The following agencies completed a Chronology of Events and Internal Management Review:
- Public Health Wales Safeguarding Children Service (BCUHB Midwifery, Health Visiting and General Practitioner services in relation to Child J, Child J's mother and

Child J's siblings, School Nursing and Hospital Records); North Wales Police; Gwynedd Social Services (Adult); Gwynedd County Council Local Education Authority and Hafal, a voluntary mental health support organisation who had been commissioned to undertake statutory carer assessments.

- Betsi Cadwaladr University Health Board had also conducted an internal Serious Case Review Report in relation to Adult Mental Health and General Practitioner services in relation to Child J's father, which was made available to the overview author in July 2013.
- The following agencies reported that they had no contact with the family during the review period:
  Gwynedd County Council Social Services Children's Department; Bangor and District Women's Aid; Wales Probation Trust; All Wales Domestic Abuse and Sexual Violence Helpline; South Gwynedd Domestic Violence Services and North Wales Fire Service
- The individual agency chronologies were merged and the author wishes to thank North Wales Police for their assistance in this regard.
- In May 2013 additional information and clarification was sought and obtained by the BCUHB Health Internal Management Review Author (employed by Public Health Wales); NWP, Gwynedd SSD Adult and Children Services and Hafal.
- Following receiving the BCUHB (Adult Services) Internal Serious Case Review Report in July 2013 additional information and clarification was sought and obtained.
- In August 2013 additional information and clarification was sought and obtained from the NWP in relation to prosecution information.
- The Author met with relevant extended family members.

Messages from the Serious Case Review process

- The provision of central administration has been a critical factor in maintaining momentum during this process
- This case highlights the difficulties in gleaning the child's experience and 'voice' (subject of the SCR and siblings) and reflecting it in the Serious Case Review process and overview report.
- The Independent Overview Author wishes to thank everyone for their helpful and considered contributions to this process during a particularly sad and difficult time for all those involved.

Summary of the Agencies' Involvement during the designated parameters of the Serious Case Review, 4 November 2008 - 30 March 2012

On the basis of the information available it appears that neither the School Nurse nor the relevant schools had any concerns about the family and were unaware of the longstanding mental health related intervention and expressed concerns.

Gwynedd County Council Social Services Children's Department had no contact with this family and did not receive the Public Protection Referral Form CID 16s.

Five health professionals were identified as working with this family, namely the Midwife (involved for a designated time), Health Visitor, General Practitioner, Consultant Psychiatrist and Care Co-ordinator (with some student involvement). A Locum GP re-referred him to the Consultant Psychiatrist in August 2011.

The GP as the constant practitioner involved with all members of the family throughout this period had a pivotal overview role.

The SCR period has been considered in three sections.

November 2008 – April/July 2010

At the time of the ante natal booking November 2008 the Care Co-ordinator (involved since March 2006) and Consultant Psychiatrist (Psychiatric involvement since 1998) were involved with Child J's father on a fortnightly and quarterly basis respectively and this pattern of involvement continued until April / July 2010 respectively by which time Child J was 12 / 15 months of age.

The Midwife was involved for a pre-determined time and the HV became and remained involved as would be expected for a child under the age of five. The level of health visiting service had been determined as Standard rather than Enhanced due to the classification of 'risk' and 'need' on the basis that the involvement of other agencies was not known to the Midwife and Health Visitor.

The Care Co-ordinator 'discharged' Child J's father into the care of his GP in April 2010 and the Consultant Psychiatrist 'discharged' Child J's father 'from the secondary mental health services' in July 2010.

April/July 2010 – August / September 2011

NWP's twelve month involvement with Child J's father begins during this period (October 2010) and concludes (October 2011) at the same time as the second Consultant Psychiatric 'discharge' of Child J's father from the Care Programme Approach. The first NWP contact of 6 October 2010 is viewed as a potential e-crime. Subsequent contacts and increased concerns during the period up to May 2011 culminate in the making of two telephone calls

and the submission of a Public Protection Referral Form (CID 16) to the Community Mental Health Team.

During this period on 12 May 2011 the Health Visitor follows up Child J's hospital admission which may have led to an increased awareness of Child J's father's health situation.

During this period the HMR notes that Child J's father continued to see his GP during the first half of 2011. It is the 17 August 2011 Locum GP's re-referral to the Consultant Psychiatrist which ends the 16 month and 13 month period of Care Co-ordinator and Consultant Psychiatrist non –involvement. This referral suggests that Community Psychiatric Nurse involvement would be helpful.

On the 30 August 2011 Child J's mother sees GP to express 'grave concerns' about Child J's father.

September 2011 – March 2012

Child J's father is seen twice by the Consultant Psychiatrist (1 and 8 September) who asks the Care Co-ordinator to resume contact with him. Following Child J's father's failure to attend two further CP appointments (15 and 27 September) he is again 'discharged' from the service, although he remained involved with the Care Co-ordinator until March 2012 (with some Student involvement).

Following two further visits to his GP (30 September and 5 October) and on his request he is re-referred to the Consultant Psychiatrist again as he had 'paranoid delusions'.

On 4 October NWP's noted concern about Child J's father's 'delusional behaviour' and expressed concern 'that his wife may be having problems with his behaviour' resulted in the submission of a further CID 16 and a Protection of Vulnerable Adult referral to the Community Mental Health Team, a concern which is communicated to the GP.

On the 10 October Child J's father had expressed that he had thought of harming himself with a gun, although the NWP were involved with the retrieval of the gun, the express connection between the 'gun incident' and Child J's father was not made at the time.

Further concern about Child J's father expressed by the Care Co-ordinator and the GP resulted in two further appointments to see the Consultant Psychiatrist, (11 and 18 October 2011), who following this 'made no arrangement to see him again'.

During October 2011 Child J's mother requests an assessment of her own needs and a referral is made to HAFAL, a voluntary mental health support organisation who remain

involved with her until March 2012, with 2 appointments / interviews noted (21 December 2011 and 18 January 2012).

An 8 December 2011 ‘999 incident’, wherein Child J’s father is described by the Emergency services who visited as being depressed, results in liaison with the GP.

Summary of Themes and Conclusions

This case highlights the difficulties in providing services to adult clients or patients who, are themselves partners, have partners and are parents to dependant children.

Child J's Voice

The lack of direct child testimony in both the case notes and the agencies' subsequent documentation appears to resonate throughout this case. There are no self- reported references to the experience of the three children as members of this family.

The Voice of Child J's Mother

There is some self-reported testimony from Child J's mother. Some of this information relates to frustration and difficulties whilst other information is positive and gave no indication of her feeling threatened or at risk. In January 2012 she made a statement to HAFAL that she did not want information shared with anyone.

There were opportunities for her to see professionals on her own and during September and October 2011 both the Consultant Psychiatrist and the NWP were concerned enough about her situation to request that she be seen alone.

Voice of the wider family members

An invitation to meet directly with the siblings, made through their carers, was declined by Child J's siblings.

The author met with four of the wider family members and they were asked what messages they wished to convey. They wished to emphasise that, when dealing with families, mental health services should consider all members of the family and especially children. They felt that where relevant, the wider family as well as the patient and the 'next of kin' should be consulted as the 'next of kin' may be too emotionally involved with the patient.

Understandably the most pressing concern expressed by the wider family members was the current and future well-being of Child J's siblings.

Assessment of Need and Risk - Child

Quantifying and agreeing levels of 'need' and 'risk' i.e. thresholds of Child in Need and Child in Need of protection / at risk of harm within and across agencies forms part of a very difficult balancing act which requires the application of confident professional judgement in assessment. In her review Munro refers to Lord Laming's conclusion in the Victoria Climbie Inquiry Report:

"What is needed most of all is a structure in which there is no ambiguity about the decision-making process for the quality of services to children and families" (4.1)

Whilst parental mental health in itself is not prohibitive to successful and safe parenting the statistics and messages (Ofsted 2010) about the prevalence of contributory factors such as mental illness, substance misuse, alcohol and domestic abuse related factors in Serious Case Reviews are reinforced by Cleaver et al (2011), highlighting the need for early identification and assessment of parental factors which may impact on children.

In respect of mental health this balancing act involves different assessment processes (Framework for the Assessment of Children in Need 2001 and the Care Programme Approach 2003); different thresholds of intervention; different status and levels of client self -determination and different providers' duty of care. Whilst in most cases and circumstances the needs of adults and children are synonymous, one with another, it is essential that the arrangements to identify and cater for the possibility of divergence in needs, reflect the differences outlined above.

Although within the individual agencies' SCR related information reference was made to respective individual agency guidance (NWP POVA Guidance 2010; North Wales Multi - Agency Protocol 'Supporting Children, Supporting Parents – A framework for Safeguarding Children 2009) there is no evidence to confirm that the daily impact of the parental mental health (in terms of parenting capacity and father – child; mother – father; mother – child; child - child relationships and possible status of the children as 'young carers') was identified, assessed and quantified in a formal way.

Undoubtedly Child J's mother was a good, caring and protective parent and understandably she was viewed as a protective factor in the family and household. Indeed this assumption may in itself have become a risk factor. However, there does not appear to have been an appreciation of the impact of Child J's father's mental health on her parenting capacity or an appreciation that adult needs and welfare may diverge from the children's needs and welfare. In the author's opinion the increase in levels and sources of concern during the period August 2011 onwards led to a consideration of Child J's mother's predicament/situation but not to a consideration of the impact on her functioning as a parent and on the predicament / situation of the children who had the least control of the situation they found themselves in.

There is evidence that the practitioners involved were conscientious and caring and that the immediate welfare of the children would have been considered during home visits. However, there is no evidence that a discrete formal consideration of the children's needs,

which may have resulted in a multi -agency assessment and sharing of information, was undertaken, thus enabling a revisiting of, and projection of thresholds of need and /or risk.

In the same way that the BCUHB Health Internal Management Review author concludes that the birth father was viewed as being 'on the periphery' in respect of child health services, it appears that the child was 'on the periphery' in respect of adult mental health services. This leads to a view that the complex family dynamics were being considered in a fragmented way within a vacuum which failed to appreciate that the respective parent – parent and parent – child dynamics were inextricably linked.

Indeed it appears that the child health services professionals were on the periphery in respect of adult mental health services as the Midwife and Health Visitor were unaware of the longstanding involvement of adult services. During the October 2011 period of increasing expressed concern from a variety of sources the Health Visitor undertook a routine Child Development Assessment completely oblivious to the concerns including those expressed in the CID 16 Public Protection Referral Form of the same period.

Education and teachers play such a vital role during childhood in providing support as well as education. It is reported that the relevant schools had no concerns about the children's home lives. On the basis of the information available it appears that neither the School Nurse nor the relevant schools had any concerns about the family and were unaware of the longstanding mental health related intervention and concerns including those expressed in the CID 16 Public Protection Referral Forms.

Assessment of Need and Risk - Adult

There was longstanding involvement between Child J's father and the mental health services. The BCUHB Serious Case Review Report highlights the dilemma in relation to diagnosis in this case:

"[he] did from time to time express paranoid ideas to various people but they were not consistent and they were frequently later denied"(6.1 /p.12).

From the documentation it is evident that voluntary hospital admission had been offered to Child J's father twice, (8 September and 5 October 2011). The family's understanding (not confirmed by any other source) was that consideration had been given to a Section under The Mental Health Act 1983 'a few months' before the deaths.

Whilst an assessment of a child's needs under the Framework for the Assessment of Children and Families in Need requires a consideration of three aspects, Child Developmental Needs, Parenting Capacity and Family & Wider Environment, it appears

incongruous that an assessment of a client or patient who is also a parent does not require a discrete consideration of the needs of any children in the family.

From the information and documentation provided it is difficult to establish which, if any framework, had been used to assess the needs of Child J's father. It would have been expected that the following aspects would have been formally considered in order to ensure a holistic and comprehensive assessment of need, particularly in relation to the impact on his family.

The matter of apparent significant alcohol intake during certain periods of time within the context of difficulties in regulating and stabilizing medication and increased concern about Child J's father's conduct does not appear to have been considered in the BCUHB Serious Case Review Report or the Health Management Review, neither in relation to the impact on Child J's father and his mental health nor in relation to the impact on parenting capacity and his relationships with other family members and resulting implications for other family members.

There is no information in the agencies' SCR related documentation including case notes in relation to an assessment of the marital relationship nor of any consideration of the circular impact that marital dynamics may have on functioning and relationships.

There is no information in the agencies' SCR related documentation including case notes in relation to an assessment of the parental relationship between Child J's father and Child J, nor apparent assessment of parenting capacity, nor a consideration of the interplay between his mental health and these aspects.

The response to a prompt as to whether there were any lessons to be learnt from the case about the way in which local professionals work together to identify and respond to disclosures of domestic abuse notes:

'There were no disclosures in this case and therefore there are no lessons to be learnt' (HMR 7.1.8)

This stance could be viewed as being reactive rather than proactive and highlights the dilemma and responsibility that identification may be a wider 'obligation' than self-reported disclosure (The Right to be Safe WG 2010). Similarly a reference is made in the CID 16 that the application of the DASH Risk Model was not relevant in this case.

In accordance with the statutory requirements of The Carers (Equal Opportunities) Act 2004 whereby all persons who provide 'regular and substantial' care to another person should be offered an assessment of their own needs, BCUHB and Cyngor Gwynedd have commissioned Hafal, a voluntary community based mental health support organisation to

undertake this function. Child J's mother was referred to Hafal in late October 2011. The referral information provided was limited and did not advise of the wider context of concern nor of the Public Protection Referral Form CID 16s, one of which was dated three weeks prior to referral. In the author's opinion this inevitably led to an assessment which was not fully informed and may have provided the referrer with an artificial assurance that the situation was being more robustly supported. There were no apparent arrangements to liaise with the referring agency and work together in conjunction with the Support Plan. It appears that Child J's birth mother's expressed wish for confidentiality was a factor in this and gives the impression that this service was perceived, at least by the provider, as supportive rather than a means of assessing and quantifying need. It is not known whether the relevant Service Level Agreement details the requirements regarding child protection and vulnerable adult responsibilities nor whether it complies with the statutory Carer legislation requirements including appropriate documentation.

It became known to the author during the latter stages of the Serious Case Review process (September 2013) when additional information was sought from the NWP prosecution process that the family had been involved and supported by members of a local Church. In retrospect the Church expressed concern about the behaviour of Child J's father including words expressed by him. Whilst it is recognised that Child Protection policies and procedures are well established within mainstream churches, this case highlights the importance of raising awareness in regard to responsibilities in relation to mental health and vulnerable adults' issues.

Management of Mental Health including Care Programme Approach

The recognised framework to deliver mental health services, the Care Programme Approach programme (Guidance 2003; July 2010) consists of five components – assessment, planning of care and treatment, delivery of care and treatment, monitoring & review and discharge. The Care Programme Approach has two levels – **Standard** and **Enhanced**.

In this case difficulties in complying with the Care Programme Approach Guidance have been identified at various points during the management of the mental health process: at allocation and designation of Care Co-ordinator; assessment of risk including revisiting and revising risk in light of emerging concerns from professional and lay sources; multi – disciplinary Care Planning; professional supervision; and discharge from the Care Programme Approach.

It is a requirement that all service users assessed by secondary mental health services have a risk assessment completed. Accurate risk assessment relies upon high quality history-taking, effective sharing of information between individuals and services and accurate

identification of past information which may indicate areas of current and future risk. There is an expectation that the Risk Assessment forms the basis for a fully agreed care and treatment plan.

Although the CPA does not prescribe a standard assessment tool (BCUHB appear to use a modified Checklist matrix format referred to as Risk identification Form), there is an expectation that the development of a fully agreed care and treatment plan is based on a thorough assessment of need and risk. Once completed the Risk Assessment and Management Plan should be discussed within a Multi-Disciplinary Team meeting and reviewed at least six monthly to coincide with the Enhanced status level of the Care Programme Approach.

In this case there are only two examples of a completed Risk Identification Form (dated 10 November 2011 and 11 April 2012) and in relation to the October 2011 Care Plan the BCUHB Serious Case Review Report notes:

"There was no written evidence that the Care Plan was written in consultation with the multidisciplinary team…"

The importance of clinical and caseload supervision and training is also highlighted in this case. The organisational structure of the Community Mental Health Team resulted in two levels of supervision, i.e. professional and line management and this may have been a complicating factor.

It was recorded that Child J's father was on an Enhanced Level Care Programme Approach. However, it appears that he was 'discharged' from the CPA programme in June 2010 and the circumstances of his further October 2011 'discharge' appear to have breached the detailed requirements of the related guidance.

A reference made to Child J's father's 'stable mental state'(BCUHB Serious Case Review Report p.19) in relation to the proposed 'discharge' appears incongruous as the period from August 2011 onward appears to have been characterised by instability and increased professional and lay expressed concerns by and to various sources in relation to alcohol consumption, medication, behaviour and impact on Child J's mother.

The wider family describe this period (Autumn 2011 onwards) as very stressful and challenging. It appears that at times Child J's father presented as 'distressed and distressing, frightened and frightening'.

Working together

Five health professionals were identified as working with this family, namely the Midwife (involved for a designated time), Health Visitor, General Practitioner, Consultant Psychiatrist and Care Co-ordinator (with some student involvement). A Locum GP re-referred him to the Consultant Psychiatrist in August 2011.

There is evidence that the Midwife and Health Visitor liaised appropriately with one another. However, the information held by them was not an accurate reflection of the circumstances as it failed to identify that other health professionals were working with the Child J's father.

In relation to the General Practitioner / Community Mental Health Team there were missed opportunities:

'There was no communication with the Health Visiting Team from either the CMHT or the GP both of whom were aware of the strenuous efforts to assist Child J's father with his mental health problems. This was a missed opportunity to share this information with the Health Visiting Team and the Midwifery services both of whom were oblivious to [Child J's father's] mental health problems' (HMR 7.1.1)

In the author's opinion the apparent lack of a cohesive consideration of the dynamics and interplay between the Mid Wife /Health Visitor and the General Practitioner / Care Co-ordinator / Consultant Psychiatrist groupings; reflects both the presentation of these five professionals as two distinct groupings within the Serious Case Review related documentation and as distinct groupings when involved with this case. The separate consideration of children's health services (Health Internal Management Review) and adult health services (BCUHB Serious Case Review Report) provides a further analogy.

In relation to the Care Co-ordinator and the Consultant Psychiatrist (both of whom were based at the Community Mental Health Team), there is no evidence that they discussed the case regularly. This is of concern within a service model developed in order to facilitate communication and joint working.

In relation to the Consultant Psychiatrist and the General Practitioner there is evidence of correspondence between them regarding appointments and the Care Co-ordinator and the GP appropriately referred Child J's father to the Consultant Psychiatrist when Child J's father expressed thoughts of self- harm with a gun belonging to his late father (10 October 2011). However, whilst this has been presented as an example of good practice by the Health Management Review Author, there is no evidence that the expressed concern was referred on to the NWP at the time. There is evidence that the Care Co-ordinator confirmed that the gun had been retrieved and disposed of by contacting the NWP and obtaining an incident number on the 23 November 2011.

It appears that the NWP had not made the explicit connection between Child J's father and the firearm at that time. It appears that whilst the NWP had received a telephone call from Child J's father on 25 October 2011 to advise that he had come across an antique gun of his late father's the express link and potential significance was not made. The gun had subsequently been surrendered by a relative on the 9 November 2011.

It appears that there was a differing interpretation of the incident, the NWP, as they had not been informed about the related potential risk and concern viewed it as the collection of an unauthorised gun, whilst the health services appear to have been mindful of the directly reported possibility that he may consider using it. Sharing of this information at this time may have resulted in a further NWP consideration of concern, particularly as it coincided with other concerns expressed by them via a Public Protection Referral Form CID 16 only days before. It does not appear that Health services, having received the said Public Protection Referral Form CID 16 revisited the significance of the CID 16 in relation to the further information about the gun.

In the SCR related documentation there does not appear to have been a detailed consideration of the role of the GP who in this case had a pivotal overview role.

Sharing Concerns

'Research and experience have shown repeatedly that keeping children safe from harm requires professionals and others to share information: about a child's health and development and exposure to possible harm, about a parent who may need help to, or may not be able to, care for a child adequately and safely; and about those who may pose a risk to a child' (WT 2006 14.64)

Whilst the key principle appears unproblematic:

'the safety and welfare of a child / young person must be the first consideration when making decisions about sharing information about them'

this statement belies the complexities involved in a context subject to disclosure of information duties.

This highlights that responsibilities and processes are much clearer where there are identified and quantifiable concerns than where a consideration of or quantifying of need is required.

In echoing this exacting balancing act Munro quotes Cleaver et al's (2011) plea that diverse legal and ethical responsibilities do not hamper collaboration:

"An organisational barrier to working together is the different understanding of confidentiality and data protection held by various professionals and agencies. Relevant authorities…need to build on existing inter-agency protocols for information sharing and ensure that agencies working with adults are included'...'

As Lord Laming outlined in The Victoria Climbie Inquiry Report

"What is needed most of all is a structure in which there is no ambiguity about the decision-making process for the quality of services to children and families' (Munro 4.1)

Public Protection Referral Form CID 16 and Protection of Vulnerable Adult Referral Form

This case highlights the need to develop a shared understanding in relation to the status, purpose and application of the Public Protection Referral Form CID 16 and the Adult Protection Referral form, a need which is reflected in Recommendation Two below).

Conclusions

Hindsight along with a known outcome provides a privileged vantage point devoid of competing priorities and the complexities of exercising professional judgement in extremely complex cases such as this one. The family members noted that there were many victims of this tragedy and undoubtedly all those involved whether in a personal or professional capacity will have been greatly affected. Undoubtedly if anyone involved with this family had predicted the tragic outcome, responses would have been different.

The Overview Author's task is to strive to do justice to all those involved whilst recognising that the ultimate responsibility is towards Child J.

Health and social care professionals do not have the luxury of decision making in a vacuum, they are constantly appraising complex and inextricably linked variables and making judgements often in the context of 'least detriment'. This requires the confident exercising of professional judgement within a supportive organisational environment.

The difficulty lies in identifying and quantifying risk. There is no such thing as zero risk, particularly in relation to human relationships and human behaviour. There is no comparable experiment involving the interplay of an intricate myriad of complex variables within the safe confines of a scientific laboratory with controlled conditions. In this case a detailed and comprehensive assessment of the interplay of an intricate myriad of complex variables was and is extremely difficult. It is also evident that Child J's mother was a very private person who found it difficult to confide in anyone. Whilst not placing the onus of responsibility on her in anyway this factor undoubtedly made the task more difficult.

Whilst the outcome may not have been different, if there had been a more rigorous, discrete assessment of the children's needs, of the impact of the parental mental health on the father's parenting capacity and on the mother's parenting capacity and on their relationship, a more rigorous sharing of information, a more rigorous compliance with the Care Programme Approach Guidance in terms of allocation, assessment of need and risk, review, supervision, support and discharge the question of whether the tragedy could have been avoided may have been easier to answer.

The focus of the SCR is on learning lessons and it is evident from the individual agencies' documentation and suggested recommendations along with the additional recommendations that there are lessons to be learnt.

RECOMMENDATIONS

The Recommendations identified by the agencies involved have been incorporated into this section. Where relevant they have been amended to reflect the findings of this Overview Report. The recommendations that arise directly from this Overview Report are detailed at the end of this section:

Recommendation One

In relation to Supporting Children, Supporting Parents: A North Wales Protocol: Parents with severe mental health problems and / or substance misuse: A framework for safeguarding children (2012)

a) That BCUHB ensure that all appropriate staff (including General Practitioners, Consultant Psychiatrists, Health Visitors, Midwives and others) attend the multi-agency re-launch events for this protocol;
b) That the Protocol is circulated to all mental health teams (appropriate staff) with confirmation of receipt and distribution (BCUHB Rec 1/ SCRR Rec. 6 /);
c) That the Gwynedd & Ynys Môn Safeguarding Board ensures that all appropriate staff (including Education)attend the multi-agency re-launch events for this protocol.

Recommendation Two

In relation to CID 16 / POVA

The ongoing work in relation to the pilot study of a Multi- Agency Safeguarding Hub should be informed by the messages arising from this review – to include:

- Any flowchart that is being / has been developed needs to involve and be accepted by all agencies not one in isolation.
- The flowchart needs to detail the process for outcome feedback.
- Education involvement and representation.
- NWP Recommendation 1 – 'raising awareness of need for family details'.
- All POVA referrals should be made on the designated POVA referral form and screened by the Local Authority POVA Co-ordinator with actions/decisions recorded
- Consideration to be given to removing Vulnerable Adult Box on Front sheet and replacing with Mental Health with children present / in family.
- BCUHB recommendation that CID 16s should be discussed under the Safeguarding Agenda to inform the decision making process relating to those individuals (HMR Rec. 3 /SCRR Rec. 6)

- Consideration of SCRR Rec. 3 (b) 'process for CID 16s should be reviewed to ensure it is clear which actions should be taken as a result of reviewing these documents and that all actions taken are properly documented and followed through'.

Recommendation Three – That BCUHB action the specific recommendations arising from this case.

- To add Mental Health Problems to the Midwife to HV Liaison Form (HMR Rec. 4).
- Audit a sample of health visiting and midwifery records in accordance with their record keeping policy (HMR Rec. 5).
- Review their governance arrangements for the return and storage of post natal midwifery records (HMR Rec. 6).
- Complete a Clinical Record Audit of the Safeguarding Form / Issues concerning Children / Young People in order to ensure compliance, implementation and outcome (HMR Rec. 8).
- Consider ways of engagement with fathers/significant males and ensure that this is documented accordingly in records (HMR Rec. 7).
- Progress of SCRs and DHRs commissioned by the LSCB are cascaded down to staff and that staff who may be part of the reviews are kept up to date with progress (HMR Rec. 9).

Recommendation Four

In relation to the Community Mental Health Team

That current processes be audited to ensure compliance with the Care Programme Approach Guidance, to include:

Clarity and consistency of referral management and case allocation:

- One point of entry for all referrals into the team including those addressed direct to the consultant
- Review the Protocol for allocation of clients (and assignment of Care Co-ordinator) to ensure that it is led by the clinical need of the client whilst taking into account geography, capacity and work load (SCRR Rec. 1)

Care and Treatment Planning

- To include a consideration of the roles and responsibilities of team members for the supervision of cases held as care co-ordinators and for managerial / professional supervision. This will need to take into account professional body supervision

guidelines, relevant CPG supervision guidelines and the role of the health care professional as an autonomous practitioner (SCRR Rec. 4).
- Establishing processes to ensure that all members of the team must be aware of each client's required needs and the implications of this for the development of Care and Treatment Plans (SCRR Rec. 2).
- Ensuring that all assessments and care plans of clients with children must reflect on the impact of their mental health on the family and any children even if there is no perceived risk to the family (SCRR Rec. 6 (b)).
- Ensuring that the team have processes in place to ensure all clients on the caseload of the team are reviewed at a weekly meeting on a regular basis (SCRR Rec. 3 (a)).
- Ensuring that all risk management plans are discussed with colleagues to ensure access to clinicians' collective skills and experience, awareness of potential hazards and clients' early warning signs and to prevent team members working in isolation' (SCRR Rec. 3 (c)).
- The team should review and develop a robust single discharge procedure (SCRR Rec. 3 (d)).
- All Care Co-ordinators should have knowledge of risk assessment and how this risk is placed into a formulation (SCRR Rec. 7).
- All team members should keep accurate and full notes to include assessments and reasons behind key decisions taken and that documents are not post dated (SCRR Rec. 5).
- In accordance with the Enhanced Care Programme Approach BCUHB should ensure that care plans and risk assessments are reviewed regularly.

Recommendation Five

The Mental Health service provider (The Local Health Board and Local Authorities) should develop and implement a standardised approach to risk assessment. In providing a robust and quantifiable framework for the assessment of risk, such an approach should minimise the potential for:

- Harm to self (including deliberate harm)
- Suicide
- Harm (including but not limited to violence) to any other person(s) – including adult(s) and child /ren
- Self neglect
- Adverse risks associated with abuse of alcohol or substances
- Social vulnerability

Recommendation Six

In relation to the Community Mental Health Team

That any organisational change implemented following this incident is appraised in relation to the messages from this review.

Recommendation Seven

That BCUHB and Cyngor Gwynedd should review the arrangements for undertaking Carer Assessments and their compliance with statutory requirements and guidance and:

- In this respect the Service Level Agreement with Hafal including documentation should be reviewed.
- It is also recommended that Hafal undertake an audit of any parallel arrangements across Wales.

Recommendation Eight

The Local Authority should ensure that community and faith groups are provided with guidance in relation to the protection of vulnerable adults.

Recommendation Nine

It is recommended:

- That the messages arising from this case including in relation to working together and the sharing of information and concerns are considered within the wider context of the Regional Safeguarding Children's Board;
- That the local experience of the combined Domestic Homicide Review and Serious Case Review process informs the national experience.

6. KEY / GLOSSARY

BCUHB	Betsi Cadwaladr University Health Board
TCA 1989	The Children Act 1989
CC	Care Co-ordinator
CIN	Child in Need
CID 16	Public Protection Referral Form
CP	Community Psychiatrist
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model (2009)
DHR	Domestic Homicide Review
GMC	General Medical Council
Hafal	Voluntary, community based mental health support organisation
HV	Health Visitor
HMR/HIMR	Health Management Report /Health Internal Management Review/Report
IMR	Internal/ Independent Management Report
LEA	Local Education Authority
LSCB	Local Safeguarding Children's Board
MW	Midwife
NWP	North Wales Police
NWC	National Midwifery Council
POVA	Protection of Vulnerable Adult Referral Form
PPU	Public Protection Unit

SCR	Serious Case Review
SCRR	Serious Case Review Report (BCUHB Internal Report) – services for Child J's father
SLA	Service Level Agreement

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