# GWYNEDD COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Overview report into the death of Adult 1.

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23.06.2014

## 1. INTRODUCTION

### 1.1 - Reason for conducting the review

A “Domestic Homicide Review” means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself,

(S9 (1) Domestic Violence, Crime and Victims Act 2004)

The Review is not an inquiry into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts respectively. The Review is held with a view to identifying if there are any lessons to be learnt from the death.

This report of a domestic homicide review examines agency responses and support given to Adult 1 prior to the time of her death.

The review has considered agencies contact/involvement with the family from 2007 to 2012 in some detail and has also considered a summary of agency involvement prior to this period.

The key purpose for undertaking the review is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change and be put in place in order to reduce the risk of such tragedies happening in the future.

A decision to undertake a Domestic Homicide Review into the death of Adult 1 was made by the Gwynedd Community Safety Partnership on 27/4/2012. The period covered by the Domestic Homicide Review was 5 years from 2007 onward.

## 2. THE FACTS

### 2.1 - Family Structure

| Name | Relationship | Ethnic origin |
|---|---|---|
| Adult 1 | Wife | White |
| Adult 2 | Husband | White |
| Child 1 | Daughter | White |
| Child 2 | Daughter | White |
| Child 3 | Son | White |

## 2.2 - Circumstances of incident

In early 2012 the North Wales Police Force responded to a 999 call. Police and Paramedic Officers, upon entry into the family home, found the bodies of Adult 1 and Child 3.

Adult 2 was the husband of Adult 1 and the father of Child 3. He was arrested at the scene and was charged with the murders of both his wife and son. Adult 2 subsequently pleaded guilty to the manslaughter of both Adult 1 and Child 3 and was detained for an indefinite period under the provisions of the Mental Health Act 1983.

## 3. TERMS OF REFERENCE

This Domestic Homicide Review is being completed to consider agency involvement with Adult 1 and her partner Adult 2. The Review worked to the following Terms of Reference:

- To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

- To review the involvement of each individual agency, statutory and non-statutory, with Adult 1 and Adult 2 during the relevant period of time.

- To summarise agency involvement prior to this period.

- Each contributing agency to provide a chronology of their involvement with the family during the relevant time period.

- Each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted.

- Each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with the family, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

- In order to critically analyse the incident and the agencies' responses to the family, the review should specifically consider the following six points:

    1. Analyse the communication, procedures and discussions, which took place between agencies, including consideration of potential confusion in terminology.

    2. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.

    3. Analyse the opportunity for agencies to identify and assess domestic abuse risk.

    4. Analyse agency responses to any identification of domestic abuse issues.

5. Analyse organisations access to specialist domestic abuse agencies.

6. Analyse the training available to the agencies involved on domestic abuse issues.

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

- Improve inter-agency working and better safeguard adults experiencing domestic abuse.

- Examine the ability of agencies to identify the existence of domestic violence at its earliest stages, especially in relation to those under 18 when first coming to notice in relation to issues of DV.

- Sensitively involve the extended family in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to the process.

- Coordinate with any other review process concerned with the children of the victim and/or perpetrator.

- Commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, (jointly funded by responsible partners as required) co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

- Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

- Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

- Provide an executive summary.

- Conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Community Safety partnership.

## 4. METHODOLOGY

### 4.1 – Explanation of Joint Panel Process

As this tragic incident involved the murders of an adult and a child, the Gwynedd Community Safety Partnership and the Gwynedd and Anglesey Local Safeguarding Children Board established a joint panel to undertake both the Domestic Homicide Review and Serious Case Review. The chair of the panel was Mr David Beard. David Beard is the Assistant Director Children's Services for Barnardo's Cymru in North Wales. Mr Beard is an experienced Social Worker and Manager having qualified in 1979 and has worked in North Wales since 1998, and in his current position since 2003. He has significant experience in Serious Case Reviews (SCR) having been Chair of the Gwynedd and Anglesey LSCB Serious Case Review Panel for many years and also having been commissioned to be independent author of a number of Overview Reports for SCR's by North Wales LSCB's. Mr Beard has no prior knowledge or professional involvement with the family and has never worked for any of the agencies involved within this Review. He was able to bring seniority, professional knowledge and independence to this work and as such has met the parameters of the role.

Separate Authors were commissioned to write the overview reports for each review but worked jointly on the chronologies, formulation of the recommendations and the development of a Joint Action plan. The independent author appointed for the Domestic Homicide Review was Glyn Hughes B.A. C.Q.S.W. Mr Hughes is an Independent Social Care Consultant, who has many years' experience as a practitioner and at senior management level in Local Government and the Voluntary sector. Mr Hughes had no previous knowledge or professional involvement with the family

The panel met on 10 occasions.

### 4.2 – Chronologies and IMRs

Chronologies and Individual Management Reviews were submitted by the following services:

- North Wales Police
- Gwynedd Council Education Service
- Betsi Cadwaladr University Health Board (BCUHB)
- HAFAL (voluntary support service)

The chronologies were amalgamated into one comprehensive family chronology. Supplementary questions to the agencies were prepared by the author and follow up sessions with the authors of the Independent Management Reviews were held.

Family members were involved in, and updated on the review via home visits.

The following agencies reported that they had had no contact with the family during the period covered by the Review:

- Gwynedd Council Social Services Department (Adults/Children)
- Bangor and District Women's Aid
- Wales Probation Trust

- All Wales Domestic abuse and Sexual Violence Helpline
- De Gwynedd Domestic Abuse Service
- North Wales Fire and Rescue Service
- Supervised child Contact Service North Wales, Abbey Road, Bangor
- Tan y Maen, Blaenau Ffestiniog
- Canolfan Felin Fach, Pwllheli

## 5. DETAILS OF PARALLEL REVIEWS/PROCESSES

### 5.1 - Local Safeguarding Children's Board

Both Adult 1 and Child 3 were found at the home address as a result of the same incident, The Gwynedd and Anglesey Local Safeguarding Children Board (LSCB) undertook a Serious Case Review (SCR) in relation to Child 3.

This review was commissioned by the Gwynedd and Anglesey Local Safeguarding Children Board and was conducted under the guidelines set out in Chapter 10 of Safeguarding Children: Working Together under the Children Act 2006 (WAG, 2006).

The Local Safeguarding Children Boards (Wales) Regulations 2005 require that where abuse or neglect of a child is suspected and a child dies, the Local Safeguarding Children Board (LSCB) for the area must conduct a serious case review. The full terms of reference are held by the LSCB.

### 5.2 - Betsi Cadwaladr University Health Board

As Adult 2 was known to the Betsi Cadwaladr University Health Board Mental Health services, a Serious Case Review was commissioned in July 2012. The main purpose of this review was to consider whether there were any specific or generic lessons to be learned following this tragic event. In accordance with the Health Board's policy and procedure the investigation was chaired by an independent member of the Betsi Cadwaladr University Health Board. The Review was completed in January 2013 and the report was made available to the overview author in July 2013.

### 5.3 - Health Inspectorate Wales

As Adult 2 was known to the Betsi Cadwaladr University Health Board Mental Health services, Healthcare Inspectorate Wales (HIW) were commissioned by Welsh Assembly Government to engage with stakeholders to discuss the handling of the inquiries into the homicides of Adult 1 and Child 3. HIW agreed to monitor progress of the various reviews and to be involved in the sharing of the findings from the respective inquiries and the handling arrangements for reporting.

## 6. SUMMARY OF AGENCY INVOLVEMENT

### 6.1 – Education services

Child 3 was not known to the Education Department as he was of pre-school age. There was no contact between Central Education Services and the Family. However Child 1 and Child 2 attended school.

#### 6.1.1 - School A

School A's involvement with the family always took place through Adult 1. None of the school staff recollect seeing Adult 2 at any event, whether an open evening, concert or social event such as a summer fair or coffee evening. Adult 1 always appeared supportive and wanted the children to have the opportunity to take part in every activity they were offered. Both children appeared happy and were always clean and well-dressed.

The school did not have cause to make any child protection referrals regarding the children and they attained the expected educational levels for their age.

#### 6.1.2 - School B

There was regular contact and a good relationship between the school and Adult 1.

The school did not have any concerns and did not have cause to make any child protection referrals. There was nothing in relation to behaviours which gave the school any reason to think that there was anything wrong at home.

#### 6.1.3 - School C

Adult 1 did express some initial concerns about one of the children settling in but the school reported that she did settle in quickly and formed a group of close friends. Punctuality was good and there were no educational problems.

### 6.2 - North Wales Police

Prior to the evening of her death, North Wales Police had contact with Adult 1 on one occasion, but did have contact with Adult 2 on 7 occasions between late 2010 and late 2011.

These contacts were largely in relation to Adult 2's continuing preoccupation with his belief that there was a conspiracy against him and that he believed he was being subjected to computer hacking and was being "spied upon" by electronic means.

At the time of the second contact in 2010 the e-crime manager noted that Adult 2 was '*very emotionally fragile as is unable to work due to illness and anxiety attacks and his emotional well-being is being further damaged*'.

In 2011 Adult 2 was noted as being '*agitated' and 'excited'* in manner because he had found what he thought was a listening/bugging device located inside an electrical plug extension lead in his children's bedroom. He also stated that he was being spied on and

listened into by 'them'. He stated that he did not want officers to attend at his home address or contact him as 'they' would then know he had discovered the device and informed the police. He was advised to get expert clarification from an electrician regarding the device and if indeed it was a listening device to return to the police station for further advice.

Later in the year police records noted that Adult 2 was acting in a strange manner. The e-crime investigator requested a visit at the home by a female officer for a welfare check as Adult 2 did not trust male officers. The officer also noted that Adult 2 was "saying strange things and is perhaps showing signs of schizophrenia". It was also recorded that the officer was concerned that Adult 1 may be having problems with his behaviour.

A decision was taken not to visit the home address as it was believed that any such visit may inflame the situation and increase Adult 2's paranoia regarding police officers. A vulnerable adult referral was subsequently sent to the Social Services Department and the Community Mental Health Team.

The Police requested feedback regarding the referral and were informed by e-mail that the referral had been passed onto the mental health service. No further police action was taken.

**6.3 – HAFAL**

HAFAL is a community based support voluntary service for people affected by mental health issues. Covering all areas of Wales, HAFAL is an organisation managed by individuals whose lives have been affected by serious mental illness.

The Community Mental Health Team referred Adult 1 to HAFAL in October 2011 and HAFAL made telephone contact with her on the same day and arranged an office appointment for December. Between this date and the date of her death Adult 1 attended the HAFAL offices on two occasions:

In November 2011 she attended the office alone. She spoke to the support worker about her husband's illness but appeared to give no indication that she was feeling threatened by her husband. A further appointment was arranged.

In January 2012 she attended a second appointment together with her child 3. Again she spoke about her husband's illness and it was recorded that she was worried that her husband thought that she was against him. A care plan was agreed that included 6 weekly meetings. A further session was arranged for early 2012.

On the morning of this appointment Adult 1 contacted HAFAL by telephone in order to rearrange the appointment. An alternative appointment was arranged but she did not attend this meeting but telephoned a staff member on that afternoon. She confirmed her agreement to the 6 weekly "offload" meetings and rebooked an appointment..

### 6.4 – Betsi Cadwaladr University Health Board

#### 6.4.1 - Adult 1

The attendance of Adult 1 at the GP practice was unremarkable. She attended for routine antenatal care with all three of her pregnancies and for minor ailments when this was necessary. She attended the same GP practice as Adult 2 and there was no indication of any difficulties in her personal life or any record of any suspicion that she may have been a victim of Domestic Abuse.

Adult 1 attended the GP practice for minor ailments during the period of the review and she also accessed antenatal services via the GP from late 2008 when she became pregnant. Midwifery care was delivered by the Community Midwifery team. She attended appropriate antenatal visits at the clinic and was accompanied by her two daughters. The Community Midwife did not meet Adult 2 during the clinic or home visits and Adult 1 was discharged from midwifery care to the Health Visiting Service when child 3 was 11 days old.

In 2008 the community midwife took a full family/partner history which included asking about psychiatric illness/depression. This was recorded as “no” in the records. The midwife and Health Visitor also confirmed that they were not made aware by any other health professionals during either the antenatal or postnatal period that Adult 2 had significant mental health problems and was in receipt of mental health services from either his GP or the Community Mental Health Team.

#### 6.4.2 - Adult 2

Adult 2 was referred to Secondary Mental Health Services by his General Practitioner (GP) in 1998 for work related stress. He received care from his GP and the Community Mental Health Team between this time and the beginning of the period of the timescales for the Domestic Homicide Review (DHR) and Serious Case Review (SCR). He was treated with anti-depressants and medication to treat anxiety and by the end of this period was under the care of a Consultant Psychiatrist and had been allocated a qualified Occupational Therapist who worked in the Community Mental Health Team as his Care Coordinator.

Through the summer of 2006 he continued to be seen by the Care Coordinator, who kept extensive records of their programme. This was focused on increasing his levels of activity and social engagement. The Consultant Psychiatrist reviewed progress at three monthly intervals. This pattern of treatment continued through the following 12 months. There were some changes in medication, but these appear to have made little difference to the overall picture.

At the beginning of 2008 there was a change in Consultant Psychiatrist. The diagnosis by this time was treatment resistant depression with fatigue syndrome and anxiety. Throughout 2008 the focus of therapeutic effort was the Care Coordinator intervention. This included efforts to help him and his wife with their benefits, as well as activity scheduling and problem solving.

In early 2010 Adult 2 was discharged by his Care Coordinator back to the care of his GP. The rationale for this was that the care plan had been successfully completed, though he

continued to suffer long term symptoms that had proven intractable. In mid 2010 he was again seen by the Consultant Psychiatrist and reported himself to be feeling much better.

He described a functional improvement and reported that the nightmares and lashing out at night had stopped.

He was discharged from Secondary Mental Health Services with the plan that he should take anti-depressants for the foreseeable future. Arrangements were made that he could be referred back if the need arose.

Adult 2 continued to see his GP though the first half of 2011. He was noted to have been drinking much more heavily than normal. He was advised by his GP about this, and he subsequently reported that his alcohol intake had reduced. He complained of sleep disturbance and was prescribed night sedation.

In late 2011 he was described as "presenting with paranoid ideas of reference and ideas that people were colluding against him secondary to stress and in the context of his underlying anxious personality". At this time Adult 1 reported that there had been some improvement in the previous week. She reported that Adult 2 had often been angry in the past, but that he had never acted aggressively. Adult 2 was offered a respite hospital admission but he declined. He was then offered the involvement of the Crisis and Home Treatment Team but this was also declined. The client was open to the suggestion of seeing his previous care coordinator, and this was arranged. The Care Coordinator resumed contact with Adult 2 at this time but he failed to attend three appointments with his Consultant Psychiatrist during this period. A further appointment was arranged for two weeks later which he also failed to attend. He did attend an appointment with his GP, when he continued to express paranoid ideas.

The Consultant Psychiatrist saw him twice in late 2010 at the GP's request. The Consultant Psychiatrist reported that there were no further paranoid delusions, and there were no hallucinations or other psychotic phenomena. He could find no evidence of depression and some changes in medication were made. He did not arrange further appointments but Adult 2 remained in contact with the Care Co-ordinator. A care plan was developed by the Care Coordinator. This was discussed with Adult 1, who had also requested a carer assessment.

The Care Coordinator last saw Adult 2 in March 2012. He reported having had a mixed 3 week period and having had a viral infection. He was exploring undertaking some voluntary work. They discussed agreeing a reduction in input as a step towards discharge from the service. Prior to going on leave, the Care Coordinator prepared a risk assessment on the client which identified no current risks other than a risk of self-neglect in the event of relapse. The plan also recommended increasingly infrequent contact. The Care Coordinator intended to discuss this assessment and plan with the client on her return. The forms were not shared with the client.

In summary, there was clearly a significant amount of involvement with Adult 2 from the Community Mental Health Team (CMHT) during the timescale for these reviews. He presented as someone with significant background personality problems and a range of fatigue, depression and anxiety symptoms. He did from time to time express paranoid ideas to various people but they were not consistent and they were frequently later denied. He was not particularly pro-active in seeking his own recovery.

The BCUHB serious case review report concludes that the resulting tragic incident could not have been predicted, and found that there was no evidence that would have indicated that the client would have acted in any degree of violence, and most certainly not the degree of violence exhibited with such tragic consequences.

## 7. THEMES AND ANALYSIS

### 7.1 - Mental Health Care Programme Approach (CPA)

There was longstanding involvement from the mental health services with Adult 2 documented back to 1998.

The Care Programme Approach is based around the following principles:

- A person centred focused approach determined by the needs of the individual.
- Providing a framework to prevent clients "falling through the net".
- Recognising the role of the carer and the support they need.
- Facilitating the movement of service users through the CPA according to need and service availability.
- Embracing the "best practice".
- Involving all relevant agencies and advocacy services.
- Full integration of health and social care, wherever appropriate.
- Ensuring copies of the care plan are accessible to all relevant parties.
- Including an assessment of risk.
- Including crisis and contingency plans, where appropriate.
- Including the identification of unmet needs.
- Monitoring of the role of the care co-ordinator and the effectiveness of this approach.

There are two sub domains to the Care Programme Approach: STANDARD and ENHANCED.

Adult 2 was recorded as needing an Enhanced Care Approach. Whilst he was not discharged from care management, he was discharged from consultant care for a time. Had he been treated in line with enhanced CPA guidance and at this time this should not have occurred. In terms of reviewing his progress, the case was discussed at allocation and at 6 week review meetings but there is no record of the case being routinely reviewed by the team as there was deemed to be no cause for concern.

The role of the Care Coordinator within the approach is pivotal. The Care Coordinator's responsibilities in terms of assessment, care planning and review are outlined in the document "Delivering the Care Programme Approach in Wales Interim Policy Implementation Guidance" published in 2010.

There was no evidence that the Care Plan was written in consultation with the multidisciplinary team and whilst there is evidence that the care plan was shared with the GP, consultant and client, there is no evidence that the client or the care plan were discussed or shared with the rest of the team.

The general health needs of this family were delivered by a variety of health services within BCUHB. Midwifery and Health Visiting were coordinated. Mental Health Service and the General Practitioner services were also coordinated but there was no meaningful connection between these two groupings. There was very little evidence of communication with the Health Visiting Team from either the Mental Health Services or the General Practitioner, both of whom were aware of the strenuous efforts to assist Adult 2 with mental health issues. There was a missed opportunity to share this information with the Health Visiting team and the Midwifery services who effectively remained oblivious to the Mental Health issues affecting the family. This may have afforded additional support to the family from the health visiting service.

It is not possible to say whether the outcome would have been any different had there been better coordination between all these services but the family may have received additional support had they wished to accept them.

**7.2 - The Carers Voice**

There is some self-reported testimony from Adult 1. Some of this documentation relates to frustration and problems but some are positive and gave no indication of Adult 1 feeling threatened or at risk. In early 2012 she did make a clear statement to the support service (HAFAL) that she did not want information shared with anyone.

There were opportunities for Adult 1 to see professionals on her own and by late 2011 both the psychiatrist and the Police were concerned enough about her situation to request that she be seen alone.

**7.3 - Risk Assessment**

All service users assessed at any point in their contact with secondary mental health services should 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.

In April 2009 the Minister for Health and Social Services set out the expectations regarding the training of professionals in risk assessment and management in a letter to the Chairs of LHBs and NHS Trusts.

Assessment of risk should be kept under review and monitored in an ongoing process of professional engagement with an individual. Clear and accurate documentation of risk, including regular and ongoing reviews of potential risks, should be made. Such reviews of risk also need to be translated into reviewed plans for the management of identified risk.

The Care Management Approach does not prescribe that any specific or particular risk assessment tool should be used. A model tool is outlined in the guidance and Betsi Cadwaladr Health Board used a modified version of the tool which included specific questions relating to risk to others including threats of violence as well as actual physical aggression.

The Risk assessment process should seek to minimise the potential for:

- harm to self (including deliberate self-harm)
- suicide
- harm to others (including violence)
- self-neglect
- adverse risks associated with abuse of alcohol or substances
- social vulnerability.

A number of serious case reviews have highlighted the need to ensure that comprehensive risk assessment takes accounts of the risks to and by the individual and the assessment of these risks should be kept under review and monitored in an ongoing process of professional engagement with an individual. Clear and accurate documentation of risk, including regular and ongoing reviews of potential risks, should be made.

In this case a Risk Identification form was completed by the care coordinator in late 2011 and recorded that Adult 2 was a risk to himself and no risk to others. There was an opportunity for this information to be shared with the health visitor which may have led to enhanced support for the family and a joint assessment to assess if the children were in need of additional support services.

A further risk Assessment was dated shortly after the deaths of Adult 1 and Child 3. This document was prepared in advance of the Care Coordinator going on Annual Leave which again demonstrates that the effects of Adult 2's mental health on the children was being considered and again recorded as no history of danger to others. This document is particularly poignant in hindsight as it records "no history of danger to others. No use of Mental Health Act. No current risk to self. No current risk to others. No child protection issues. No risk of abuse by others is including domestic violence".

The increase in levels of concern during this period had led to a consideration of Adult 1's predicament/situation but not to a comprehensive consideration of the impact of Adult 2's illness and behaviours upon the rest of the family.

There was evidence that the practitioners involved were conscientious and caring and that the immediate welfare of other members of the family would have been considered during home visits. However, there is no evidence that a formal and structured consideration of their needs was undertaken which may have resulted in a multi-agency assessment, thus enabling a revisiting of, and projection of thresholds of need and /or risk.

**7.4 - Carer assessment**

The NHS Wales Policy Guidance entitled *The Care Programme Approach for Mental health Service Users* (2003) states that the needs of the service user often relate not just to their own lives, but to the lives of their wider family and all individuals who provide 'regular and substantial' care for a person on the Care Programme Approach should be offered:

*"An assessment of their caring, physical and mental health needs which will be repeated on an annual basis; or more often as needs dictate." together with:*

*"A written Carers Plan, which is agreed with the carer and relates to their caring, physical and mental health needs. For younger carers this will also cover their educational and welfare needs."*

The Carers Plan should be reviewed on an annual basis and Carers should receive information about help available to them, the services provided for the person for whom they are caring, and what to do and whom to contact in a crisis.

The Carers Strategies (Wales) Measure 2010 placed a legal duty upon the NHS in relation to services for carers in Wales. It requires Health Boards to work with their partner Local Authorities to produce Carer Information and Consultation Strategies.

Carers can choose whether or not they will care, and the level of support they are willing to accept. Those providing care on a regular basis have a legal right to ask for an assessment of their own needs and they may be eligible for services to help them, both in their caring role and to have a life beyond caring.

The arrangements in Gwynedd at the time of this review was that Carers Assessments (Mental Illness) were undertaken on behalf of the statutory agencies by HAFAL - a community based support voluntary service for people affected by mental health issues.
The Community Mental Health Team referred Adult 1 to HAFAL in late 2011. The referral was a brief two page document which consisted of basic factual information regarding names and contact details together with two brief paragraphs referring to Adult 2. The requested support plan consisted of providing "someone to talk to and receive support" and included six weekly meetings.

No further information was passed on to HAFAL by the statutory agencies. HAFAL were not informed of any wider context or concerns. There were no apparent arrangements to liaise and present an assessment nor to review and work together in conjunction with the Support Plan. The expressed wish of Adult 1 for confidentiality appears to have been a factor in this and the overall conclusion of this review is that this service was largely viewed as a supportive element rather than a means of assessing and quantifying need.

The level of need was designated as six weekly but due to the cancellation of two appointments only two direct contacts were made with Adult 1 during the period from October 2011 to March 2012.

Whilst HAFAL clearly provide a valued and helpful service, it has been clear that they were very much unaware of much of the background details. The arrangements for the discharge of the responsibility for assessing the needs of carers and providing support by the statutory agencies fell short of what should have been in place.

**7.5 - Working Together**

**7.5.1 – Health**

Five health professionals were identified as working with this family namely the Midwife, Health Visitor, General Practitioner, Consultant Psychiatrist and Care Coordinator (with some student involvement).

There was evidence that the Midwife and the 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 family in relation to mental health issues within the family.

In relation to the Care Coordinator and Consultant Psychiatrist (both were based at the Community Mental Health Team), the CMHT held weekly clinical meetings whereby allocation of cases were made and discussion of cases at six weekly reviews. Whilst the consultant was regularly present at the clinical meetings, there was no evidence that as the only two members of the team involved with this client's care, the care coordinator and the consultant discussed this case regularly. As a result the care coordinator did not have the advice or support of colleagues in ensuring her approach to this client was the most appropriate. This is of concern within a service model developed in order to facilitate communication and joint working. In relation to the Consultant Psychiatrist and General Practitioner there was evidence of correspondence regarding appointments.

In relation to the Health Visitor and General Practitioner/Community Mental Health Team, there was very little communication with the Health Visiting Team from either the CMHT or the GP both of whom were aware of the strenuous efforts to assist Adult 2 with his mental health problems. There was a missed opportunity to share information with the Health Visiting Team and the Midwifery services both of whom were oblivious to the mental health issues affecting Adult 2.

The School Nurse was not aware of the mental health intervention and it appears that the school was not aware of the mental health related concerns including those expressed in the Police Reports.

**7.6 - Responding to Police Concerns**

The Community Mental Health Team received Police reports regarding Adult 2.

During 2011 and 2012 the Health Board held discussions with the Police after commencing an internal review of the Governance arrangements relating to the receipt of these reports. Significant concerns were raised and internal processes were developed and implemented within the Mental Health services to strengthen the response when a Police Report is received. In light of the concerns raised regarding communication and information sharing the agencies are currently engaged upon the pilot study of a Multi-Agency Safeguarding Hub which will have immediate engagement of all statutory agencies on receipt of referrals and Police report. A further directive from the Police Public Protection Unit has been given to Police Officers.

Prior to April 2011 there was no documented procedure for the Mental Health Team to deal with incoming reports from the Police. In April 2011 the Mental Health Clinical Programme Group of BCUHB approved a flow chart for the management of these reports to ensure appropriate responses.

**7.7 - Protection of vulnerable adults**

In Adult Services all new referrals / allegations to be considered under the Protection of Vulnerable Adults procedures should be channelled through the Social Services Adult

Advice and Assessment Team unless the service user is already allocated to a social worker.

In October 2011, the police had concerns regarding the behaviour of Adult 2. Police records noted that the officer was also concerned that Adult 1 may be having problems with these behaviours. The Intake team considered this referral and the record of the Allocation/Review meeting noted that the referral had been received, that the case was currently open to mental health services but recorded no action or outcome. It appears that the referral was handed to the case coordinator who read and filed it but there was no written record made of this.

The Public Protection referral form was used by North Wales Police. This may well have contributed to confusion within the CMHT and Local Authority as the referral was not made on the designated POVA referral form.

**7.8 - The Extended Family**

Following the death of their mother and brother, Child 1 and Child 2 became Looked After Children (s20 Children Act 1989) and were placed by the Local Authority with their paternal Aunt and Uncle who were subsequently approved as foster carers for the children. The children continue to be looked after by the Local Authority and are receiving significant counselling support and supervision. Their placement, welfare and progress is formally reviewed by the Independent Reviewing Officer every six months. The SCR and DHR authors met with the paternal uncle and aunt, and separately with the maternal grandmother and husband. The arrangements were made via their respective social workers whom also attended the meetings.

Although the event took place 24 months ago it is evident that the family are still in shock. Both sets of family members stated that there were, and continue to be, many victims in this case.

An invitation to meet directly with the siblings made via their carers was declined by them.

Whilst both siblings appear to have settled in placement, it is understandable that it is difficult to quantify the current and future impact of this tragedy on them. Working through the children's social worker, the authors have received limited carer reported information from their Doctor (with consent), which was further confirmed during our meeting with them.

The paternal stepfather wished to convey a message (referring to reported incident of considering a section approximately 3 months prior to the incident), that agencies should involve wider family members in the provision of mental health services, and in particular when considering sectioning rather than just next of kin, who may not be the 'right' person to make a judgement as they are emotionally involved. The most pressing concern expressed by the family members was the current and future well-being of the siblings. To describe how they feel, two family members used the term 'frightened' - in respect of what has happened, what could have happened and what may happen in the future.

### 7.9 - Domestic violence/abuse

"Domestic Abuse is the emotional, physical, sexual, psychological or economic abuse of power and the exercise of control by an individual or individuals, of a family member, partner or ex-partner, regardless of gender, age or sexual orientation." (North Wales Multi-Agency Protocol)

There was some evidence that the marital relationship within this family was fraught at times and the probability that that this was due to a combination of the mental health issues and the pressures on the ability of Adult 1 to cope with the difficulties does not render the impact less potent.

Individual agency processes and strategies have been developed to identify domestic abuse including in Midwifery and Health Visiting. During the timescales of this review BCUHB and its predecessor organisations had developed a Domestic Abuse Training Strategy and were undertaking training to raise the awareness of domestic abuse and provide front line practitioners with the tools and skills to undertake risk assessments.

### 7.10 - Alcohol

Alcohol is identified as a significant risk determinant in many spheres including marital and parent -child relationships. It can be a stimulant and when combined with medication can have negative effects including making the medication ineffective. There are very few references to alcohol intake in the records relating to this case but there were some suggestions that Adult 2 was drinking heavily at times.

The matter of significant alcohol intake within the context of difficulties, in regulating and stabilizing medication and in relation to the impact on parenting capacity and relationships with other family members, was not considered to be significant in this case.

### 7.11 - Community and Faith Groups

Both Adults were involved with a Faith group. Guidance and procedures in relation to Child Protection are well established within Churches. However, this case highlights the importance of awareness in regard to mental health and Protection of Vulnerable Adults for Community and Faith groups.

## 8. CONCLUSIONS

In extremely complex cases such as this one, hindsight along with a known outcome provides a privileged vantage point devoid of competing priorities and the complexities of exercising professional judgement. The family members noted that there have been many victims of this tragedy and undoubtedly all those involved whether in a personal or professional capacity have been greatly affected.

Undoubtedly, if anyone involved with this family had predicted the eventual tragic outcome responses would have been different. The difficulty lies in identifying and quantifying risk. There is no such thing as zero risk, particularly in relation to human relationships and human behaviours. In these circumstances a detailed and comprehensive assessment of the interplay of an intricate myriad of complex variables is extremely difficult. It has been evident that Adult 1 was a very private person who found it

difficult (or was reluctant) to confide in anyone and without placing the onus of responsibility on her in any way, this factor undoubtedly made her position more vulnerable.

Whilst the outcome may not have been different, if there had been a more rigorous holistic assessment of the family's needs together with more effective sharing of information and a more rigorous compliance with the CPA guidance in terms of allocation, review, discharge, supervision and support the question of whether the tragedy could have been avoided may have been easier to answer.

Had this occurred, the impacts and risks arising from paternal mental health problems upon the family dynamics may have been better understood by the agencies working with the family.

The Focus of the Review is on learning lessons and it is been evident from the Individual Agencies' documentation and our recommendations that there are lessons to be learnt.

## 9. RECOMMENDATIONS

**Recommendation 1:**

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.
c) That the Gwynedd & Ynys Môn Safeguarding Board ensures that all appropriate staff (including Education) attends the multi-agency re-launch events for this protocol.

**Recommendation 2:**

In relation to the management of CID's 16, the ongoing work of the multi-agency safeguarding hub CID 16's needs to be completed.

**Recommendation 3:**

All POVA referrals should be made on the designated POVA referral form and screened by the Local Authority POVA coordinator with actions/decisions recorded.

**Recommendation 4:**

BCUHB and Cyngor Gwynedd should review the arrangements for undertaking Carer Assessments and their compliance with statutory requirements and guidance Service level agreement and role of HAFAL should be reviewed
It is also recommended that HAFAL undertake an audit of any parallel arrangements across Wales.

**Recommendation 5:**

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 seek to minimise the potential for:

- harm to self (including deliberate self harm)
- suicide
- harm to others (including violence)
- self neglect
- adverse risks associated with abuse of alcohol or substances
- social vulnerability.

**Recommendation 6:**

In accordance with the Enhanced Care Programme, BCUHB should ensure that care plans and risk assessments are reviewed regularly.

**Recommendation 7:**

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

**Recommendation 8:**

BCUHB should add Mental Health Problems to the midwife to HV Liaison Form

**Recommendation 9:**

BCUHB should audit a sample of health visiting and midwifery records in accordance with their record keeping policy.

**Recommendation 10:**

BCUHB should review their governance arrangements for the return and storage of post natal midwifery records.

**Recommendation 11**:

BCUHB consider ways of increasing engagement with fathers/significant males and ensure that this is documented accordingly in records.

**Recommendation 12:**

BCUHB and the Local Authority should complete the review of the Community Mental Health Team and implement the Serious Case Review Report action plan.

This should include:

- 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.

- Establishing one point of entry for all referrals into the team including those addressed direct to the consultant.

- Review the Protocol for allocation of (and assignment of Care Co-ordinator to) clients to ensure that it is led by the clinical need of the client whilst taking into account geography, capacity and work load.

- Establishing processes to ensure that all members of the team are aware of each client's required needs and the implications of this for the development of Care and Treatment Plans.

- Ensuring that all assessments and care plans of clients with a family 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.

- 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.

- Ensuring that all risk management plans should be 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.

- Reviewing and developing a robust single discharge procedure and,

- Ensuring that all team members should keep accurate and full notes to include assessments and reasons behind key decisions made, and that documents are not post-dated.

A written action plan in relation to this recommendation has been developed following the BCUHB Serious Case Review Report.

**GLOSSARY OF TERMS**

| | |
|---|---|
| BCUHB | Betsi Cadwaladr University Health Board |
| 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 |
| SLA | Service Level Agreement |