Report of the Independent Inquiry into the Care and Treatment of Richard Smart

A report commissioned by Somerset Health Authority and Somerset County Council

December 2001

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Membership of Inquiry Team

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Preface

We were commissioned to undertake this inquiry by the Joint Commissioning Board on behalf of Somerset Health Authority and Somerset County Council. The Inquiry was invited to examine the care and treatment of Richard Smart by the Somerset Partnership NHS and Social Care Trust as is required by the guidance laid down when a homicide has been committed by a person in receipt of mental health services[1]. The guidance states *'in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved.'* The guidance was further reinforced in the document *Building Bridges* (Department of Health 1995) and, as yet, has not been amended. *The National Confidential Inquiry into Suicides and Homicides* published in 1999[2] recommended that alternatives to the existing system of external inquiries should be considered. Independent inquiries such as this are considered to be expensive and the money could be better spent. There is a common held opinion that to view the quality of mental health services through one particular incident may not be particularly helpful in identifying factors that could lead to improvements on a wider basis. The introduction of a clinical governance framework of setting standards, sharing information and developing partnerships will encourage a culture of openness and move away from the 'blame culture' which currently inhibits learning from experience.

Mental health services could learn from the experience of children's services. Following the death of a child there is an immediate review carried out by each agency and then this information is further reviewed by a subgroup of the Area Child Protection Committee (ACPC). In the future, whatever system for homicide inquiries is in place, the needs of families for information and support should continue to be taken into account.

The members of the inquiry team wish to express their sympathy to the family, children and friends of Donna Smart, whose tragic death led to the establishment of this inquiry. We are particularly grateful to the respective families of Donna and Richard Smart who came to talk to us – we are aware just how difficult this will have been for them.

Richard Smart, who was suffering from stress and, possibly, post traumatic stress disorder, was seen on only three occasions by a community psychiatric nurse (CPN) from 15 March 2000 until the death of his wife Donna on 18 April 2000. At the time of his involvement with the community mental health services he was subject to a two-year probation order.

Donna Smart had been a patient of the same community mental health services since 1995, following two admissions to hospital, and was being followed up in the community. Although it was inevitable that during our inquiry we learnt about aspects of Donna's care, it was not part of our remit to make comments about that care, save when her needs related to Richard's - for example, whether or not he should have been perceived to have been her carer.

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1 NHS Guidance HSG(94)27/LASSL(94)4 para. 34.

2 Safer Services: the report of the confidential inquiry into suicides and homicides by people with mental illness 1999

The trust conducted its own investigation into this tragic event. We have been impressed by the speed with which it was completed and are supportive of the ensuing report and the action plan produced. However, we were disappointed to hear that the report had only recently been presented to, and accepted by, the trust board. We understand that the report was discussed with staff to formulate a response and this meant further delay. We endorse the recommendations contained in that report and, therefore, have only made comments in the areas which we felt required more clarity.

The Somerset (now Avon and Somerset) Probation Service also conducted a Serious Incident Management Review. We endorse the recommendations set out in that review and, again, have only made comment in the areas which we felt required more clarity.

We are aware that we conducted our inquiry with the benefit of hindsight, drawing on documentation, information and verbal evidence, from a wide range of people. We tried to seek clarification about the collection of documents for the Internal Inquiry from Mr A Coles, Locality Manager. Unfortunately, this was not resolved as during our Inquiry he was taken ill.

The only member of staff we were not able to see was Mr I Mustafic, who was Richard's CPN. He has been on sick leave since March 2001 and, despite our representations to him, he was advised not to see us or answer any communication until he felt completely well. This was unfortunate as we were unable to establish with anyone else a detailed account of the episode when Richard Smart said that he had tried to hang himself in early March 2000.

Our terms of reference are set out in Appendix 1.

Jane M Mackay

Jane M Mackay
Chair Inquiry Team

Acknowledgements

We are grateful to all the people who came and gave their evidence, despite the personal distress this may have caused, and would like to acknowledge the effect that this incident had on everyone involved.

All witnesses were written to prior to their attendance and sent the terms of reference and the inquiry procedure; see Appendix 2. (A full list of the witnesses can be found at Appendix 3).

We are indebted for the help and administrative support of Mrs Anthea Watson who organised the inquiry and ensured that we had all the documentation we required. We were also greatly helped by the efficient and prompt manner that the Fiona Shipley Transcription Service provided us with the transcriptions of all our interviews.

Summary

Richard and Donna Smart were married in 1987. Donna had a son, born in 1985, from an earlier relationship and they had two more sons born in 1988 and 1992.

Richard was described as hard working and earned his living driving lorries and heavy plant vehicles. He was self employed for some of the time and also worked for one of his brothers and was away from home for long hours, leaving his wife to cope with the three children.

Donna was admitted to hospital on three occasions, twice in 1995 and once in 1997, when she was admitted under Section 3 of the Mental Health Act 1993. She was diagnosed as having bi-polar disorder and, until her death, was in regular contact with the community psychiatric services.

Richard had a series of drink related offences commencing, apparently, at 18 years when he was disqualified from driving for one year for driving with excess alcohol.

The police were called to the family home on several occasions from 1994 onwards as a result of domestic incidents and violent quarrelling.

In October 1999, the police were once again called to the home when Donna had accused Richard of attempted rape. He was bailed to stay at his parents' farm. However, in the following month Donna, with the agreement of the Crown Prosecution Service, withdrew the allegation and the bail conditions lapsed. Richard was arrested the day following this incident, was breathalysed and found to be three times over the limit permitted in law when driving. When the case came to court, he pleaded guilty and was made subject to a two-year probation order. As a condition of the order, he had to attend a Drivewise Programme scheduled to last for 12 weekly sessions.

In the meantime, Donna began to make a life for herself and her sons, alone but with support from her family and her CPN. However, sometime in the New Year, Richard returned home to live, mainly at the weekends, because he missed the children.

On 15 March 2000, Donna telephoned the GP who visited Richard and then made an urgent referral to the community mental health team. About 10 March 2000 Richard said that he had become more anxious and had tried to hang himself at his parents' barn. Instead of returning to where he was living on his parents' farm, he went to his own home in Shepton Mallet. Richard was seen by a CPN and was also given medication. He had become emotionally distressed and reported suffering from flashbacks from his eldest brother's accident in 1994.

His attendance on the Drivewise Programme was suspended until his mental state improved. The CPN was able to see him on three occasions before going on annual leave on 17 April 2000.

The police were called to the home on 18 April 2000 where they found Donna, who had been strangled. Richard was arrested and charged with her murder. The murder charge was later changed to one of manslaughter with diminished responsibility to which he pleaded guilty. He is currently serving a five-year custodial sentence.

Following his arrest and subsequent examinations by psychiatrists for both the prosecution and defence, he has maintained that he cannot remember anything about Donna's death and the period leading up to it, possibly as far back as December 1998.

Chapter 1
Significant events up to and including 1997

1.1 Richard Smart (date of birth 25.12.68) was the youngest of three boys born into a farming family who lived in Pensford, some few miles from Bristol. Apart from some deafness diagnosed at his primary school, he had an uneventful childhood on the farm. On leaving school, he decided to pursue employment in driving. In 1986, aged 18 years, he was banned from driving for one year and fined for driving with excess alcohol. He later obtained his HGV licence in 1989 enabling him to drive lorries and heavy plant. He was considered to be hard working and *"happy go lucky"*.

1.2 Donna Smart (date of birth 14.5.67) was the younger of two sisters born in Shepton Mallet and brought up by their mother following the tragic death of their father, who was crushed in a lorry accident when Donna was aged four.

1.3 Richard met Donna when she was a single parent caring for her son from a previous relationship. They were married in 1987 and continued to live in Shepton Mallet. Richard and Donna had two sons, one born in 1988 and the other born in 1992.

1.4 In April 1994 the police were called to the family home as a result of a quarrel between Richard and Donna during which furniture was thrown about. Donna was concerned about Richard's disciplining of her eldest child who lived in the main with his maternal grandmother. Although not making a complaint, Donna told the police that she was going to see her solicitor with a view to obtaining a divorce. They had both been drinking. There were allegations of a domestic incident, which involved the eldest child, but we were not able to access any documents to confirm this.

1.5 In August 1994 Richard's eldest brother suffered severe head injuries. He had been inflating a lorry tyre when it blew up and the centre wheel hub struck his head. Richard was involved in clearing up the aftermath, which included blood and skull fragments. He was particularly upset because, when he removed his brother's clothes, he realised that someone, possibly a work colleague, had stolen his brother's money.

1.6 This was a very difficult time for all the family including Donna. The brother was not expected to live and had to have major surgery at Frenchay Hospital. The family felt they were left to cope with this on their own with no external assistance.

1.7 In 1995 Donna became unwell and was admitted to hospital as an informal patient on two occasions in April and May of that year. She was diagnosed as having bi-polar disorder.

1.8 Richard was again disqualified from driving in October 1996, this time for three years, and fined £320 with £40 costs as a consequence of driving with excess alcohol. Two months later, on 31 December 1996, he was charged with driving whilst disqualified and, in February 1997, was found guilty and was made subject to a community service order for 200 hours. He was also found guilty of using a vehicle without insurance and was fined £400 with £50 costs. He missed one community service session in March 1997 because the children were unwell and he had to look after them. In April 1997, he was involved in an "*extremely serious*" incident and, as a result, had to undertake another nine and a quarter hours of work. The community service order was completed in September 1997 and he was described as "*a very willing and likeable individual*".

1.9 During this time Richard was able to go to work because he had made arrangements to receive lifts to and from Avonmouth, Bristol, where he worked as a fitter/driver on private land. In June 1997 there was an altercation with the person who was driving him to work. This person suffered severe bruising and cuts to his face and Richard was later charged with assault occasioning actual bodily harm. He was bailed to reside at his parents' home in Pensford – this condition was later varied for him to reside at his home address with a curfew between 11 p.m. and 4 a.m. In September 1997 he was bailed to appear in the Crown Court at a later date for this alleged assault.

Comment

There was no reference to this incident or the pending court hearing in the Probation Community Service record.

1.10 In October 1997 Donna was again admitted to hospital but, this time, under section 3 (Mental Health Act 1993). Donna had jumped out of a window, was seen by the GP and was taken to the Accident and Emergency Department by her sister because she had injured her ankle. She had discontinued her medication the previous week and had become increasingly distressed. She was discharged in December 1997 to be followed up in the community by Ms Morgan, a CPN.

Comment

Donna was more unwell during this admission. Richard was having to cope with his full time employment which took him away from home for long periods of time during the day. He also had the children to look after as well as coming to terms with his wife's illness. It was difficult for the inquiry team, from the information available to them, to come to a view as to whether Richard's needs as her carer were taken into account at this time.

Chapter 2
Significant events in 1998

2.1 In March 1998 Richard had a hernia repaired.

2.2 On 2 April 1998 Richard was acquitted at Taunton Crown Court of the alleged offence of assault occasioning actual bodily harm.

2.3 On 7 April 1998 the police attended the home as, during an argument in which Richard had alleged that Donna had not taken her medication, she sustained injuries to both her neck and hand. Richard was arrested and detained in police custody for breach of the peace. Donna declined to make a statement of complaint regarding the assault. Richard was released at 4 a.m. the following day on the understanding that he went straight to work. The police automatically informed social services' children and families team of domestic violence incidents which occurred when there were children in the house. This was done on this occasion using a Domestic Incident Form then known as Form 131.

Comment

The Inquiry would like to commend this exchange of information as good practice and it will be discussed later in the report.

2.4 In May 1998, following a letter to her from the duty social worker, Donna was seen by appointment in the social services office. She described the incident as a "*one off*" as the family was under stress. Donna had been seen by a psychiatric social worker in the past but it was felt that her input was no longer appropriate. Donna was told that, if any more 131 forms were received, further investigations would be undertaken. A decision of "*no further action*" was taken, although there had been a telephone conversation with the CPN. This was recorded in the social services notes: *"She does have concerns for the emotional well-being of the children, she believes that the children frequently witness domestic violence, caused by both parents' excessive alcohol consumption. Lynne Morgan also voices concerns about frequent physical illnesses that keep them away from school".*

Chapter 3
Significant events in 1999

3.1 Although there was some further involvement with the police as a result of damage to vehicles owned by both Richard and Donna, it was not until 21 June 1999 that there was another call of a domestic nature. Donna informed the police that Richard had gone off in his van taking their ten year-old son with him. Although he had been drinking – two pints of lager - she did not think their son would come to any harm.

3.2 On 10 August 1999 a senior medical adviser to the Driver and Vehicle Licensing Centre (DVLA), wrote to Richard's GP. Richard had had some blood tests which were above the normal limit and, in the absence of liver disease or medication, the application for a driving licence would be refused on the grounds that these abnormalities would be a direct result of alcohol abuse. There was an expectation that the GP would return any relevant medical information in two weeks. In the absence of any alternative explanation, an assumption was made that there was none and the driving licence would be withheld.

Comment

On 3 November 1999 a doctor from the DVLA wrote again to Richard's GP concerning the recommendation made by the licensing authority, which was that Richard should not drive. This was in response to the earlier letter and, as nothing had been received from the practice about any relevant liver disease or medication to account for the irregular blood tests, Richard would not be granted a licence until the tests reverted to normal. Despite this later correspondence between the DVLA and the GP, Richard appears to have had his licence restored in March 1999.

3.3 On 16 October 1999 Richard, Donna and the children went out for an evening meal, returning home at about 8.30 p.m. Later that evening, there was a fight between them, leaving Donna with visible injuries. Richard left the house and, the following morning, Donna telephoned the police who called at the house. They took photographs of the bruising as Donna was intending to press charges on this occasion. Later that day at 1.30 p.m., whilst driving, Richard was apprehended for the assault, when his speech was found to be slurred and he smelt of alcohol. He was breathalysed and, as he tested positive, the reading being three times over the permitted limit, he was arrested. On 18 October 1999 at 5.30 a.m., Richard eventually tested negative and, later that morning, he was bailed to stay away from Shepton Mallet and his wife with a condition that he reside at his parents' farm.

3.4 On 25 October 1999 Richard was charged with driving with excess alcohol and driving whilst disqualified, as well as with a separate charge of assault occasioning actual bodily harm to his wife.

3.5 On 5 November 1999, the duty social worker telephoned Donna's CPN, having received the domestic violence form from the police on 25 October 1999, who still remained concerned about the children witnessing the violent behaviour of their parents. Donna did not want Richard back in the home. He was seeing the children at their paternal grandparents' home. Further telephone calls to the school revealed that the elder of the two boys was not coping very well and had been crying and attention seeking. Both boys were reluctant to leave their mother.

3.6 On 19 November 1999, the same duty social worker from the children and families team, visited Donna. In consultation with her manager, the decision following this meeting was to take no further action.

Comment

We were told that two or three notifications of domestic violence on the form 131 from the police over that kind of time span were not considered unusual. However the inquiry team felt that there was probably enough information for a planning meeting to have been called with all known professionals to discuss any future involvement with the family and subsequent action. This was at least the third incident of this nature reported to social services. When checks with other agencies were made, there were still the same concerns about the children. When we interviewed the area manager, children and families, he offered the view, with hindsight, that possibly a planning meeting should have been held following receipt of the October 1999 131 notification from the police.

3.7 In any event, on 30 November 1999 Donna withdrew her complaint of assault saying that she was "*trying to get it straight*" with Richard and that to go ahead with it was not in either of their interests. Now that she had retracted her original statement about the assault, Richard's bail conditions lapsed.

3.8 On 7 December 1999, at Wells Magistrates' Court, Richard pleaded guilty to driving whilst having excess alcohol (112mg, the normal limit being 80mg) and was referred for a probation pre-sentence report (PSR). The request form indicated that the offence was "*so serious*" that custody was under consideration.

3.9 On 15 December 1999 Richard was assessed as a suitable candidate for the Drivewise Programme and the programme manager's report, which drew attention to the domestic stresses, was submitted to the court along with the PSR, which was completed on 30 December 1999.

3.10 On 26 December 1999 Donna telephoned the police because she wanted Richard removed from the house because he had come home drunk and was now asleep on the settee. The police took no action on this occasion.

Chapter 4
Events in 2000

4.1 On 4 January 2000, at the adjourned court hearing, Richard was again disqualified from driving for three years and made subject to a two-year probation order with a condition to attend the Drivewise Programme. The next day Richard reported to the probation office, as instructed, when the requirements of the probation order were explained to him.

4.2 On 11 January 2000 Mr Porter, Probation Officer, visited Richard at home. Donna was present for the whole of the interview. Some issues became apparent during the interview. Richard was not currently living with his wife. He lived at his parents' farm during the week and spent the weekends at home with Donna and the children. The reason for this was given as his heavy drinking and he was consuming larger amounts of alcohol than he had admitted to before. Donna also confided to the probation officer that she was being seen by the mental health services.

4.3 On 19 January 2000 Richard attended the probation office and his marital situation was discussed although he was evasive.

4.4 On 26 January 2000 Richard again attended the probation office and was more open about his situation at home, acknowledging that the last few years had been very stressful.

4.5 On 2 February 2000 the Drivewise Programme Manager, Mr Bradley, completed an initial interview in which the programme details were explained to Richard and he completed an alcohol knowledge test scoring 6/20. In all, 12 sessions were planned, nine at the Yeovil Probation Office and three at Yeovil Police Station and were to take place every Tuesday. Richard's parents had agreed to take him as he was staying at the farm for some of the time during the period of the programme.

4.6 On 15 February 2000 Richard attended the first Drivewise session. He was considered to be co-operative, fairly open and honest, particularly about his drinking levels.

4.7 On 22 February 2000 Richard attended the second Drivewise session.

4.8 On 7 March 2000 Richard attended the third Drivewise session. He participated well in the group and enjoyed expressing his views on the course material.

4.9 On 8 March 2000 Donna failed to keep her appointment with Dr Dobson, Consultant Psychiatrist, and, following discussion with Ms Jacks, Team Manager Community Mental Health Team (CMHT), Ms Morgan was to undertake continued contact with Donna on behalf of the team.

4.10 On or about 10 March 2000 was the date on which Richard said he attempted to hang himself at his parents' farm. He alleged that in fact a beam broke during the attempt. Instead of staying on his parents' farm, he went to his own home in Shepton Mallet.

Comment

It is worth noting that neither Mr and Mrs Smart nor Richard's elder brother had any knowledge of this event and were sceptical that it might have occurred.

4.11 On 11 March 2000 Donna called the police, who attended at 2.55 a.m. Richard had returned drunk and she thought this would lead to other problems. There was no sign of violence on this occasion.

4.12 On 14 March 2000 Richard failed to attend the fourth Drivewise session.

4.13 On 15 March 2000 Donna telephoned Dr Walker who called at the house and referred Richard to the CMHT because he was suffering acute stress. Dr Walker's hand written note recorded *"Acute stress reaction urgent referral to CMHT"*. The computer record of his visit stated *"Acute stress. Self harm attempt yesterday. Has been working long hours 18+ per day, separated from wife and children and missing them very much, also elements of post traumatic stress synd over brother's horrific accident 6-7 years ago. Very heavy drinking and is currently attending Drivewise drink/drive course as a condition of having lost his licence".*

4.14 Dr Walker also telephoned Mr Porter, the Probation Officer, to say that Richard was not fit to attend the Drivewise Programme due to health concerns and was going through an acute emotional crisis and he was possibly going to admit him to hospital. Richard was now living back at home and had decided to give up work. Mr Mustafic (CPN) saw Richard with Donna at the mental health centre.

4.15 Mr Mustafic wrote a letter dated the same day to Dr Walker: *"He came along with Donna his wife and he let her do the talking initially but eventually requested to speak himself. Once he began to speak, he spoke quite spontaneously and gave a good account of his situation during the last six years. Significant points were: he continues to have flashbacks of 'blood and bits of skull' just as he witnessed at the time of his brother's accident. He had been working up to 18 hours a day with little sleep in between. Last October he received a drink driving ban of three years, adding to his difficulties in getting to work. At this time he was living away from Donna and the children. He had been drinking up to 15 cans of lager a day but now cut it down to 2-4 cans/day. He has very recently returned to the marital home partly at Donna's request to help in supporting the children. Things became critical for Richard at the end of last month when he tried to hang himself at his father's farm. Fortunately he got the mechanics of it wrong – the support broke. He says he is now very relieved that this happened, describing himself as someone who has never had suicidal thoughts and certainly does not want to end his life now. It certainly appears to me to have been a desperate response to overwhelming life stressors. I felt that the most helpful way forward in the short term was to offer him another early appointment next week, to refer him to the out of hours telephone service at Phoenix, Wells and to liaise with Lynne Morgan to ascertain the wider picture. I also thought that a few days supply of Lorazepam would be a good idea".*

Comment

Dr Walker and Mr Mustafic were the only people to make any reference to this self harm incident. Dr Walker told us that an event of this kind was significant enough to make a note of it. In Dr Walker's written evidence to us he said: "*He* (Richard Smart) *recounted that he had tried to hang himself previously, fortunately had failed and for which he expressed some remorse in having tried as he realised that he did not to wish to be successful*".

In verbal evidence to us, Dr Walker told us he had no recollection of whether Richard had told him or it was the letter from Mr Mustafic which informed him of the attempted self harm. We were unable to clarify this with Mr Mustafic

4.16 On 16 March 2000 Donna's CPN telephoned the out of hours service and informed Dr Sharp (Donna's GP) by fax, to give them an update of the current situation. She said that she would visit daily and that Mr Mustafic would visit the following week.

4.17 On 19 March 2000 Donna contacted the out of hours service as Richard was complaining of feeling dizzy and he had not taken any Lorazepam. She was feeling much better and was going back to work the following Monday. Advised to take Lorazepam as prescribed.

4.18 On 20 March 2000 Richard was seen by Dr Walker in the surgery. Notes state: *"Chronic alcoholism. Has been drinking quite heavily today. Requesting help with coming off. Would take Antabuse if given. Lorazam tablets 1mg 1 bd* (twice per day) *6 tablets given".*

4.19 Later that night the out of hours doctor was called. *"Psychiatric problem. Mother trying to take him home from his estranged wife's home and can't get him into the car. Visited – disturbed eventually persuaded to accept inj. Halperidol 3mg and taken away by mother at 01 25. Agitated depression".*

4.20 On 22 March 2000 Mr Porter (Probation Officer) telephoned Richard at home but there was no reply. According to the community psychiatric nursing notes, a risk assessment was completed and noted that Mr Porter was visiting weekly and Richard was attending a course on the effects of alcohol in connection with a drink/driving ban. Richard attended the mental health centre in Shepton Mallet and appeared more at ease than the previous week but "*Feels embarrassed at coming here. Does not want to be seen coming into the building. Pleased to be back with Donna and the children. Plan – to offer more appointments for a short period as a crisis management package. See in 1/52".*

4.21 On 23 March 2000 Richard did not attend the fifth Drivewise session and, as this was the second session he had missed, he was suspended from the programme.

4.22 On 27 March 2000 Richard was seen in the surgery by Dr Sharp. On examination *"Acute anxiety. Medical certificate given. Lorazepam very helpful but recurrence of adrenergic. Sees Ismet weekly – helpful. Cut down on alcohol to one strong lager a day. Lorazepam tablets 1mg 1 up to tds* (three times per day) *and 15 tablets given. Counselled. Element of alcohol withdrawal (but no blackouts)".*

4.23 On 29 March 2000 Mr Porter telephoned Richard again and this time had a conversation with him. Richard told Mr Porter that he had had a breakdown following the build up of pressure over the years, was now on medication and preferred him not to visit during the day. Richard went to Charlton Road with Donna to see Mr Mustafic and was much more relaxed and said he was not drinking at all and he was planning to stay with Donna.

4.24 Ms Laird (duty social worker) also saw Donna that day, having written to her following the receipt by social services of the domestic incident form from the police, issued as a result of the incident on 11 March 2000. Donna was joking and laughing quite a lot and told Ms Laird that she was making a life for herself, saying this is what she wanted and she was going to stick to it, appearing quite positive about her future.

Comment

From the note made at the time it was unclear to us exactly which agencies were contacted by the duty social worker but we do know that the probation service was not, as it was not on the usual check list. Probation was only contacted if their involvement was known to social services. It was also unclear from the notes what information, if any, was obtained from the GP. The duty social worker did not know of probation staff involvement or that Richard was attending the Drivewise Programme. She did not know that he was also seeing a CPN and taking medication because of an emotional breakdown.

The inquiry team was pleased to hear that link workers have now been nominated to work between Community Mental Health and Children and Families Teams so that information can be shared on a regular basis.

4.25 On 31 March 2000 Ms Morgan (CPN) left a 'post it' note on the front of Donna's records for Dr Dobson: *" Suzanne, not sure if you will have known about Richard (h'band) – tried to hang himself mid 3/00- moved back into marital home. Ismet providing short-term individual input. R. is on probation for drink driving- if found guilty would prob. be considered for short custodial sentence. He has considerable drink alcohol prob. (+ some drug use). Lynne"*

4.26 Dr Dobson did not see this note at this time as the case-notes were kept in a different location.

4.27 On 3 April 2000 Mr Porter made a home visit and found Richard marginally better though recognising that the effect of the long working hours he had been doing over the last seven years had finally caught up with him and that it would probably be another six months before he was able to return to work. Mr Porter helped Richard to complete an unemployment benefits application.

4.28 On 6 April 2000 Richard failed to keep his appointment with his CPN.

4.29 On 10 April 2000 Richard was reviewed by Dr Walker at the surgery: "*Anxiety state. Has reduced his drinking considerably, but still easily stressed. Takes approx. 2 Lorazepam/day. Not sleeping, difficulty in going to sleep. Continues with Ismet and probation officer on a weekly basis*".

4.30 On 12 April 2000 Mr Porter again visited Richard at home and Richard told him he was feeling much better and wanted to return to work. His GP had advised against this idea. When going through the Probation Supervision Plan, Richard was reported as able to recognise what some of the issues were and was prepared to look at ways to recognise when stress levels were rising and how to deal with them. Donna joined them and Mr Porter observed that their relationship had improved, although there was still some friction. As Richard was feeling better, Mr Porter advised him to wait for an appointment; in other words, Richard was saying that he now felt able to travel to Wells for an office visit.

4.31 On 13 April 2000 Mr Mustafic telephoned Richard and made a further appointment for 3 May 2000. On the same day, Donna failed to keep an appointment with Dr Dobson who recorded that no further appointments for medical review would be sent unless requested by Ms Morgan.

4.32 On 17 April 2000 Mr Mustafic wrote to Dr Walker: "*I have now seen Richard on three occasions on a weekly basis. The immediate emotional crisis seems to have blown over, and accordingly Richard failed to turn up for the fourth session. I have offered another appointment on 3 May and will let you know how things are then*".

4.33 On 18 April 2000 the police were called to the house at about 9.30 pm, following which Richard Smart was arrested for the murder of Donna.

Chapter 5

Domestic violence and the responses from the different agencies

5.1 The Chief Medical Officer's Report for 1996 highlights problems associated with domestic violence. In the following year, a joint letter by Sir Herbert (now Lord) Laming, the Chief Inspector of the Social Services Inspectorate, and Dr G Winyard, Director of Health Services (NHS Executive), was sent to all health authorities and social services departments. This set out a framework that staff could use to identify signs of violence, questions to ask to clarify potential and actual violent situations and appropriate documentation.

5.2 In England and Wales in any one week, two women are killed by either a current or former partner and around 25% of women experience domestic violence at some point in their lives[3]. Research has shown that domestic violence is likely to become more serious and more frequent the longer it continues. Research has also shown that children, who are either present at or hear incidents of domestic violence, can be deeply affected, i.e. distressed and confused. In 90% of incidents occurring within families children are in the same or next room.

5.3 Some children may not display any visible reaction but it should not be assumed they are unaffected. Evidence also suggests that the risk of violence against women is increased in separating couples, in poor households and in situations where women lack their own economic resources and are dependent on their partners.

5.4 In England and Wales domestic violence is defined as: *"Any violence between current or former partners in an intimate relationship wherever and whenever it occurs. The violence may include physical, sexual, emotional or financial abuse".* Recognising that no one agency can tackle the issue of domestic violence, the Home Office published multi-agency guidance for addressing domestic violence in the document *'Domestic Violence: Break the Chain' (2000).*

5.5 We learnt that the Avon and Somerset Constabulary has now appointed five domestic violence officers for the different police divisions within Somerset. We learnt that in the Mendip area the forms, which are completed by the attending officer/s, are now hand delivered to social services and, in the case of those involving children under five, to the health visitor. If necessary they are handed to the CMHT. The designated domestic violence police officer also makes contact with the family, visits and, when necessary, refers to Victim Support for ongoing support. This happens if it is a second occurrence within a 'rolling' year or when it was judged to be serious enough.

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[3] Domestic Violence: Revised Circular to the Police HOC 19/2000

5.6 The inquiry team was pleased to learn that the police in Avon and Somerset had been informing the children and families branch of social services of all incidents of domestic violence in households where there were children at risk of abuse and had been doing so for some years. A form known as the '131' was sent to social services some time following an incident. The form has since been amended and is referenced as CID1/Dom1 (Appendix 5). The receipt of the form by children and families teams was followed up with a series of checks to other professionals who might have some information about the family. These checks were made to health staff, the health visitor and/or CPN and GP, as well as education staff if the children were of school age. The inquiry team was surprised to learn that the probation service was not an automatic contact. In this case, if the duty social worker had contacted the probation service in March 2000, she would have learnt that Richard was attending the Drivewise Programme and the probation officer would have been made aware of the recurrent, serious nature of the family violence.

Comment

Whilst the inquiry team is not suggesting that sharing information about the previous domestic violence would have changed the outcome of this particular incident, there is no doubt that agencies work better together when there is a free flow of information. We were told that the police now notify the health visitor direct rather than relying on the information to be passed on by the children and families team.

Recommendation

We recommend that social services children and families teams include the probation service on the list of agencies to be contacted when they are in receipt of a form CID1/Dom1.

5.7 The inquiry team was pleased to learn that a seminar, facilitated by the South Somerset and Mendip Domestic Violence Forum, was held in April 2001. The team received a copy of the report and action plan from the day's activities. This included the need to:

- Produce a directory of services
- Develop a tool kit to assist professionals to identify domestic violence
- Explore the opportunity to provide specific training support for agencies
- Establish a follow up event

Recommendation

We recommend that this action plan be implemented across Somerset.

We also recommend that a multi-agency group be set up, following the publication of this Independent inquiry's report, with the following remit:

i) To identify the level of domestic violence in Somerset

ii) To identify criteria which would trigger an inter-agency response

iii) To develop a multi-agency training programme which takes account of the issues as described in the Home Office Circulars: *'Domestic Violence: Break the Chain' and 'Domestic Violence: Revised Circular to the Police'*. The training programme should also take account of the letter from Sir Herbert (now Lord) Laming and Dr G Winyard dated 6 November 1997

iv) To provide support to agency workers who are faced with domestic violence as part of their professional relationships with clients

v) To identify appropriate funding and administrative support for designated staff working in the field of domestic violence.

Chapter 6

Use of alcohol and the risk of domestic violence in homicide

6.1 It is well established that alcohol is a major risk factor in relation to offences of violence and road traffic accidents as well as accidents at work and in the home[4]. In 1998 it was estimated that 460 people died in drink-drive accidents and 2,520 were seriously injured. Accidents with alcohol as a contributory factor are estimated as 20-25% of all workplace accidents. Research has consistently shown that a high proportion of violent crimes (50% - 80%), including assault, rape and homicide, are committed by intoxicated persons. Public drunkenness is associated with 40% of violent crimes, 78% of assaults, 88% of criminal damage, with alcohol often consumed by offenders and victims.[5] The association of alcohol as a risk factor in violence is greater than as a risk factor in mental illness.

6.2 Both Richard and Donna were recognised to have had major problems with alcohol over a number of years and Donna's CPN had discussed this with both of them and offered referral to specialist alcohol services in 1999. This was declined by both of them at the time.

6.3 Richard and his family minimised his alcohol intake at times. Such minimisation makes it harder to engage with treatment. Drivewise was a first step programme designed to enable a participant to go on to further levels of intervention as necessary.

6.4 The inquiry team met with two probation officers involved in running the Drivewise Programme including Mr Bradley, who assessed Richard's suitability for it, undertook the introductory session with him and was present on the three occasions he attended. It is a rehabilitation programme for 'drink drivers' established in 1989 by the then Somerset Probation Service and Avon & Somerset Police Road Traffic Department.

6.5 Its objectives are entirely directed at the drink/driving nexus, e.g. changing attitudes to drink/driving, knowing its consequences, managing drinking patterns. It is a programme that is accredited nationally and thought to be very effective in meeting its objectives in reducing repeat offending.

6.6 It appears that two broad types of people attend the programmes: those whose attitude to the law with respect to drinking and driving is faulty; and those for whom inappropriate use of alcohol creates problems. However, it appears that the programme is not about the use of alcohol *per se* but about its

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[4] alcohol and accidents - Alcohol Concern fact sheet 9

[5] Tackling Alcohol Related Crime, Disorder and Nuisance: Action Plan, Home Office, 2 August 2000

impact on driving. The programme could be diagnostic in terms of more acute difficulties associated with alcohol abuse and once a programme had been completed it was up to a supervising probation officer to make referral to a specialist alcohol treatment service.

Comment

It did not appear that staff from the local Alcohol Advisory Service were involved in the management of the Drivewise Programme.

Recommendation

We recommend that health, police, probation and social services implement a training programme which acknowledges the effect of alcohol on aspects of family life increasing the risk factors in homicide, domestic violence and child abuse. The subject of this report could be used to illustrate the dilemmas faced by professionals.

Chapter 7
Sharing information

Sharing information between team members

7.1 Communication and the sharing of information is the essence of good professional practice and should never be underestimated, particularly because practitioners know their clients really well. Bearing this in mind we feel it necessary to say something about one aspect of this case which caused us some concern. Two professionals were working alongside each other and working with two family members. It was difficult to ascertain just how much of the history was known to both practitioners.

Comment

The Inquiry noted that one worker received a form of supervision outside of the team management setting. That may have been valuable for individual professional development but should not be a substitute for the structured support and review provided by a team manager.

7.2 Following the events of the previous months and the incident in October 1999, professionals working with either Richard or Donna became unclear as to whether they were truly living together as a couple or in fact were living apart. Even if they were separated, the fact that they had children together who had contact with their father when he resided elsewhere, meant that they should have been looked at in a linked way. They were a couple who, essentially, had an "*enmeshed*" relationship as it was so eloquently described by one of our witnesses. Their individual needs, requiring one-to-one working with a professional worker, should have been assessed in the context of their family responsibilities as carers to both their children and, when Richard became unwell, their own roles of adult carer to each other.

Recommendation

We recommend that the consultant and team manager of each mental health team take responsibility for joint reviews and supervision with individual practitioners of those cases which meet the following criteria: enhanced CPA, multiple family members and/or multi agency involvement, on a regular basis.

We recommend that in cases where there is a long-standing familiarity with clients, more attention is given in supervision and case management to formal reviews of situations with review decisions recorded.

We also recommend that the consultant and team manager of each mental health team should be made aware of all new clients within four weeks of the referral.

7.3 Not dissimilar points may be made in respect of the probation officer and duty social worker. Both indicated that they were frequently in touch with other agencies but in this case, while its usefulness was identified, contact was not made. Client confidentiality may have been one aspect of this situation; another may have been current work constraints that led to a narrower, in-house work focus. Clearer frameworks or protocols should encourage practitioners to be in more frequent contact. However, what will still be required is a culture of practitioners being in touch and willing to say, as it was put to us: *"We are working with this person. It seems that you are too. What information do we need to exchange so that we can both discharge our responsibilities more effectively?".*

Recommendation

We recommend that this case be used a learning tool to promote the notion of 'family dynamics' and a different approach to working with individuals when different family members are being seen. This should not detract from their individual needs but seek to enhance them by completing the picture.

A multi agency framework

7.4 The sharing of information deemed to be confidential has already been established in two areas of working practice, these being child protection and the management of potentially dangerous offenders. Good working arrangements in community services rely on individual professionals trusting each other and sharing knowledge of each other's concerns about some of the people they are working with in the community. Whilst this is highly commendable and good practice, it should be within a suitable framework which has been signed up to by all agencies concerned with community safety.[6]

7.5 The purpose of such a framework would be to ensure that appropriate levels of confidentiality are maintained at the same time as minimising the risk posed by any person in the community to themselves and to the public at large. For any framework like this to work, it should not be bureaucratic but rooted in the practice of individual professionals. Sharing responsibility across the range of relevant agencies concerned about community safety not only strengthens the management of individual cases but also reduces the likelihood of a serious incident occurring. It should also provide support to staff when having to make difficult decisions.

7.6 Working within a framework for sharing of information should engender trust between individual agencies as well as individual practitioners. However, it is important to define the areas of concern which can be discussed in this forum so that individual practitioners do not contravene any professional code of conduct but use the framework and their own codes to reinforce the need to share information.

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[6] The Sharing of Information Protocol within Warwickshire agreed March 1998

7.7 This kind of framework should not detract from the already agreed protocols and legal requirements for child protection and disclosure under the Sex Offenders Act 1997.

Recommendation

We recommend that chief officers of agencies concerned with community safety agree a framework for sharing information about individuals who are either at risk or potential risk. The framework should include:

i) Agreed definitions of risk
ii) Existing legal frameworks
iii) Principles regarding risk
iv) Existing professional codes of conduct

We also recommend that a multi-agency training programme is developed to implement an agreed protocol and to reinforce working together.

We further recommend that the outcome of working within this framework is monitored and reported back to the chief officers.

Chapter 8

Internal inquiries (Somerset Partnership NHS & Social Care Trust and Somerset Probation Service)

8.1 Although one of our terms of reference was: *"To examine the recommendations of the report from the locality manager in response to the internal inquiry published in January 2001 and to assess the implementation of them"*, we also looked at Somerset Probation Service's Serious Incident Management Review.

The trust's internal inquiry

8.2 This inquiry was chaired by Mr D Wilkes, Non–Executive Trust Board member, who was assisted by Dr D Mawson, Consultant Psychiatrist and Mr A Coles, Locality Manager. The terms of reference of the internal inquiry can be found at Appendix 6.

8.3 The internal inquiry team met on five occasions, commencing on 9 May 2000. During the course of the Inquiry they interviewed Dr Dobson, Mr Mustafic and Ms Morgan, who were accompanied by Ms Jacks. At the second meeting on 16 May 2000 all the relevant papers became available, although it was not clear to the internal inquiry when all the entries had been completed. We were told that Richard's main file was held in Frome and that Mr Mustafic had taken the integrated care programme approach (ICPA) document to Shepton Mallet, pending his next meeting with him.

8.4 It was explained to us that, because of leave commitments, Mr Mustafic had pended his ICPA assessment in the Shepton office ready for this to be discussed with Richard and signed by him on his return.

8.5 Record keeping is an integral part of nursing practice, the United Kingdom Central Council, regulatory nursing organisation, UKCC[7] expects that nurses make contemporaneous notes and provide clear evidence of the care planned and any decisions made. Good record keeping allows for continuity of care, better communication and dissemination of information between members of teams, particularly in the absence of the key worker, care co-ordinator or named nurse.

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[7] Guidelines for Records and Record Keeping UKCC 1998

Comment

Good practice would dictate that records must be readily available in a practitioner's absence in the event of another colleague needing to provide care or in the rare event of a serious incident.

8.6 On completion of their report, the internal inquiry team presented it to Mr P Cooney, Chief Executive Somerset Partnership NHS and Social Care Trust on 3 June 2000.

8.7 In conducting the investigation only informal notes were taken rather than typed interview notes. On reflection it would have been helpful to us if typed notes had been taken, as this was the only opportunity we had of reviewing Mr Mustafic's role with Richard Smart.

Recommendation

We recommend that the trust ensures that administrative support, including typing of interviews, is available in the event of a serious incident inquiry.

8.8 The internal inquiry concluded that:

1. Communications were not good enough neither within the mental health team nor between them and other agencies.
2. The quality of documentation was weak and not kept in one file.
3. There were indications that Richard Smart may have been unwell; there was no evidence that this was pursued.
4. There is a weakness if files are kept off site from the normal place of use.
5. There should have been a joint evaluation of any risks posed in this case, given that there was a well documented history of domestic violence of a serious nature on many occasions involving the police.

8.9 Having come to these conclusions, the internal inquiry then went on to recommend:

1. Patient documentation must be kept up to date, in order by date, with dates clearly shown on each document........
2. Where couples both use the service, a clear joint case review should take place and be recorded in both sets of notes.........
3. Case notes and ICPA forms must be kept together and must be brought up to date with within five days....
4. Where violence occurs within a family setting, the needs of the children should be addressed by social services by the involvement of the link worker....
5. Where other agencies such as probation, police, or child services are involved in a case, they should be involved in all case reviews and the outcome recorded.

8.10 The locality manager prepared a response and action plan and presented it in January 2001 and it was accepted by the trust board sometime later. This inquiry endorses the recommendations and has decided, therefore, not to go over the same ground covered by the report and the locality manager's response paper.

Recommendation

We endorse all the recommendations of the internal report and in addition **we recommend**:

i) that the action plan is shared with the other locality managers and managers of associated services, including those from other agencies

ii) that the trust undertakes an audit of professional records

iii) that the trust board has a regular agenda item to monitor the implementation and progress of the action plan.

We also recommend that the Joint Commissioning Board should develop an action plan, based on our recommendations, in consultation with Somerset's Community Safety Strategy Partnerships.

Probation Service Serious Incident Management Review

8.11 The inquiry team met with Mr Paul Stopard, Assistant Chief Probation Officer (ACPO), author of this review. His conclusions (which we have composited) were:

- "The killing of Donna Smart could not have been predicted on the basis of the information available.

- The risk assessment, procedurally, was in accordance with national standards and local policy. The subsequent management of the case was commensurate with the level of risk identified [i.e. further drink/drive offences]. The case was supervised in accordance with national standards, and the planned intervention, to address the key factors in the offences of which Richard Smart had been convicted, was implemented promptly.

- The content of the risk assessment was, however, undermined by not taking into account information concerning behaviour which did not result in formal convictions, and information potentially available from other agencies involved with the family. Liaison with other agencies involved did not take place, and would have helped in information gathering and ongoing assessment. Had this information been taken into account, it is likely that there would have been an assessment of a higher risk of harm, leading to discussion with the senior probation officer and greater information sharing and joint decision making with the other agencies involved. It is unlikely, however, that this would have prevented the killing."

8.12 Mr Stopard also made a number of recommendations, now broadly implemented, which have parallels with those from the Partnership's internal inquiry:

1. *Paragraphs 2.1.6 and 2.1.7 of the Somerset Probation Service Public Protection Policy should be moved to section 4 (Guidelines for Assessing Risk) in Version 3 of the Policy [Issued August 2000].* The more important of these two paragraphs reads:

"In assessing whether an offender should be classified as potentially dangerous, all behaviour whether resulting in prosecution or not should be considered. This will include matters which have come to the notice of the agencies involved from a variety of sources, and may include behaviour which is not in itself criminal. Whilst care should be taken to verify all such information, lack of corroboration should not prevent it from being taken into account in the assessment process."

2. *Version 3 should be accompanied by team briefings and practice meetings by senior probation officers on the Guidelines for Assessing Risk section of the policy.*

3. *An internal inspection planned for the autumn of 2000 to assess the level of ... 'defensible decision making in respect of harm in all cases'. The inspection brief should contain an objective specifically addressing the issue of information taken into account in reaching assessments of risk.*

   This recommendation was implemented via work undertaken as part of the regional performance inspection programme carried out by HM Inspectorate of Probation between February and May 2001. This involved reading significant samples of case files against checklists covering all aspects of supervision including *'sufficiency'* of risk assessments. The report of this Inspection is due autumn 2001.

4. *Senior probation officers should develop individual objectives and action plans for staff on risk assessment as part of supervision and appraisal processes. Learning and development needs should be identified and communicated to the training manager.*

   This is now to be addressed (from 1 October 2001) through a national system for monitoring performance in relation to all aspects of national standards, including those for the assessment and management of risk.

5. *The assistant chief probation officer with responsibility for 'Effective Practice' should develop practice guidelines for supervision planning and case management in cases where the main focus of intervention is structured programme delivery* [e.g. "Drivewise"].

6. *Where the probation service is supervising a case in which the Somerset Partnership is also involved, there should be an invitation for involvement in any reviews held by either agency. The manager with responsibility for 'Public Protection Policy' should agree the detail of this with representatives of Somerset Partnership.*

   The Mendip SPO and the Mendip Partnership locality manager have taken this forward and this has resulted in regular, planned meetings between staff from both teams. Work on more routine checking and exchange of information has not been completed because national guidance in the context of data protection and human rights legislation is awaited.

Comment

It was encouraging that Mr Stopard had met with Mr Cooney, Chief Executive of the Partnership, to progress sharing of information between health and probation with work ongoing to develop a shared protocol for information exchange. Mr Stopard agreed with the inquiry team that there was merit in joining forces to conduct such reviews.

Recommendation

We endorse the recommendations of the Probation Service Serious incident management Review.

Probation service assessment: the pre-sentence report (PSR)

8.13 Reference is made in the conclusions of the probation service's serious incident management review to the importance, where risk assessment is concerned, of taking into account information concerning behaviour which did not result in formal convictions.

8.14 In looking at the assessment role of the PSR in this case, we have identified two occasions in which pressures on PSR writers meant that the only information they had available, other than from previous probation records, was the unverified account given by the defendant. In February 1997 when Richard was made subject to a 200 hours community service order for driving while disqualified, a PSR was presented to the court. That report was based on only one interview with him with no examination of domestic or social factors as to why a young father and husband might be using alcohol in a way that threatened his livelihood. Nor had the Crown Prosecution Service made a pre-sentence package of relevant information available to the report writer. A home visit at that time would have revealed that a few months previously Donna Smart had been sectioned and, on release from hospital, was needing substantial support.

8.15 Richard was subject to a probation order at the time of his wife's death. Mr Porter was the probation officer who undertook the preparation of the PSR and, because of the drink/drive implications, referred him, quite properly, to the probation officers running the Drivewise Programme for assessment. The PSR was based on one interview with Richard drawing very much on his account of the situation. At the time of interview the report writer did not have the pre-sentence package from the Crown Prosecution Service so was unaware of the background to the offending behaviour, which had commenced with an allegation of violence nor, apparently, did he have time to undertake a home visit at that stage. There are a number of contextual factors that need to be borne in mind in respect of the limited information available then. One was the pressure to prepare such reports to a tight timescale. A second was that the adjournment for report was over the Christmas and new year holiday period. A third was the staffing situation in Mr Porter's office: the office manager had just been promoted, one of the five team members was on long term sick leave and another on extended leave.

Comment

The inquiry team does not think it is in the public interest or that of courts that PSR assessments should be as constrained by factors of time, officer availability and lack of information from the prosecuting authorities as manifested in this case.

8.16 We were encouraged to learn of some changes envisaged with the imminent introduction of a new assessment procedure for probation and prisons called OASys, and also by moves afoot nationally to give the PSR assessment process a higher profile. Key questions likely to be posed in respect of the monitoring of national standards for PSRs are along the lines of: *"Was the assessment of risk, e.g. to others, to self, to the victim of the offence, a 'sufficient' one?"*, and: *"Was all the available, relevant and verifiable information taken into account when the risk assessment was formulated?"*

Comment

Probation officers and others who work in the criminal court setting become used to working with *'beyond all reasonable doubt'* as their touchstone. In the context of their responsibility for public protection, based on accurate risk assessment and management, it might be helpful if their touchstone were to be *'on the balance of probabilities'* - the burden of proof in the civil jurisdiction.

Chapter 9
Conclusions and recommendations

9.1 The inquiry team was asked to examine all the circumstances surrounding the care and treatment received by Richard Smart from the community services. We have already acknowledged that Richard Smart was only in contact with the mental health services for a short time. We have concluded that Donna Smart's death was not as consequence of any deficit in the care received by Richard Smart. We hope that we have identified areas of practice where lessons can be learnt, especially in understanding the role alcohol plays in domestic violence as well as the way people use it to cope with life crises.

Domestic violence and the responses from the different agencies

9.2 Throughout the time Richard and Donna Smart were married there were intermittent episodes of domestic violence resulting in them coming to the attention of the police on several occasions. Problems associated with domestic violence are compounded by historical structures in society and condoned by many institutions such as the prosecuting authorities and in some instances the police. There has been a popularly held view that without a woman being willing to give evidence against her spouse or partner there would be little chance of a prosecution succeeding. In the last few years there has been a greater emphasis on addressing this belief, with positive approaches both nationally and locally with the setting up of inter and intra-agency initiatives.

We recommend that

1. Social services children and families teams include the probation service on the list of agencies to be contacted when they are in receipt of a form CID1/Dom1.

9.3 We were pleased to hear about the seminar arranged by the South Somerset and Mendip Domestic Violence Forum and the subsequent action plan developed there.

We recommend that

2. The action plan from the seminar held in April 2001 be implemented across Somerset.
3. A multi-agency group be set up, following the publication of this independent inquiry's report, with the following remit:
   i) To identify the level of domestic violence in Somerset
   ii) To identify criteria which would trigger an inter-agency response
   iii) To develop a multi-agency training programme which takes account of the issues as described in the Home Office Circulars: *'Domestic Violence: Break the Chain' and 'Domestic Violence: Revised Circular to the Police'.* The training programme should also take account of the letter from Sir Herbert (now Lord) Laming and Dr G Winyard dated 6 November 1997

iv) To provide support to professionals who are faced with domestic violence as part of their professional relationships with clients

v) To identify appropriate funding and administrative support for designated staff working in the field of domestic violence.

Use of alcohol and the risk of domestic violence in homicide

9.4 *"All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption"* (The World Health Organisation's European Charter on Alcohol).

9.5 This case demonstrates how alcohol can influence family life and increase the stresses and strains. It was interesting to hear different views of Richard Smart's drinking behaviour and its consequent outcome. Even when we met him in prison, having had to attend alcohol related courses, the only thing he said he had learnt was the amount of time a pint of beer took to be eliminated. The effects of alcohol had severely impaired his liver and yet at no time was his consumption of alcohol seen as a major area of work to be undertaken by him other than how it related to his driving.

We recommend that

4. Health, police, probation and social services implement a training programme which acknowledges the impact of alcohol on aspects of family life, thus increasing the risk factors in homicide, domestic violence and child abuse. The subject of this report could be used to illustrate the dilemmas faced by professionals.

Sharing information between team members

9.6 The inquiry team quickly became aware that this family was well known to different agencies and yet there was little recorded in the way of sharing of information either by individual practitioners or agencies. Had there been then known 'pockets' of information about the dysfunctional nature of Richard and Donna's relationship and repeated incidents of domestic violence could have been put together either in supervision, case discussion or in inter-agency case conferences and there might have been a different outcome. In this way individual practitioners, facing situations of known complexity, can obtain support and guidance from managers as well as, on occasion, such direction as would occur, say, in a child protection meeting.

We recommend that

5. The consultant and team manager of each mental health team take responsibility for joint reviews and supervision with individual practitioners of those cases which meet the following criteria: enhanced CPA, multiple family members and/or multi agency involvement, on a regular basis.

6. In cases where there is a long-standing familiarity with clients, more attention is given in supervision and case management to formal reviews of situations with review decisions recorded.

7. The consultant and team manager of each mental health team should be made aware of all new clients within four weeks of the referral.

8. This case be used as a learning tool to promote the notion of 'family dynamics' and a different approach to working with individuals when different family members are being seen. This should not detract from their individual needs but seek to enhance them by completing the picture.

A multi agency framework

9.7 In already agreed public protection and personal safety circumstances different agencies have already begun to share knowledge about risks posed by certain individuals. The forum in which such sharing takes place does not take away the need for each agency to act in accordance with its own codes and policy guidance but rather enhances their collective knowledge and understanding.

We recommend that

9. Chief officers of agencies concerned with community safety agree a framework for sharing information about individuals who are either at risk or potential risk. The framework should include:
   i) Agreed definitions of risk
   ii) Existing legal frameworks
   iii) Principles regarding risk
   iv) Existing professional codes of conduct

10. A multi-agency training programme is developed to implement an agreed protocol and to reinforce working together.

11. The outcome of working within this framework is monitored and reported back to chief officers.

Internal inquiries

9.8 Serious incident reporting has become a feature in all agencies over recent years. The Somerset Partnership NHS and Social Care Trust and the probation service each conducted their own investigations. Such investigations are not designed to apportion blame but to learn lessons for those involved and for other agencies delivering similar services. Outcomes of such investigations are not always disseminated. In the future there will be less ad hoc external inquiries such as this one but until the National Patient Safety Agency is up and running arrangements locally should be consistent with good practice.

We recommend that

12. The trust ensures that administrative support, including typing of interviews, is available in the event of a serious incident inquiry.

13. The recommendations of the internal inquiry report are endorsed and, in addition, **we recommend that:**
    i) The action plan is shared with the other locality managers and managers of associated services, including those from other agencies
    ii) The trust undertakes an audit of professional records
    iii) The trust board has a regular agenda item to monitor the implementation and progress of the action plan.

14. **We also recommend** that the Joint Commissioning Board should develop an action plan, based on our recommendations, in consultation with Somerset's Community Safety Strategy Partnerships.

15. We endorse the recommendations of the Somerset Probation Service Serious Incident Management Review.

Appendix 1
Terms of reference

1. To examine all the circumstances surrounding the treatment and care of Mr Richard Smart by the mental health service from 15 March 2000 to 18 April 2000, taking into account his earlier mental health history, in particular:

   i) The quality and scope of any health, social care and risk assessments

   ii) The appropriateness of any treatment, care and supervision in respect of:

      a) Assessed health and social care needs
      b) Assessed risk of potential harm to himself or others
      c) Any previous psychiatric history, including drug and alcohol use
      d) The number and nature of any previous court convictions
      e) Any dealings between the probation service, the police and Mr and Mrs Smart

   iii) The extent to which Mr Richard Smart's care responded to statutory obligations; relevant guidance from the Department of Health (including the care programme approach, HSG(90)23/LASSL(90)11, supervision registers, HSG(94)5, and the discharge guidance HSC(94)27; and local operational policies

   iv) The extent to which his prescribed care plans were:

      a) Effectively drawn up and documented
      b) Delivered
      c) Complied with by Mr Richard Smart

2. The appropriateness of the professional and clinical supervision of those involved in the care of Mr Richard Smart or in the provision of services to him and, where appropriate, consideration of in-service training.

3. To examine the adequacy of the collaboration and communication between the agencies involved in the care of Mr Richard Smart or in the provision of services to him and, in particular, to include the period whilst he was a carer.

4. To examine the recommendations of the report from the locality manager in response to the internal inquiry published in January 2001 and to assess the implementation of them.

5. To prepare and make public a report on the inquiry's findings, which will include recommendations to Somerset Health Authority and Somerset County Council via a report to the Joint Commissioning Board.

Appendix 2

Procedure to be adopted by the inquiry

1. All sittings of the inquiry will be held in private.

2. Every witness of fact will receive a letter, in advance of appearing to give evidence, informing them:

   i) Of the terms of reference and the procedure adopted by the inquiry

   ii) Of the areas and matters to be covered with them

   iii) That they are requested to provide written statements to form the basis of their evidence to the inquiry

   iv) That when they give oral evidence they may raise any matter they wish which they feel might be relevant to the inquiry

   v) That they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness

   vi) That although it is the witness who will be asked questions and who will be expected to answer, there may be an occasion when the person accompanying him/her may be asked to clarify a point

   vii) That their evidence will be recorded and a copy sent to them afterwards for them to sign

3. Any points of potential criticism will be put to witnesses of fact, either verbally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

4. The evidence which is submitted to the inquiry, either orally or in writing, will **not** be made public by the inquiry, except insofar as it is disclosed within the body of the inquiry's report.

5. The draft report will be made available to the health authority, probation services and the NHS trust for any comments as to points of fact.

6. The findings of the inquiry and any recommendations of the inquiry will be presented to the Joint Commissioning Board and made public by that route.

Appendix 3
List of witnesses

Mr S Bradley	Probation Officer (Programmes), Avon & Somerset Probation Area
Mr P Cooney	Chief Executive, Somerset Partnership NHS & Social Care Trust
Mr N Dhruev	Locality Manager (Mendip), Somerset Partnership NHS & Social Care Trust
Dr S Dobson	Consultant Psychiatrist, Somerset Partnership NHS & Social Care Trust
Mr R Hayward	Joint Commissioning Manager for Mental Health Services
Ms K Holt	Domestic Violence Officer (Mendip), Avon & Somerset Constabulary
Mrs M Jacks	Team Leader, East Mendip Community Mental Health Team, Somerset Partnership NHS & Social Care Trust
Ms S Laird	Social Worker, Intake Team, Children & Families Branch, Frome Social Services
Ms L Morgan	Community Psychiatric Nurse, East Mendip Community Mental Health Team, Somerset Partnership NHS & Social Care Trust
Mr R Porter	Probation Officer, Avon & Somerset Probation Area
Dr R K W Reeves	Consultant Forensic Psychiatrist, The Priory Hospital Bristol
Mrs P Ryan and family members	Donna Smart's mother
Mr J Sellars	Area Manager (Mendip), Children & Families Branch, Social Services Department
Mr C Smart	Richard Smart's father
Mrs J Smart	Richard Smart's mother
Mr R Smart	Subject
Mr T Smart	Richard Smart's elder brother
Mr P Stopard	Assistant Chief Officer, Avon & Somerset Probation Area
Mrs T Thomas	Donna Smart's sister
Dr T Walker	GP, Park Road Surgery, Shepton Mallet
Mr D Wilkes	Non Executive Director, Somerset Partnership NHS & Social Care Trust
Ms M Wilkinson	Police Officer, Avon & Somerset Constabulary, Frome Police Station

Appendix 4
Documents relating to Richard Smart

General practitioner records

Probation service records

Somerset Partnership NHS & Social Care Trust healthcare records

HM Prison healthcare records

Medical report: Dr R W K Reeves, Consultant Forensic Psychiatrist

Psychological report: Dr David Torpy, Clinical & Forensic Consultant Psychologist

Medical report: Dr Alan R Lilleywhite, Consultant Forensic Psychiatrist

Somerset Health Authority and Somerset Social Services

Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings January 2000

Report to the Joint Commissioning Board re Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings 17 March 2000

Report to the Joint Commissioning Board re Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings 13 November 2000

Somerset Joint Mental Health Strategy 1999 – 2002

Evaluation of the Implementation of the Mental Health Review Report, Centre for Mental Health Services Development, King's College London September 1999

Evaluation of the Implementation of the Mental Health Review in Somerset – 2nd Interim Report to the Joint Commissioning Board, Centre for Mental Health Services Development, King's College London

Somerset Health Authority

Reporting Mental Health Incidents/Near Misses – NHS Executive South West

Suicide and Deliberate Self-Harm in Somerset 1995 -1999, April 2001

Somerset Partnership NHS & Social Care Trust

Protocol for the sharing of client information relating to social care between Somerset Partnership and social services, and vice versa

Safeguarding vulnerable adults – procedural and practice guidance

Policy for the management of incidents of violence and aggression

Integrated Care Programme Approach (ICPA) – Structure and Standards

Serious Incident Policy

Commissioning & Service Integration in Somerset – Paddy Cooney

Delivering the NHS Plan and National Services Framework for Mental Health in Somerset

Letter from Dr Martin Eales to Mr Paddy Cooney re above

Recommendations for a change to practice or protocols – Dr Christopher Mortimore

Internal Inquiry into the Care and Treatment of Richard and Donna Smart

Report from the locality manager in response to the internal inquiry into the care and treatment of Richard and Donna Smart

Somerset Probation Service (now Avon & Somerset Probation Area)

Serious Incident Management Review – Paul Stopard, Assistant Chief Probation Officer 30 June 2000

Public Protection Staff Handbook

Duluth Domestic Violence Programme

Drivewise Programme

Children & Families Branch - Somerset Social Services Department

Child Care Protocols: Operational Delegation

Link working with social services staff (mental health) operating within the Somerset Partnership

Child Care Philosophy in Somerset – Children in Need

Children in Need in the Community and Family Support Services (Section B)

- Policy statement and referral route
- Case recording guidance
- Eligibility criteria
- Assessing and reviewing need
- Service response protocol for the children & families teams
- Supervision

Somerset Area Child Protection Committee – Child Protection Handbook

South Somerset & Mendip Domestic Violence Forum

Positive Responses Identifying "Circles of Support" for Victims of Domestic Abuse – Conference Report 4 April 2001

Department of Health

The Care Programme Approach HSG(90)23/LASSL(90)11 1990

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27 1994

Building Bridges a guide to arrangements for inter agency working for the care and protection of severely mentally ill people 1995

A National Service Framework for Mental Health 1999

Code of Practice Mental Health Act 1983 HMSO 1994 and 1999

Effective Care Co-ordination in Mental Health Services A policy booklet 1999

Still Building Bridges. The report of a national inspection of arrangements for the integration of care programme approach into care management 1999

Framework for the Assessment of Children in Need and their Families Referral and initial information record, initial assessment record and core assessment records 2000
An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS 2000
Building a Safer NHS for Patients – implementing An Organisation with a Memory 2001
Safety First Five-year report of the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness 2001

United Kingdom Central Council

Guidelines for Records and Record Keeping 1998

Home Office

National Standards for the Supervision of Offenders in the Community 1995
National Standards for the Supervision of Offenders in the Community 2000
Domestic Violence: Break the Chain Multi-agency guidance for addressing domestic violence 2000
Tackling Alcohol Related Crime, Disorder and Nuisance: Action plan, 2 August 2000

Reference

Jones, Richard (1999), Mental Health Act Manual sixth edition, Sweet & Maxwell, London

Appendix 5

AVON AND SOMERSET CONSTABULARY

DOMESTIC INCIDENT REPORT

Crime No ....
HO Code ....
DVO Ref.

INITIAL REF ☐ ☐☐☐☐ ☐☐ ☐☐ ☐☐☐☐ ☐☐

OFFENCE .... Location Beat No ....

1st PARTY/VICTIM DETAILS

Mr/Mrs/Miss/Ms/Other .... *Circle One* Ethnicity Code ☐☐ *See overleaf*

First Name .... Surname .... Age .... DOB ....

Telephone (Home) .... (Work) .... (Mobile) ....

Address .... Post Code .... Gender M/F

INJURIES Yes ☐ No ☐ **INJURY PHOTOGRAPHED AT SCENE** Yes ☐ No ☐ **ARRESTED** Yes ☐ No ☐ **CHARGED** Yes ☐ No ☐ **OFFENCE** ....

Time: From .... To .... Date: From .... To ....

Location of Offence ....

Repeat Victim Y/N ☐ R Same Offence Y/N ☐ S When? ☐☐ Months Ago Reported Y/N ☐ T

VOC Leaflet Given Y/N ☐ V Neigh/Watch Y/N ☐ W Other Scheme Y/N ☐ Z

Victim agrees to Victim Support Yes ☐ No ☐ **Safe to Contact Victim at Home** Yes ☐ No ☐ **Violence in the Home Booklet Given** Yes ☐ No ☐

2nd PARTY/SUSPECT/OFFENDER DETAILS *(Delete as appropriate)*

Name (Surname first)	Age	DOB	Gender M/F	Custody No	DIs

Address .... Post Code ....

Temp Address – Party 1/Party 2 ....

RELATIONSHIP BETWEEN PARTIES

Partner/Ex Partner ☐ Sibling ☐ Elder ☐ Other Relative ☐ .... Ethnicity Code ☐☐ *See overleaf*

Did a Power of Arrest Exist Yes ☐ No ☐ * *(If power of arrest not exercised, explain in officer's report opposite)*

ARRESTED Yes ☐ No ☐ **CHARGED** Yes ☐ No ☐ **OFFENCE:** ....

Bail Conditions/Court Date ....

	Alcohol	Drugs
Party 1	☐	☐
Party 2	☐	☐
Third Party	☐	

Brief Circumstances (continue opposite): Include Details of Injuries/Property Damaged or Stolen: TVO £ ....

FOR CMU USE ONLY DOMESTIC INCIDENT PROFILE (tick relevant boxes and input into MOTAG1 field)

Abuse Type		Children		Aggravating factors		Did a power of arrest exist?		Arrest Made?	
Domestic "Intimate"	DV11 ☐	Present/ Observers	DV21 ☐	Weapons	DV31 ☐	Domestic	DV41 ☐	Domestic	DV51 ☐
Sibling	DV12 ☐	Injuries direct/indirect	DV22 ☐	Alcohol	DV32 ☐	Sibling	DV42 ☐	Sibling	DV52 ☐
Elder	DV13 ☐			Drugs	DV33 ☐	Elder	DV43 ☐	Elder	DV53 ☐
Other	DV14 ☐								

Name of Child	DOB	School	On Premises	Witness to Incident	Injured	Seen

CHILD PROTECTION UNIT INFORMED Yes ☐ No ☐

Disposal Details

Charged ☐ Summons ☐ Caution ☐ Other Means (specify) ☐ TIC ☐ Wanted ☐ Reported ☐

Allocation Code DET ☐ PNA ☐ CNA ☐ UNF ☐ CNF ☐ SNF ☐ LEU ☐ LEC ☐ LES ☐ LEM ☐

Form CID1/Dom1 **WHITE COPY TO CMU – YELLOW COPY TO DVO** 6.2000

WITNESSES

OFFICERS REPORT/CONTINUATION

* Please explain actions taken. If a Power of Arrest was not exercised, give reasons. (Include measures taken to protect victim)

Harassment

Course of Conduct Yes ☐ No ☐ Arrested Yes ☐ No ☐ First warning if applicable Yes ☐ No ☐ Statement Yes ☐ No ☐

DETAILS OF ANY 3rd PARTY INVOLVED...

Doctor	Social Worker
Solicitor	Other

Victim agrees to information being passed to other agencies Yes ☐ No ☐ **Victims Signature**..

Agencies informed:

Complainant Informed of Investigation by:...................................... **How:**.................... **Date:**....................

Officer Completing (Collar No./Name).. Group/Sector ....

Officer Signature .... Supervisory Signature & Collar No. ....

Date/Time	Initial DVO Actions

File Date: .... **Signature:**..

FOR COMPLETION BY DVO

[illegible]		Phone		Visit		Alarm		[illegible]		Previous Incidents		Violence		Other	

Notes