Single Unified Safeguarding Review Report

Learning from the Past to Make the Future Safer

Name of Regional Safeguarding Board: Cardiff and Vale **Name of Community Safety Partnership:** Cardiff Community Safety Partnership
Case Reference Number: CV SUSR 01/2021
Pseudonym 1: James **Pseudonym 2:** Karen **Pseudonym 3:** Marcus **Pseudonym 4:** Gemma **Pseudonym 5:** Mary **Pseudonym 6:** Daniel
Date of incident which led to the Review: October 2020
Date of death where applicable: October 2020
Review's start date (commissioned): February 2021 **Review completion date (approved and signed off):** 15/04/2024 **Publication date: 05/02/2025**

1.1 Cardiff Community Safety Partnership were approached by Welsh Government to pilot this review under the Single Unified Safeguarding Review (SUSR) process in 2020. Along with the Cardiff and Vale Safeguarding Board, the Cardiff Community Safety Partnership were fully supportive of piloting this case under this methodology, with the aim to improve engagement with families and bring learning from reviews into action in the most effective way.

1.2 The complex dynamics surrounding the legal and governance arrangements for the SUSR process, unfortunately resulted in a delay in progressing the review as envisioned. In response to the statutory obligations of Welsh Government and Home Office, a bespoke agreement had to be reached, to ensure the review would be accepted at the end of the process. This agreement and process took until the autumn of 2022 to finalise between all key parties.

1.3 The review was further delayed by the appointment of appropriately experienced independent Chair and Reviewers, to meet the statutory requirements. Due to unforeseen circumstances the Chair and Reviewers stepped down from their roles in May 2022, with replacements appointed in October 2022 and the first official panel meeting held on 24 October 2022. Unfortunately, in March 2023 the Chair had to resign from the position due to a conflict of interest, and a replacement Chair appointed in April 2023. The first panel meeting with the new Chair was held on the 18 May 2023.

Family Tribute

"Our Partner/Dad was a doting family man who'd say his biggest achievement in life was his 4 children. He was a man of faith who kept Jah Rastafari close to his heart, living a clean, righteous, and full life.

He was a quiet, shy man unless in his comfort zone at home with his family. Add to that roots and reggae music, formula one, football and some rice and peas and he was satisfied. He was a simple man who didn't care for material things. Home was his happy place.

He was the epitome of a family man - strong, reliable, present, and had so much love to give. His smile lit any room he entered. As tragic as the circumstances are that lead to us losing Dad, he left doing what he does best - loving and protecting us.

It mustn't be overlooked that we've also lost someone else amongst this tragedy. Whilst physically he's still present, we've also lost what once was a gentle, soft, harmless and sport loving Son and Brother.

Sadly, it took for his unthinkable actions that led to the loss of our Dad and near loss of our Mum to get the help he so desperately needed. We pleaded for this help for two years prior. It could have been prevented.

There will never be enough words to describe the impact this awful life changing tragedy has had on us as a family. We've been left with a hole in our lives and hearts and a broken family.

We hope that the learning opportunities/recommendations identified in this report encourage change. Change within the way that the agencies responding to mental health sufferers work, to avoid a repeat of the tragedy we have sadly suffered. For us as a family, this will be the closest we will get to justice."

Outline of circumstances resulting in the Review:

2.1 Following a domestic homicide that occurred in October 2020, it quickly transpired that several independent reviews would be commissioned in relation to circumstances of the case. These included a Domestic Homicide Review (DHR), Health (Internal) Serious Incident Review and a Mental Health Homicide Review (MHHR). Welsh Government proposed that the case be reviewed as a pilot using the Single Unified Safeguarding Review (SUSR).

2.2 The proposal from Welsh Government and case details were considered by Cardiff and Vale Safeguarding Board in January 2021, and subsequently by Cardiff Community Safety Partnership Board in February 2021 who on the recommendation of the Case Review Group commissioned an SUSR in accordance with the Guidance[1] for carrying out an SUSR. At the time of the commencement of the review the Guidance was still in draft format and subject of consultation processes. The Reviewers and Independent Chair maintained regular contact with the Regional Safeguarding Board to ensure that they were informed of any significant changes arising from the consultation phase.

Legal context

3.1 The criteria for this review is met under the following –

- Domestic Homicide Review (DHR) – to be completed in accordance with Home Office Statutory Guidance 2016[2]
- Health (Internal) Serious Incident Review
- Mental Health Homicide Review (MHHR)

Parallel Investigations

4.1 An inquest had been opened and adjourned by H.M. Coroner. The inquest had not taken place at the time of the conclusion of the SUSR. A copy of the SUSR was shared with H.M. Coroner at the conclusion of the process.

4.2 The Independent Office of Police Complaints completed an investigation in relation to contact by South Wales Police with the subjects of the review. The investigation had not been published at the time of the conclusion of the SUSR.

[1] https://www.gov.wales/sites/default/files/publications/2023-03/single-unified-safeguarding-review-draft-statutory-guidance.pdf
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

4.3 South Wales Police completed a criminal investigation into the circumstances of the case. The Crown Prosecution Service reviewed that investigation and determined the progression to a criminal trial, details of which are included below.

Case Background

5.1 This case is about James, Karen, and Marcus. James and Karen had been in a relationship for many years. Together they had four children, Marcus was the second youngest of their children. Karen and Marcus lived together. James had moved out of the family home in 2016 and lived with one of their children. The remaining two children lived in their own accommodation.

5.2 In October 2020, the Police attended at Karen's home address following a call from a neighbour. James was inside the property. James was described as lifeless and had several stab wounds to his body. James was pronounced deceased at the scene. Karen was found with several stab wounds to her body and was receiving first aid treatment from a member of the public. Upon the arrival of health professionals Karen was given life sustaining treatment at the scene, which saved her life. Marcus was not at the address upon Police arrival but was found by Police a short distance away. Marcus was arrested by Police.

5.3 A Home Office Post-mortem determined that the cause of James death was –

- 1a - multiple stab wounds to the trunk, involving the lungs, heart and aorta.

5.4 Karen received treatment and surgery for an incisional wound on the left posterior chest wall causing a collapsed lung (pneumothorax) and an incisional wound to her left forearm. She also received treatment to repair a diaphragmatic injury.

5.5 On 18 October 2020, Marcus was charged with the murder of James and the attempted murder of Karen.

5.6 In July 2022 Marcus pleaded guilty to the manslaughter of James and pleaded guilty to the attempted murder of Karen. Marcus received a hospital order/restriction order under Section 41 Mental Health Act 1983 and was detained without limit of time.

Time Frame

6.1 This review covers the period from August 2018 up to and including October 2020. The time frame was chosen to capture a series of domestic abuse incidents between Marcus and Karen, which occurred in August 2018 and subsequent events and contacts with agencies prior to James's death. The time frame extended the 12-month time period which is normally used within an SUSR. The decision to extend the time frame was made by the Review Panel to allow analysis of significant events and agencies involvement within the agreed Key Lines of Enquiry. The review also considered significant events that took place prior to the agreed timeline which was considered to have had an impact on the review.

Methodology

7.1 The first panel meeting took place on 24 October 2022. In total the panel met 12 times. Panel meetings were held via Microsoft Teams and face to face meetings. During panel meetings robust discussions took place with all agencies involved contributing to the review process.

7.2 The methodology took cognisance of the process contained within the SUSR Guidance and Home Office DHR Guidance.

7.3 All agencies were asked to provide a timeline of their agency's contacts within the agreed time frame. The Review Panel reviewed the combined timeline and from their discussions agreed Key Lines of Enquiry' (KLOE) for the case. All agencies were then asked to undertake further work in analysing events within their timeline.

7.4 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information sought.

7.5 The family were informed of the methodology being undertaken and the agreed Key Lines of Enquiry. Further information on family involvement is captured later in the report.

Key Lines of Enquiry

1. What were the key points or opportunities for intervention, assessment, and decision- making in this case?
2. What risk assessments did your agency undertake for the subjects of this review and what was the outcome? Were risk assessments accurate and of the appropriate quality?
3. Do assessments and decisions appear to have been reached in an informed and professional way? Did the actions or risk management plans fit with the assessment and decisions made? N.B. Please consider the mechanisms your agency has in place to escalate risk assessments both internally and to multi-agency processes such as Multi Agency Public Protection Arrangements (MAPPA) and/or Multi Agency Risk Assessment Conference (MARAC).
4. What consideration did your agency give to any mental health, domestic abuse and/or substance misuse when identifying, assessing, and managing risks?
5. How did your agency ascertain the ability of family, friends, and the wider community in managing any identified risks?
6. Did your agency consider that the subjects of this review could be an adult at risk within the terms of the Social Services Wellbeing (Wales) Act 2014? Were there any opportunities to raise a safeguarding adult report?
7. What indicators of domestic abuse, including coercive and controlling behaviour and Adolescent to Parent Violence and Abuse (APVA) did your agency have that could have identified James and Karen as a victim of domestic abuse, and what was the response?

8. Was there sufficient focus on reducing the impact of Marcus's alleged abusive behaviour towards James and Karen by applying an appropriate mix of sanctions (arrest/charge) and other interventions?
9. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?
10. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.
11. What learning has emerged for your agency? Does the learning for your agency appear in any other safeguarding review undertaken by your agency? If so, please provide details of when this learning was identified and action taken to address this.
12. Are there any examples of outstanding or innovative practice arising from this case?

Agencies who Provided Information to the Review

- Cardiff Community Safety Partnership
- Cardiff and Vale University Health Board
- Welsh Ambulance Services, NHS Trust
- Primary Health Care GP Services
- South Wales Police
- Adult's Services, Cardiff Council
- Children's Services, Cardiff Council
- National Probation Service
- Housing Services, Cardiff Council
- Cardiff Rise
- Safer Wales
- H.M. Prison and Probation Service, Cardiff
- H.M. Prison and Probation Service, Swansea
- ASSIA, Bridgend
- Crown Prosecution Service
- H.M. Courts Service
- Elysium Healthcare
- Young Men's Christian Association (YMCA), Housing Support

Review Panel Membership

- Community Safety Partnership, Cardiff – Operational Manager for Community Safety
- National Probation Service - Senior Probation Officer
- Cardiff and Vale University Health Board – Deputy Director of Nursing for the Mental Health Clinical Board

- Cardiff and Vale University Health Board, Safeguarding – Safeguarding Nurse Advisor
- Cardiff and Vale University Health Board, Headroom – Consultant Nurse
- South Wales Police – Independent Protecting Vulnerable Persons Manager
- Welsh Ambulance Services, NHS Trust – Senior Safeguarding Specialist
- Adult Services, Cardiff Council – Operational Manager, Mental Health
- Children's Services, Cardiff Council – Operational Manager
- Housing Services, Cardiff Council – Accommodation and Support Manager
- Housing Services, Cardiff Council – Improvement Project Manager, Gender Specific Services
- Housing Services, Cardiff Council – Domestic Abuse Coordinator
- Cardiff Rise – Service Manager
- Safer Wales – Director Service Standards
- South Wales Police and Crime Commissioner's Office – SWP & Crime Commissioner Victims Lead

This list can also be found in Appendix 1.

8.1 The Review Panel were supported in their role by the appointment of a Consultant Psychiatrist from outside the Health Board area who has extensive experience in working with mental disordered offenders and the multi-agency arrangements required. The Consultant Psychiatrist is currently Clinical Director for Specialist Services within a Health Board area. They provided advice and supported the reviewers understanding of the complexities of mental disorder, mental health services and the mental health act. They also gave advice on risk assessment in mental health services and discharge planning and aftercare arrangements.

8.2 The Review Panel sought information in relation to Rastafarian culture. This took place in the form of presentation to the panel by a representative of Rastafari Movement UK. In addition to information provided during the presentation, the Review Panel also had access to literary documentation – 'Seven Ways to Good Mental Wellbeing and Rastafari'[3].

Contact with agencies outside of panel meetings and learning events

9.1 Marcus's GP was unable to attend the learning event and agreed to meet with the Independent Chair and Reviewers ahead of the learning event to discuss their involvement and analysis against key incidents.

9.2 The Review Panel sought information from the Crown Prosecution Service and H.M. Courts to understand further their involvement and decision making on criminal and civil matters.

[3] https://goodthinking-strapi.s3.eu-west-2.amazonaws.com/Five_Ways_Wellbeing_Rastafari_v6_ed627e7426.pdf?updated_at=2022-10-26T11:21:47.251Z

9.3 The Independent Chair and Reviewers met with the Deputy Chief Crown Prosecutor to discuss their involvement and gather further information. This has been captured in the report where necessary.

Contact with Marcus

10.1 The Independent Reviewers were keen to engage with Marcus as part of the review process. Contact was made with medical professionals responsible for Marcus's care at various points throughout the review. The clinicians responsible for Marcus informed the review they did not feel it was in Marcus's best interests to be involved in the review as this could cause a deterioration in his mental state. The Independent Reviewers maintained contact throughout the review process with the medical professionals and frequently re-visited this matter. However, at the time of the review's conclusion engagement with Marcus had not been achieved.

Learning Events

11.1 Two separate learning events were held which brought together front-line staff and Managers from agencies involved in the case. Attendees at these events were identified by panel members for their respective agencies. Agencies that were in attendance can be found in Appendix 2.

11.2 The learning events provided an opportunity for professionals to reflect on their involvement with the family and identify any systems and organisational learning. The learning events were led by the Reviewers and Independent Chair with support from the Consultant Psychiatrist.

11.3 Prior to the learning event, professionals were provided with a copy of the combined timeline, the Key Lines of Enquiry and information on the circumstances of the case and the review process being undertaken. Professionals attending the learning events were briefed by their relevant panel member in accordance with SUSR guidance.

11.4 In order to facilitate the learning event, the Reviewers separated the timeline into 7 key time periods. Each time period identified key events to be considered and discussed by practitioners during the learning event. The learning events provided additional information which has been captured within the report.

11.5 The Reviewers would like to thank all practitioners that attended the learning events and contribution to identified learning in the review process.

Equality and Diversity:

Address the nine protected characteristics under the Equality Act 2010[4] to the Review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted, give consideration to the Socio-Economic Duty[5]. Make reference to:

12.1 The Review Panel agreed to use the format currently undertaken in accordance with Home Office Guidance on Domestic Homicide Reviews.

Age

12.2 James was 54 years at the time of his death. Karen was 50 years old at the time she sustained serious injuries. Marcus was 21 years old at the time of the incident.

Disability

12.3 Section 6 of the Equality Act defines 'disability' as:

[1] A person [P] has a disability if —
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[6]

12.4 The review has seen no evidence that James and Karen met the definition of disabled.

12.5 Between January 2020 and June 2020 Marcus was detained under Section 2 and subsequently, Section 3 of The Mental Health Act 1986. It was recorded that during this period Marcus was suffering from psychosis and intervention and treatment was in response to this psychosis. Marcus was currently detained.

Gender reassignment

12.6 Not of relevance for this review.

Marriage

12.7 James and Karen had been in a long-term relationship. They were not married.

Pregnancy and maternity

12.8 Not of relevance for this review.

[4] Equality Act 2010. Equality Act 2010 (legislation.gov.uk)
[5] Socio-economic Duty: an overview | GOV.WALES
[6] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

Race

12.9 The family stated that James was black Caribbean. Marcus was white black Caribbean. Karen was white British.

Religion or belief

12.10 James followed Rastafarian faith. Marcus did not identify to one particular religion. Karen did not define to one religion but followed in Rastafarian “livity”. This is captured later in the report.

Sex

12.11 Male victims of domestic abuse and domestic homicide –

James’ death was domestic abuse.

12.12 According to the Office for National Statistics homicide report 2021/22[7], there were 134 domestic homicides in the year ending March 2022.

12.13 Of the 134 domestic homicides: 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son, or daughter, and 16 were killed by another family member.

12.14 Males were much less likely to be the victim of a domestic homicide, with 11% (50) of male homicides being domestic related in the year to March 2022.

12.15 According to the ONS Domestic abuse in England and Wales overview: November 2023[8] 26.5 % of domestic abuse victims are men. That equates to 751,000 male victims of domestic abuse in 2022/23.

12.16 Female victims of domestic abuse –

The Review Panel acknowledged that Domestic Abuse is a gendered crime with women being more likely to be victims than men. Karen had been a victim of domestic abuse.

12.17 In November 2022, the Office for National Statistics published the following data: - ‘Domestic abuse in England and Wales overview’[9] –

7 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

8 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023#:~:text=The%20police%20recorded%20889%2C918%20domestic,the%20year%20ending%20March%202022

9 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

- The Crime Survey for England and Wales (CSEW) estimated that 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).
- Approximately 1 in 5 adults aged 16 years and over (10.4 million) had experienced domestic abuse since the age of 16 years.
- There was no significant change in the prevalence of domestic abuse experienced by adults aged 16 to 59 years in the last year, compared with the year ending March 2020; a year largely unaffected by the coronavirus (COVID-19) pandemic and the last time the data were collected.
- The number of police recorded domestic abuse-related crimes in England and Wales increased by 7.7% compared with the previous year, to 910,980 in the year ending March 2022; this follows increases seen in previous years and may reflect increased reporting by victims.
- The Crown Prosecution Service (CPS) domestic abuse-related charging rate in England and Wales increased for the first time in four years to 72.7% in the year ending March 2022 but remains below the year ending March 2018 (75.9%).
- The National Domestic Abuse Helpline delivered 50,791 support sessions through phone call or live chat in the year ending March 2022, a similar number to the previous year.

Sexual Orientation

12.18 The details of the sexual orientation of the review subjects was not captured.

Socio-economic duty

Socio-economic disadvantage

12.19 The area of St Mellons is split between to electoral ward areas Pontprennau & Old St Mellons and Trowbridge. This incident and where the family reside took place in Trowbridge, where there is a population of 17,200 people. Information from the Office of National Statistics Census 2021 (ONS) shows that this ward has 60.7% of households with one or more dimension of deprivation (Education, Employment, Health and Housing). The majority of the population identifying as White (82.5%) and 5.1% as Black, Black British, Black Welsh, Caribbean or African. 22.4% are reported as disabled under the Equality Act. In terms of employment rates, 33.9% are listed as 'never worked,' and 52.6% as 'not worked in the last 12 months'.

12.20 There are a number of primary schools in this location with two secondary schools within catchment, Eastern High and St Illtyd's Catholic School. A number of facilities running voluntary services to support the community including food parcels.

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Cardiff & Vale Safeguarding Board

Involvement of family and principal individuals:

13.1 In accordance with the SUSR guidance and having cognisance of the DHR guidance there has been contact with the family members throughout the review process.

13.2 In January 2023, an introductory meeting was held in person with the family, with the original appointed Chair of the Review Panel and one of the Independent Reviewers. The family consisted of Karen, Mary and Gemma, partner, and daughters of James. The family were supported by a Police Family Liaison Officer during the meeting. The Victim Support Homicide Worker was unable to attend the meeting. During the meeting, the SUSR process was explained to the family including the purpose of the review process, what it would entail, who would be involved and how it would progress. The family agreed to engage with the review process and confirmed that it was their wish to liaise with the Independent Reviewer and Chair directly.

13.3 Subsequent contact was made with the family over the review process and at key points, via email, letter, and telephone.

13.4 In May 2023, the family were notified of the change of Chair. In June 2023, a meeting was held with the family, in person, with the newly appointed Independent Chair and the Independent Reviewers. During that meeting the family provided information about their family, which has been captured within the report. The family shared what was important to them as a family to be considered as part of the review process. It was also reiterated to the family that they could be supported by an advocate throughout the process, but they declined.

13.5 The family provided the Chair with a list of questions for panel members together with photographs of their family. The questions and photographs were shared with panel members and practitioners during the Learning Events.

13.6 In September 2023, the family attended a panel meeting. This meeting was held in person and offered the family an opportunity to speak with panel members directly.

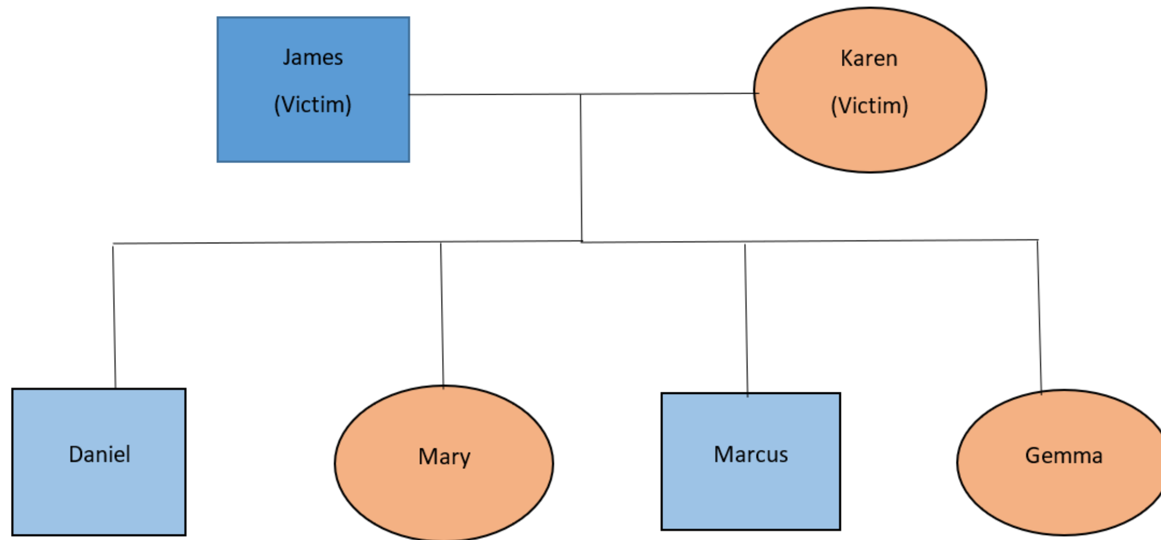
13.7 On 1 February 2024, the family attended a meeting with the Chair and Reviewers and were provided access to a draft copy of the report. The family provided additional information which has been captured in the report. The family reviewed an updated version of the report on 22 February 2024.

13.8 Throughout the review process, including discussions with the Senior Investigating Officer in charge of the criminal investigation, there were no additional relatives or friends identified who could have supported the review.

13.9 The review originated from an incident involving specific family members and the review has centred around those family members and their engagement with agencies. The Review Panel recognised that engaging with wider family and friends could identify additional information to inform the review process; however, after discussing the review process with the family the Review Panel concluded that it would have been insensitive to the family to widen the scope of contact outside immediate family members without good reason.

Family History and/or Contextual Information:

Genogram



Family Background

14.1 Karen was 18 years old when she met James whilst staying with family in London. Not long after the relationship started, Karen became pregnant with their eldest child, and they moved to Cardiff, initially staying with Karen's family before moving to their own family home.

14.2 The family described that although James did not particularly like living in Wales, he was a very proud man and was determined to support Karen and their four children, Daniel, Mary, Marcus and Gemma. The family were very clear that the most important thing to James was his children. The family stated that if James was still alive, he would say how proud he was of them.

14.3 James was a spiritual Rastafarian. James' mother was from Guyana and his father from Jamaica. James had a sister.

14.4 The family stated that James used cannabis for spiritual reasons to keep him close to Jah Rastafari. Marcus was a user of cannabis and this is covered later in the report.

14.5 James, Karen and all the children were vegetarians. James was strict in respect of not eating anything living or that had been living because this did not align with his way of clean living. James would not cut his hair.

14.6 James was very family orientated. James went out to work whilst Karen stayed at home to bring up the children. James worked for a car manufacturer and ended his employment due to ill health. James had good morals; he was respectful and did not use indecent language. The family stated that James was unable to understand how Karen could tolerate Marcus because of the way he spoke.

James did not know how to manage Marcus's behaviour because of the mental health or manage the risks he presented as the family stated that James was a father and not a mental health Professional.

14.7 Around August 2016 James left the family home. The family stated that James resided locally and continued to support Karen and the children. James visited Karen almost every day and whenever any of the children needed support or assistance, he provided it. At this time Daniel and Mary had already left home and Gemma decided to reside with her father. This left Karen and Marcus living together in the same house.

Marcus

15.1 Marcus was described as a good student in school. Marcus was very athletic enjoying football, martial arts and basketball. Marcus had an interest in media and business studies and photography.

15.2 Whilst in college Marcus had a good friendship group but the family stated that like many individuals, Marcus took the wrong path and became involved with individuals who were involved in the drug scene. Prior to this time the family described Marcus as a 'mummy's boy'. Around this time, the family stated that Marcus stated he was going to Bristol and that he had become interested in rap music. The family stated, that as a family they enjoyed more reggae and R and B type music.

15.3 In 2017, when Marcus was 18 years old, the family described how he had been involved in an incident which resulted in him being chased by armed individuals during which time he tried to scale a wall. Marcus was stabbed in the foot and as a consequence of his injuries he was unable to continue his engagement in sport. The family stated that following this incident, Marcus's mental health declined. The family stated that on reflection they believed that Marcus may have suffered from Post-Traumatic Stress Disorder (PTSD) following the incident. Throughout the period of the review, it was documented that Marcus did not recognise that he had mental health needs and did not engage with agencies who were working with him and seeking to support him around his mental health.

15.4 In July 2018, Marcus was reported as missing. Marcus was living in young person's temporary accommodation at the time. Marcus was found by his family in Brixton, London after they had seen a number of posts on social media sites. The family went to London; however, Marcus initially refused to return to Wales, and they returned home without him. Marcus was sighted by the Police and a charity – RedThread[10] and was therefore no longer recorded as a missing person. The following day, Marcus then attended at hospital, in London, with abdominal pains. The family were concerned about Marcus and his vulnerabilities, and he returned to Wales with Karen and James.

Family Expectations

16.1 During an initial meeting with the family, they were asked what they expected to see from this review. The family agreed that the review was not a blameworthy process but that they would like to know –

- What were the barriers and did agencies make relevant referrals and if not, why not?
- The family stated that the Police should not be the primary agency for responding to mental health calls and wanted to know which agencies could respond and how this would happen?
- The threshold for individuals when they fail to engage with agencies and have capacity to do so, but there is an evident risk present. What is the point at which agencies can intervene to address that risk?
- Changes to be implemented to prevent this happening to another family.

16.2 Prior to attending a panel meeting the family were asked to provide any specific questions that they wished to raise. These were provided to the Chair ahead of the meeting to help facilitate family engagement in the panel meeting.

16.3 A summary of the questions has been included below –

- Decision making around Marcus's discharge from hospital, to include progression around Marcus's mental health.
- Accommodation provision upon Marcus's discharge.
- Allocation of care co-ordinator.
- Police response to mental health incidents and what training Police have received on mental health.
- Communication and referrals with mental health services.
- MARAC processes.
- Response to Marcus's mental health after discharge from hospital including planned meetings.

16.4 Finally, the family never once referred to words ''murder' or 'killed' when talking about James. The family did not agree with the use of the word 'perpetrator' for Marcus. The family were very clear during contact for the review that they had not only lost a partner and Father, but they had lost a son and brother.

[10] https://www.redthread.org.uk/
Redthread is a collaborative charity that embeds youth workers within health settings.

Agency Timeline:

17.1 The combined timeline produced an extensive record of agencies contact with over 500 entries. The Review Panel separated the combined timeline into 7 key time periods. This method was undertaken to allow the Review Panel and practitioners attending the learning events to focus on specific incidents within each time period against the agreed Key Lines of Enquiry.

17.2 The Review Panel wanted to highlight that the below events are factual entries and analysis of specific events is captured within the Practice and Organisational Learning Section.

17.3 The Review Panel acknowledged that there was limited reference to James and James voice within agency records, and therefore the majority of information in the below section related to Karen and Marcus, as this was the factual information provided to the review.

17.4 The Review Panel was reassured during both learning events that James had been present during a significant number of meetings and contact between health professionals and the family; however this had not been recorded within agencies records and is a learning point for the review.

August 2018 – December 2018

17.5 At the beginning of August, the Police responded to three incidents involving Karen and Marcus. All incidents occurred at Karen's home address. In the first two incidents, Karen reported that she had been having 'problems' with Marcus whom she had recently allowed to return to live with her. Marcus was advised by Police to leave the house.

17.6 On the 3rd incident, damage had been caused to Karen's house. The call to the police on this occasion was made by James following a call he had received from Karen. Marcus was arrested and later charged with an offence of criminal damage. During contact with the Police, Karen spoke about her concerns for Marcus's mental health. The case was later reviewed by a lawyer from the Crown Prosecution Service, Karen did not support a prosecution. The case was discontinued as it was determined not to be in the public interest to proceed.

17.7 On 15 August, Karen contacted a GP and expressed concerns about Marcus's mental health. Marcus refused to attend the surgery to meet with the GP but agreed for the GP to attend the family home as he was experiencing pain in his foot. The Community Mental Health Nurse (CMHN) based in the GP practice accompanied the GP on the visit to Marcus. This was the first of two occasions during the review period when Marcus was seen by a GP.

17.8 During the visit Marcus appeared concerned with his ankle, however engaged in some conversation with the CMHN about his mental health. Marcus denied any mental health concerns, and stated his mood was stable. The CMHN reported in her case notes that Marcus did appear anxious and possibly paranoid but was

able to rationalise this. The CMHN offered Marcus an appointment to meet with her and he agreed to this. A letter was sent offering an appointment for the 22 of August, which Marcus did not attend. Marcus and Karen were advised that should Marcus require an appointment sooner to contact the GP.

17.9 In October, Marcus was arrested for an offence of criminal damage. Whilst in custody, Marcus was seen by Health Care Professional and Mental Health Nurse. During the assessment, Marcus stated he used cannabis on a daily basis. The assessment concluded there was no evidence of acute mental health needs. Marcus was signposted to several support agencies and charities. No further action was taken in relation to the criminal damage.

January 2019 – April 2019

17.10 In March, Marcus contacted the Police and reported that he had been assaulted by Karen. Karen was arrested. Marcus declined to support a prosecution and Karen was released from custody. No further action was taken. This case was not referred to the Crown Prosecution Service for decision making.

May 2019 – July 2019

17.11 At the end of May, Marcus assaulted Karen. Marcus was arrested and later charged with an offence of assault. Marcus was remanded in custody and appeared at court the following day. At court, Marcus pleaded guilty to assaulting Karen and he was released from custody. Marcus received a conditional discharge for 12 months and was ordered to pay £20 compensation.

17.12 On the day of his release from custody (3 June 2019) Marcus damaged James' car. Marcus was arrested and charged with an offence of criminal damage. Marcus was remanded in custody to appear at the next available court. At court, Marcus pleaded guilty to the criminal damage. James had told the Police that he did not support a prosecution, and that Marcus needed help with his mental health.

17.13 The Probation Service presented an oral report to the court which detailed that Marcus had been assessed as high risk of serious harm towards Karen and James. A mental health assessment presented to court identified ongoing risk of future violence towards Karen and James. Karen and James spoke with a mental health court liaison worker and raised concerns about Marcus's mental health.

17.14 Marcus was convicted of criminal damage and made subject to a 12-month Community Order. At the point of Marcus's release from court, Marcus was homeless. In response to this the Probation Worker contacted HANR Outreach Team and he was offered floor space. The Outreach Team were made aware of Marcus's vulnerabilities and a referral was made to MARAC by the Probation Worker. The Police had no record of receiving the MARAC referral.

August 2019 – December 2019

17.15 At the beginning of August, Marcus assaulted Karen. Marcus was arrested and charged with an offence of assault. Marcus was remanded in custody to appear at court. Marcus pleaded guilty to assaulting Karen. Marcus was sentenced to 10 weeks imprisonment and post sentence supervision. A restraining order was made to protect Karen from further conduct which amounted to harassment or would cause fear of violence from Marcus and contained the following terms:

- Marcus was prohibited from entering the street where Karen lived.
- The order was to remain in place until 01 August 2020.

17.16 On 22 August, Marcus's Probation Officer followed up the MARAC referral they had made in June. The Police had no record of this contact.

17.17 On 4 September, the case was discussed in a multi-agency domestic abuse daily discussion meeting. The case had been referred verbally and resulted in several immediate actions taking place. The following day, the case was discussed at an emergency MARAC and additional actions raised.

17.18 In October, Marcus was released from prison. Marcus was now subject of post sentence supervision; however, Marcus failed to comply with his licence conditions and the court issued a warrant for Marcus's arrest. Marcus was arrested on 8 November having been found at Karen's address. Marcus was sentenced to a period of imprisonment and was released on 18 November.

17.19 At the end of November, Karen submitted an application to the court requesting the Restraining Order granted in August 2019 be discharged. The court informed the review that notification of this application was sent via email to –

- Crown Prosecution Service;
- Safer Wales[11];
- Independent Domestic Violence Advisor team in Bridgend
- Witness Care Unit, South Wales Police
- Police Officer in charge of the case (and via a letter)
- The applicant's email address

17.20 In December, the court discharged the Restraining Order. The court informed the same agencies/individuals of the discharge.

Covid-19

17.21 It should be noted that events contained within this review timeline took place within the context of the Covid-19 pandemic and associated restrictions. In March 2020 UK government announced restrictions in non-essential contact and travel in response to the pandemic. Stay at home messaging was promoted. Social distancing was also introduced.

[11] https://www.saferwales.com/

17.22 There were significant changes to how services were delivered at this time.

January 2020 – 16 April 2020

17.23 On 2 January, Karen contacted Welsh Ambulance Service NHS Trust (WAST) and reported that Marcus was "having a breakdown". The ambulance crew referred Marcus to his GP, and Marcus was seen by a GP at Karen's home address. Due to Marcus's presentation the GP requested a mental health act assessment, which took place on 3 January. The outcome of the assessment concluded that there was sufficient evidence to suggest that there was a deterioration in Marcus's mental state which may pose a risk to self or others, and he was detained under Section 2 Mental Health Act 1983. Marcus was conveyed to hospital for a period of assessment of his mental health needs.

17.24 On 29 January, following a further assessment Marcus was detained under Section 3 Mental Health Act 1983 to allow for further treatment of his mental health.

17.25 Karen and James were frequent visitors to Marcus and were involved in discussions with staff who were treating Marcus's mental health.

17.26 At the beginning of March, there was a reported deterioration in Marcus's mental health with increased psychotic behaviour, evidence of thoughts to harm self and intimidating and threatening behaviour towards other patients and staff. It was agreed that Marcus would be transferred to the Psychiatric Intensive Care Unit (PICU).

17.27 On 12 March, whilst in PICU, Marcus assaulted another patient and to support the safeguarding of the other patient Marcus was transferred to another ward. However, Marcus's behaviour continued to be threatening towards others and it was agreed that he would temporarily be transferred back to PICU whilst an out of area PICU bed was sought.

17.28 On the 16 March, Marcus was transferred to a funded specialist mental health hospital in England. Marcus remained there until 16 April when he returned to his local mental health hospital. As per covid 19 guidelines at the time, of his return from the hospital in England a covid swab was taken. On the 18 April Marcus was transferred to a dedicated mental health Covid ward. During his admission to the ward Marcus was polite, pleasant, and more engaged with staff. For the initial parts of his admission to this ward electronic records documented that there was no evidence of distress or responding to unseen stimuli.

17.29 On 25 April, Marcus began to refuse to take his medication and a change in his mental state was noted. The on-call consultant was contacted for consideration of utilising Section 62 Mental Health Act 1983, which allows treatment to be given without consent or a second opinion. The appropriate paperwork was completed and the Section 62 applied. As the Section 62 did not include intramuscular

antipsychotic medication this was reviewed by the on-call consultant on the 27 April and amendments were made to allow for this.

17.30 On 2 April, Marcus initiated an appeal of his detention under Section 3 Mental Health Act 1983.

<u>17 April 2020 – July 2020</u>

17.31 On 1 May, Marcus was transferred from the dedicated Covid ward to the treatment ward as his period of isolation had ended.

17.32 5 May, Marcus was seen during ward round, and it was noted that there were no active signs of psychosis, his engagement had improved, and he was polite. Marcus acknowledged the potential risks of non-compliance with his medication. Marcus requested to be discharged to his mother's address and it was agreed that this would be discussed with Karen.

17.33 Following this, upon discussion with Karen plans commenced to allow Marcus a period of home leave. The family understood that at this point, Marcus had been discharged from his section under the Mental Health Act. Karen was involved in discussions and meetings for Marcus to return home. Marcus's Probation Officer had not been involved in the discussions around Marcus's leave.

17.34 On 13 May, Marcus left hospital on what was documented as authorised leave with support from the Crisis Team. Marcus returned to Karen's address. The Crisis Team visited Marcus the following day. Karen and James were present during the meeting.

17.35 On 18 May, Karen telephoned Marcus's Probation Officer and informed them that Marcus had been discharged from hospital to her address. The Probation Officer contacted the Crisis Team and queried the discharge. Over the following days, the Probation Officer raised concerns regarding Marcus's discharge with health professionals.

17.36 On 20 May, Marcus returned to hospital due to risks that Marcus presented that had been identified by the Probation Officer. The same day, a Social Worker contacted James, as part of the completion of the tribunal report.

17.37 On 22 May, Marcus's Probation Officer submitted a referral to MARAC. The case was discussed four days later as part of a daily domestic abuse discussion meeting.

17.38 On 4 June, Marcus was discharged from hospital to temporary accommodation provided by the YMCA as an interim placement until permanent suitable accommodation was identified. Marcus was to be supported by the Crisis Team and Headroom. Marcus's Probation Officer was not present at the discharge planning meeting; however, information shared during panel meetings stated that Karen, James and one of Marcus's sisters had been present during the discharge planning meetings.

17.39 It was documented that Marcus's mental health deteriorated after his discharge and that he was not engaging with mental health services or support worker at the YMCA. Evidence was documented of mental health services making attempts to engage with Marcus. Records also demonstrated Karen raising her concerns regarding Marcus's mental health.

17.40 In July, Marcus's Probation Officer raised these concerns, and the case was re-listed for MARAC; however, it was determined that the case had been discussed in May and actions identified. All agencies were emailed to state that the case would not be listed at MARAC and the case was removed from the list. There was no record that any agency challenged this decision.

August 2020 – October 2020

17.41 During this period Marcus had temporary accommodation at YMCA with direct support being provided by a Keyworker at YMCA and a Community Psychiatric Nurse (CPN) from Headroom, who was also the Care Co-ordinator. Marcus refused to engage in discussions about his mental health but the Keyworker and CPN maintained regular contact. Multi Disciplinary Team (MDT) meetings were also taking place. Marcus refused to engage in those meetings.

17.42 Marcus's Probation Officer remained involved having regular phone contact with Marcus and Karen, with advice being provided to Karen about risks of having Marcus at the home address. Marcus's Probation Officer continued to liaise with mental health services.

17.43 On 20 August, Marcus was removed from Karen's address by police and taken to YMCA, this was at Karen's request.

17.44 On 5 September, the Probation Service involvement ended with Marcus as the post sentence supervision had expired. During the final contact with Probation, Marcus self reported to be in really good mood and stated that he had no issues with his family or his mental health.

17.45 On 9 October, a Psychiatrist and CPN had a meeting at Karen's home. James and Karen were present. Karen reported that Marcus appeared better than when in hospital as, in her view, whilst in hospital Marcus had appeared overmedicated. However, concerns had been identified by his CPN that Marcus was not taking medication and a potential relapse planning was required. During the meeting, Karen was of the view that Marcus appeared more of "his old self," it was documented that James disagreed with this.

17.46 A meeting in accordance with Section 117 Mental Health Act 1983 was being arranged.

17.47 During this period Karen advocated to mental health services that Marcus's housing situation needed to be resolved and that the YMCA was a temporary

measure and not suitable in the longer term. Information recorded that Marcus was regularly staying at Karen's address.

17.48 In addition, throughout this period Marcus refused to engage in support or processes that would enable appropriate supports to be put in place for his housing/benefits entitlements. Marcus also refused to engage with any mental health services or support. It was recorded via housing support and mental health services that Marcus did not believe he had any mental health issues and would not engage with discussions that focused on any mental health related support needs.

Review Panel Practice and Organisational Learning

18.1 Within the following section, the Review Panel were conscious that the events being reviewed occurred between 2018 and 2020, and that analysis of these events in 2023, would need to take account of changes since that time to policies, procedures and legislation to ensure that the learning was relevant for agencies working across the region in 2023.

Domestic Abuse

18.2 James was the victim of domestic homicide. There were no records of concerns raised about domestic abuse and the risk posed to James from Marcus, apart from the incident in June 2019 when Marcus damaged James's car.

18.3 Between August 2018 and August 2019, there had been five incidents of domestic abuse in which Karen was the victim. All these incidents had been reported to the Police, who completed Public Protection Notifications and risk assessments. The abuse towards Karen included physical abuse, verbal abuse, and criminal damage. It was clear to the Review Panel that the incidents of domestic abuse occurred alongside concerns raised by Karen around Marcus's mental health. The Review Panel also recognised that the level of violence towards Karen had escalated.

18.4 Marcus was arrested on four occasions and appeared at court on three separate occasions. Marcus pleaded guilty for all offences that he had been charged with. Whilst Marcus was convicted of domestic abuse offences; neither Karen nor James were keen to support a prosecution, as their primary focus had been for Marcus to receive help in relation to his mental health.

18.5 Cardiff Magistrates Court has a Specialist Domestic Violence Court (SDVC) which sits every Monday. Cases are dealt with by domestic abuse trained Magistrates, District Judges, Court Legal Advisors and Crown Prosecution Services (CPS) Prosecutors. An Independent Domestic Violence Advisors (IDVA) is usually in attendance. On the three occasions that Marcus appeared in court in 2019 he appeared in custody in the remand court, and not the SDVC.

18.6 The Review Panel were informed that whilst the cases were not heard by the SDVC that Prosecutors should consider the risks posed to family members when dealing with domestic abuse cases. Where defendants are released back into the community following a grant of bail or the conclusion of proceedings, the Police will be notified of the outcome and have responsibility for managing safeguarding issues in conjunction with other relevant agencies.

18.7 The Review Panel agreed that agencies primary focus in relation to the risk of domestic abuse was centred around Karen, which was influenced by the fact that Marcus was living with Karen, and that most incidents of domestic abuse had been towards her. The Review Panel saw no evidence of any wider consideration within agencies records of the risk that Marcus posed to James and other family members.

18.8 The risk of domestic abuse re-occurring and the risk towards Karen, James and family members was not considered during meetings held to consider Marcus's discharge from hospital. During the Learning Event, practitioners discussed that the risk of domestic abuse was not recognised as a risk upon discharge, as the discharge planning meetings focused on immediate risk, as opposed to other agencies such as Police and Probation Service who consider previous events to inform current and future risk assessments. The discharge process is covered in further detail in this section.

18.9 The review heard how health are delivering a training package which covers Adolescent to Parent Violence and Abuse, including familial domestic abuse. In addition, there has been the development of multi-agency teams to respond to young people who are on the verge of criminality and seek to engage with those individuals in providing advice and support. The NHS Violence Prevention Team (VPT) which is now in place, focuses on delivery advice, support, and guidance to patients of any age who have experienced violence with injury. The dedicated nurses and advocates engage with those injured whilst they are in hospital with the aim to help break the cycle of violence at the point of crisis. Post-discharge, the VPTs follow up with the patients to ensure that the ongoing support arrange during engagement is still in place and to reassess the need for additional support.

18.10 Following access to the report, Karen said to the Chair and Reviewers that the abuse from Marcus continued and that there were incidents when she had been physically assaulted by Marcus. Karen stated that she did not report these to Professionals as she was fearful that Marcus would be prosecuted and criminalised and potentially return to prison. Karen stated that she did not see herself as a victim and that Marcus's behaviour was due to his mental health. Karen recalled an incident when Marcus had punched her twice on the leg and that she had begged James not to tell Professionals in a meeting the following day what had happened. Karen stated she was never asked by any Professional following Marcus's discharge from prison as to how her relationship was with Marcus and whether there had been any incidents of abuse.

Learning Point

The additional information provided by Karen identified the barriers that are faced by victims of domestic abuse in allowing them to discuss incidents of abuse, particularly within a family relationship and the need for Professionals to be proactive in seeking to discuss domestic abuse when engaging with individuals.

Research on Adolescent to Parent Violence and Abuse

18.11 There is an increasing recognition within the UK of Adolescent to Parent Violence and Abuse (APVA). An information guide published by the Home Office states[12]:

18.12 'There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse'.

18.13 The guide provides some important information to practitioners and, in particular, some of the barriers that parents may face. Whilst it was recognised that Marcus was not an adolescent when he killed James, or assaulted Karen, there was still a parent/child relationship. Hence, the Review Panel felt some of the information in the guide may be applicable in this case which states that all forms of domestic violence and abuse are under-reported and parents are, understandably, particularly reluctant to disclose or report violence from their child.

Research on Patricide

18.14 The Review Panel reflected on research around patricide[13] and acknowledged that whilst patricide is relatively unusual there is research to show that elder abuse by sons and daughters is not. An extract from the Hourglass[14] policy brief "Building a UK-wide Picture of The Abuse of Older People: Domestic Abuse of Older People"[15], states –

> "Data from the Hourglass helpline from April to September 2020 showed that 12% of calls pertained to abuse by a partner, whilst 38% concerned a son or daughter."

18.15 The Review Panel recognised that parricide is a rare and currently neglected area of research. The Review Panel were aware of some recent research in the

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[12] Information Guide: Adolescent to Parent Violence and Abuse
This document has now been removed from the Home Office website due to the introduction of the DA Act 2015.

[13] The meaning of PATRICIDE is one who murders his or her own father.
[14] **Hourglass, the only UK-wide charity dedicated to calling time on the harm and abuse of older people.**
[15] https://wearehourglass.org/sites/default/files/inline-files/Domestic%20Abuse%20Of%20Older%20People.pdf

UK[16] and whilst the research provides some interesting findings, it does not provide any insight into the barriers that parents may face in reporting abuse by children.

18.16 The Review Panel noted research by Dr Kathleen M Heide, University of South Florida, which describes typologies of parricide[17]. The research describes three typologies of which the Review Panel felt the below was of relevance for this review –

The severely mentally ill parricide offender

Adult offenders are often diagnosed as severely mentally ill and in adolescent offenders, findings often indicate they were gravely mentally disturbed at the time of the murder. Most often there is a diagnosed long-standing mental illness and the killing of a parent or both parents is directly related to the mental illness in these cases.

MARAC

18.17 None of the incidents of domestic abuse reported to the Police, resulted in a referral to MARAC, as the risk was either not graded as high or referred on professional judgement.

18.18 In June 2019, it was documented that Marcus's Probation Officer made a referral to MARAC. The referral was based on professional judgement and followed Marcus's arrest and conviction for an assault on Karen and causing criminal damage to James's car. A copy of the MARAC referral was shared with the Review Panel. The Police stated that they did not receive this referral.

18.19 In August 2019, it was documented that Marcus's Probation Officer chased up the MARAC referral, as Marcus was now serving a custodial sentence following a further assault on Karen. The Police stated they had no record of any contact from Probation on this matter.

18.20 The Probation Officer involved at this time was no longer employed by the Probation Service when the review commenced, and the Independent Reviewers have been unable to speak to them to gather further information and understanding around the submission of the MARAC referral.

18.21 The case was discussed in a multi-agency domestic abuse discussion on 4 September. This led to a series of actions, including work to progress a subsequent arrest of Marcus for breach of his licence conditions.

[16] Dr Hannah Bows Durham Law School: Where parricide meets eldercide: an analysis of child to parent/grandparent homicides in the UK.

[17] Why kids kill parents, child abuse and adolescent homicide

18.22 The following day, the case was discussed in an emergency MARAC meeting. The Review Panel acknowledged that these latter two meetings resulted in a series of actions which went towards the reduction of risk towards Karen; however, the Review Panel were concerned in the apparent delay in the case being reviewed and discussed in a multi-agency forum having first been referred to MARAC some three months earlier. Whilst the Police informed the Review Panel that they had not received the referral in June 2019, it appeared to the Review Panel that there may have been an assumption by the Probation Officer that this had been received as the referral was not followed up until two months later and therefore, the risk that had been identified was not being addressed.

Learning Points

Responsibility of Professionals following completion and submission of MARAC referrals in terms of verification of receipt of referral and responsibility around the management of risk until the MARAC referral is addressed.

During the Learning Event information was shared on how the MARAC processes and discussion of domestic abuse incidents in a multi-agency forum had changed since this case. Practitioners stated there was now a focus on daily discussions taking place to ensure identified risks were responded to in a timely manner and that those cases risk assessed as high were then being progressed to MARAC.

Practitioners at the Learning Event raised concerns, that in their opinion, there was a conflict of interest in that the Chair of the daily discussion meetings and MARAC were the same for the two processes. Practitioners also stated that they felt the MARAC Chair should be of a person whose role was Senior within their Organisation to oversee the discussions around the management of risk and allocation of resources to address that risk.

Restraining Order

18.23 The Restraining Order issued in August 2019, was discharged by the Courts in December 2019, which was four months after the order had been issued and four weeks after Marcus had been released from prison. The application for the Restraining Order to be discharged was made by Karen who had completed an online application form. Within the application, Karen had recorded that Marcus had become vulnerable and his mental health had deteriorated and that by removing the Restraining Order it was hoped to seek professional mental health support. The family stated that the Restraining Order was preventing Karen supporting Marcus in seeking support around his mental health. The family stated that during the hearing they did not speak to anyone, other than the Magistrate, as to the reasons for their application. The family stated that there was no probing or clarification around Marcus's mental health or in relation to domestic abuse.

18.24 The process to consider the discharge Restraining Orders is covered by Criminal Procedure Rules, rule 31.5 and the Protection from Harassment Act 1997, section 5 and when an application is made, the application is referred to a Legal Adviser for consideration. The Review Panel were informed that on this occasion,

the application appeared to be in order and directions were given to list the matter before the court.

Notification of application to discharge Restraining Order

18.25 H.M. Courts informed the review that on 28 November 2019, they had sent an email to those listed below advising them of the application and hearing date. The email contained a copy of the application -

- Crown Prosecution Service
- Witness Care, South Wales Police
- IDVA Team, Bridgend
- Safer Wales
- Karen

18.26 H.M. Court told the review that a letter was sent to the Police Officer in the case via an internal transit service, and that the Police Officer was asked if they had any representations regarding the application. The Police Officer did not receive a letter or email.

18.27 H.M. Court sent a letter to Marcus's home address to inform him of the application. The address of Marcus was provided by Karen, which was also her home address.

18.28 The Review Panel sought information from those whom H.M. Courts had notified, with the exception of Karen as they were keen to know what actions had been taken upon receipt of the email. The responses are captured below –

Crown Prosecution Service

18.29 The CPS informed the Review Panel that the email from H.M. Courts did not request a response or seek the assistance of the CPS. There was no record on the CPS's case management system that the CPS responded to the application. A bundle of documents from the case file, including a copy of the application to discharge, was prepared for the prosecutor in advance of the hearing on 16 December 2019. There was no record on the CPS case management system of whether the prosecutor (who was in court on 16 December 2019) participated in the hearing. Similarly, the court's records do not indicate whether the prosecutor took part in the hearing.

Witness Care, South Wales Police

18.30 In this case there was no instruction from H.M. Court to inform either the Police Officer in the case or any Police department or any other officer linked to the investigation or management of the domestic abuse risks. As the Police Officer was not called as a witness, they were not informed of the court hearing.

IDVA Team, Bridgend

18.31 It should be noted that the IDVA Team, Bridgend do not have responsibility for cases within Cardiff. This was a Cardiff case. The IDVA Team stated that since this time there has been a restructure of the service and they are unable to confirm or deny that an email was received.

Safer Wales

18.32 Until March 2018, Safer Wales were responsible for IDVA service within the Specialist Domestic Violence Courts in Cardiff Magistrates and therefore were not in post at this time. They had no record of receiving the email.

H.M. Courts

18.33 The courts have stated that this should not have gone to the services in Bridgend.

Police Officer in the Case

18.34 The Police Officer did not receive a letter or email from H.M. Courts.

Other Notification

18.35 The application documented concerns from Karen about Marcus's mental health and stated that by seeking to remove the restraining order they would seek professional mental health support for Marcus. H.M. Court, CPS nor any agency who had received notification of the application, sought information from the family as to the nature of the comments or what support and engagement the family were in receipt of from mental health service so as to inform the court hearing who were to consider the application to remove the restraining order.

18.36 Marcus was under supervision of the Probation Service at this time, and they were not made aware that an application and subsequent discharge of the Restraining Order had been made. The Probation Service informed the Review Panel that the Probation Magistrates Court should have been notified to allow their records to be updated.

18.37 H.M. Courts informed that the applications to vary or discharge Restraining Orders are heard in the court in which they were originally heard, and that notification is not automatically given to the Probation Service.

18.38 The Review Panel sought clarification from H.M. Courts as to whether notifications of applications are case specific or if each application is sent to a generic email list. The Courts have confirmed that the list differs according to the area where the complainant protected by the restraining order resides. In this case the notification did not go to the domestic abuse services where Karen was living.

Court Hearing

18.39 H.M. Courts informed the Review Panel that it is open to any party before the court to make an application for an adjournment of a case where a discharge of a Restraining Order is being considered. H.M. Courts stated that there were no representations made on the day of the hearing.

18.40 The CPS told the Review Panel that the CPS does not routinely respond to such applications and that CPS guidance on Restraining Orders[18] provides information on the role of the Crown Prosecution Service when applications are made to vary or discharge Restraining Orders. This states that where a victim, in this case Karen, seeks to vary the restraining order legislation does not expressly state whether the Crown Prosecution Service should be involved. There is not a requirement or expectation that a CPS prosecutor is present when such applications are dealt with, however, applications will often be listed in a court with other cases and a CPS prosecutor may be present in court. However, the guidance does state that the CPS's role is to assist the court/defence through giving facts of the original case and order.

18.41 The Review Panel were informed that when applications are made for the discharge of Restraining Orders then when the case is heard before a Specialist Domestic Violence Court (SDVC) then an IDVA may be present and able to assist the victim. The court hearing for Karen's application was not heard in a SDVC.

Notification of discharge of Restraining Order

18.42 H.M. Courts informed the review that Karen and Marcus would both have been automatically sent a notification letter that the Restraining Order had been discharged.

18.43 As soon as the case was completed (verified) then the Police National Computer was updated with the outcome.

18.44 The review identified that agencies were not aware that the Restraining Order had been discharged. Information provided to the review showed that from the date the Restraining Order was discharged, agencies were making decisions on the management of Marcus and the risk that he posed to Karen, with a perception that the Restraining Order was still in place.

Awareness of processes to request variation or discharge of Restraining Order

18.45 The Review Panel sought information from agencies as to their knowledge around the processes for seeking a variation or discharge to a Restraining Order. Agencies involved in the review process were not aware of the processes around

[18] https://www.cps.gov.uk/legal-guidance/restraining-orders

application, notification of court hearings and outcomes which led to an overall assumption has highlighted in this review that those Professionals involved in the case had no knowledge that the Restraining Order had been discharged and those agencies were referencing and considering the Restraining Order still being in existence as part of their risk management processes. However, it should be noted that the Restraining Order had been removed ten months prior to the death of James within that time period there had been no further reported incidents of domestic abuse.

Learning Points

Knowledge on the application processes, notifications and expectations on interested parties in responding to requests for variance and/or discharge of Restraining Orders.

Availability of support during application process and court hearings.

Responsibility of Professionals in seeking verification of the existence of Civil Orders when assessing and managing risk.

Response to reduce risk of re-offending

18.46 The Review Panel agreed that there was a good response by agencies to the incidents of domestic abuse. Marcus was arrested on four occasions and appeared at court on three separate occasions. Marcus pleaded guilty for all the offences with which he had been charged and the Review Panel agreed that the sentences imposed were appropriate for the offences that had taken place. By the time Marcus had been sentenced to a period of imprisonment, it was evident to the Review Panel that the level of violence towards Karen had increased.

18.47 In September 2019, Marcus was discussed at the Integrated Offender Management (IOM)[19] MASP (Multi Agency Screening Panel); however, he was not selected. The Review Panel were informed that at the MASP it was suggested that Marcus be referred to WISDOM[20] - Wales Integrated Serious and Dangerous Offender Management, which is similar to IOM and is a joint initiative for Police and Probation, but the focus is on those offenders who are assessed as both a high risk of serious harm and a high risk of reoffending.

18.48 The Review Panel were informed by the Probation Panel Member that the action to refer Marcus to IOM to explore other means of working with Marcus due to the risk concerns was appropriate; however, it was unclear why Marcus was not selected and that the suggestion to refer to MAPPA/WISDOM did not appear to have been taken forward. If Marcus had been managed under IOM or MAPPA/WISDOM this may have allowed for more effective information sharing and risk management planning to have taken place.

[19] https://www.gov.uk/guidance/integrated-offender-management-iom
Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
[20] https://www.iomcymru.org.uk/WISDOM/

18.49 The Review Panel considered whether Marcus could have been referred into MAPPA[21]; however, Marcus's convictions meant that he was not eligible to be referred. The Probation Panel member confirmed that Marcus would not have met the criteria for MAPPA Level 2 as the full picture was not known at that time as has been identified in the report.

18.50 The Review Panel were keen to understand if Marcus had undertaken any offence focused work whilst under the supervision of Probation. The Review Panel were informed that there was a lack of any offence focused work being completed with Marcus, which was attributed to a number of factors which included Marcus's time he was in breach of licence conditions and 'at large' and due to his period of hospitalisation. Marcus was discharged from hospital on 5 June and his statutory supervision ended on 5 September 2020, which meant that there was a 3 month period whereby offence focused work could have been completed. The Review Panel were informed that there is no specific intervention for familial abuse and during this time period Probation were only able to see people in 15 minute slots due to the Covid 19 pandemic.

Learning Point
Options for individuals convicted of offence related to familial domestic abuse to engage in specific offender management programmes.

Probation have implemented changes for domestic abuse perpetrators assessed as high risk of serious harm in that they should be considered for MAPPA Level 2

Mental Health

18.51 The timeline considered for this review began in 2018, at this time it is noted that family are reporting that Marcus's presentation and behaviour had become out of character and Karen was contacting police to assist with removing Marcus from the home address. Marcus's first arrest was made in August 2018 following criminal damage to the home. Agency records demonstrate a recognition at this time that Marcus was presenting with some mental health related issues and was asked specific questions about whether he suffered from mental health problems or depression to which Marcus answered No. Marcus's family continually referenced their worries and concerns about Marcus's mental health when contacting agencies such as police/health services for assistance.

18.52 Family reported that Marcus's presentation and behaviour was of concern throughout the period of this review. Their recollections of this time were that in their view Marcus presented as very ill and anyone coming into contact with him could see this. Although this fluctuated, on the whole this was how Marcus presented. The family recall Marcus putting lit cigarettes in his hair and in his socks; he would refer to himself as "God" and "Jesus Christ;" would not eat for

[21] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

days at a time; was paranoid and delusional; violent and aggressive towards family; damaged items and property in Karen's home; had little awareness of his own self care and hygiene.

18.53 There were also number of contacts made by Marcus's mother to the GP service expressing concern for Marcus's mental health and appointments were made for Marcus to attend the surgery, he did not attend any of the appointments offered.

18.54 Due to the increasing concerns being expressed by mother in relation to Marcus's poor mental health and his continued non engagement with any support services, the GP and CPN from CMHN based within the GP practice undertook at home visit to see Marcus in August 2018. An assessment of his mental health was undertaken during this visit and Marcus was noted as presenting as irritated when asked questions and it was noted that he was anxious, suspicious/paranoid but was able to rationalise this. It was deemed that at this time that Marcus did not require any further intervention and did not require any interventions under the Mental Health Act.

18.55 It was noted during panel discussion and both the practitioner and manager learning events that this visit was an example of positive, good practice. Both the GP and CMHN visited and appropriate assessment undertaken. This is not the normal practice and was above and beyond what would be reasonably expected. The review noted that this arrangement is no longer in place and there is no CMHN role attached to the GP surgery. This review recommends that this point is highlighted to strategic leads in health services to inform future planning of services.

18.56 Marcus was offered follow up appointments with both GP and CMHN, but again did not attend any of these appointments.

18.57 Marcus was seen again by mental health service in October 2018, following Marcus being arrested for attempted burglary, this was unrelated to his family and took place in a different area of the city. Whilst in custody he was seen by Mental Health Care Professional and Dyfodol. Marcus was seen by this service due to recognition that family had been expressing their concerns about Marcus's mental health and in relation to understanding Marcus's ability to engage with any interview whilst in custody, ensuring his safety and well-being. During this initial assessment with Marcus he was reporting no mental health problems, he presented as hostile and uncooperative, but the assessment continued, recognising and recording an awareness of increased concern from family and GP/CMHT visit in August. The mental health nurse had liaised with CMHT and GP to inform their understanding and there was some query that Marcus may have a developing mental health issue.

18.58 This assessment did not determine any immediate mental health issues on that day and there were no concerns identified in relation to his capacity or cognition. Marcus maintained throughout the assessment that he had no issues with his mental health. Marcus did confirm daily cannabis use which in his own words said, "helps me with my mental health". The outcome of the assessment at that

time was that there was no evidence of any acute mental health needs and advise provided to Marcus to seek support from the GP if needed.

Research linked to High Potency Cannabis use and Psychosis

18.59 Rethink Mental Health are a leading charity for mental health services. Information contained within their website provide an overview of how cannabis can interact with an individual's mental health (Cannabis & Mental Health) How does cannabis affect my mental health? (rethink.org). It is widely acknowledged that there are varying degrees of potency and language used to describe different types of cannabis. The frequency of use, the potency of cannabis being used and an underlying mood or mental health disorder has been shown to contribute to some individuals developing psychosis as a result. High potency cannabis linked to higher rates of psychosis | Website archive | King's College London (kcl.ac.uk)

Learning Points

This is the first recorded instance of Marcus reporting daily cannabis use. There is little focus on how this level of cannabis use impacts either positively or negatively on Marcus's mental health and/or symptoms of psychosis.

Clear evidence that Marcus is not recognising he has any mental health related issues/needs. Marcus did not attend any of the appointments being offered by GP or CMHT. Issues balancing this degree of mental health deterioration/presentation (lower level than MHA intervention) with risks and concerns being expressed by those closest to him.

It was evident that Marcus did not attend follow up appointments with GP and/or Community Mental Health Services in the two years prior to him being detained in hospital under the Mental Health Act. The approach taken to engage Marcus was to offer follow up appointments or provide advice to family to contact GP if they were concerned. However, it was clear that Marcus would not engage with services in this way and this was a clear barrier to both Marcus and family. There was no opportunity to develop a professional understanding of Marcus's mental health needs in the community from a holistic perspective and no opportunity to build any relationship or level of understanding of Marcus's individual presentation and needs.

18.60 There was no further contact with Marcus from the GP or mental health services for the remainder of 2018.

18.61 Early 2019, Karen makes contact with the GP reporting that Marcus's mental health is no better and he is no longer leaving the house. It was established during the consideration of timelines that Marcus was not working at this time and had been receiving sick certificates from the GP stating Marcus was unable to work due to anxiety and depression. These sick certificates were renewed with no evidence of the GP seeing Marcus when each sick certificate ran out.

18.62 Further contact is made with police in March 2019, when Marcus has physically assaulted his mother, this took place in the community reportedly following a discussion between Marcus and Karen where she had stated he could no longer live with her as she could no longer manage his temper and behaviour. Following his arrest for this offence a police risk assessment was undertaken which asked about any mental health issues, Marcus stated he had no issues. On this occasion he did not see the HCP* whilst in custody. Marcus was again given information and advice on how to seek support for his mental health and information in relation to drug support agencies. Marcus continued to maintain that there were no issues with his mental health or drug use.

18.63 Following a further arrest for criminal damage of James car in May 2019, Marcus was again seen by the HCP whilst in custody. During this contact Marcus reporting that he has regular contact with his father although living away from the family home and describes a happy childhood. Marcus stating that his father is a Rastafarian and although parents are separated, they spend their days together. It was recorded following this contact that there did not appear to be mental health related needs for Marcus. This appears to be in direct opposition to the observations and views of family who continued to state that Marcus's mental health was deteriorating.

18.64 The family have reiterated throughout this review that Marcus's cannabis use was known to them, but this was not something that was condoned or supported by James and Karen. As referenced previously James had clear boundaries and expectations for all the children and would not allow Marcus to smoke cannabis in his presence nor encourage or condone his use of cannabis.

18.65 Due to breaching previous bail/licence conditions Marcus attended court the following day and again seen by a mental health court liaison practitioner (MHCLP). The MHCLP liaised with family to ascertain their views, concerns and issues in relation to Marcus's mental health and time spent with Marcus. Marcus reporting no concerns about his mental health. It was recorded that there was no evidence of thought disorder, his mood was bright, and he was reactive. It was noted that the practitioner recorded that there was no time for a Mental Health Act Assessment due to time constraints and Marcus being released from custody, whilst also recording that Marcus was refusing any further support or assessment.

18.66 Karen contacts NHS111 service on the same day as Marcus has appeared in court expressing her ongoing concerns for her son, his denial that he is experiencing any mental health issues and physical violence towards her. She references the contact with the custody mental health service and queries why they had not picked up on these issues. This was a lengthy discussion, and the clinician took time for Karen to discuss the situation and her concerns about Marcus. It was acknowledged by the Review Panel that there were limited options in terms of mental health support services that could be referred onto.

Learning Point

Karen informed the Chair and Independent Reviewers that the physical abuse from Marcus, continued following his release from prison and in hospital. Whilst it was noted that there was lengthy interaction with Karen by professionals around the provision of support, there was no evidence that Karen was asked directly if the abuse was continuing, and without this focus the considerations of Ask and Act were not evident.

18.67 Probation become involved for the first time in June 2019. Marcus had received a 12-month unconditional discharge for the Section 39 assault against his mother in March 2019 and the further incident of criminal damage. There was no probation supervision requirement at this time. Marcus has an initial appointment with the Probation Officer and support for alternative accommodation is explored. There is recognition that Marcus has been violent towards his mother and there is a pattern of aggressive behaviour from Marcus towards his parents.

18.68 James has contact with the GP for his own health related matters, during this consultation he reports his continued concern for Marcus's mental health, although records are not explicit in what these concerns were. James reporting that he doesn't understand why Marcus cannot be sectioned.

Learning Point

Families' frustrations and lack of knowledge of mental health services and systems.

18.69 August 2019 – Police contacted by Karen asking for assistance to remove Marcus from property. Karen reporting that Marcus had assaulted her the previous day and she felt unsafe in her home if Marcus was still there, Karen stating that she believes Marcus is experiencing poor mental health but will not engage with GP or any other service.

18.70 Following this reported incident Marcus was arrested and subsequently remanded into custody. At the court hearing he refused to engage with Mental Health Court Liaison Practitioner (MHCLP), making threats of harm towards them and saying he didn't trust the mental health workers. Marcus was sentenced to 10-week custodial sentence which included a licence period and post sentence supervision via Probation.

18.71 Marcus was identified as a vulnerable prisoner and appropriate arrangements were put in place whilst in custody. He did not engage with any mental health assessments whilst in prison. Information was shared from CPN Prison in reach to CMHT and GP raising concerns about possible emerging psychosis, patterns of hostility when trying to assess and ongoing refusal to engage with mental health services.

18.72 Throughout this period Marcus refuses to engage with professionals in the community, custody and with his GP. There were numerous contacts with Marcus

from a range of professionals who assessed his mental health, at no point during this time was it felt that a mental health act assessment was required or that he posed a risk to himself or others that required formal intervention within the legislative framework of the mental health act.

Mental Health Inpatient/Home Leave/Discharge

18.73 On 3 January 2020, a mental health act assessment took place following Karen contacting WAST on 2 January, reporting that Marcus is “having a breakdown”. Crew attended, following their observations of Marcus and Karen’s description of what is taking place an urgent referral was made from the GP for a mental health act assessment to take place. This assessment took place on 3 January 2020 and Marcus was subsequently detained under section 2 of the Mental Health Act, this resulted in a further detention under section 3 of this act on 29 January 2020.

18.74 Marcus was an inpatient initially under section 2 then section 3 of the Mental Health Act from January 2020 until May 2020. It should be noted that the COVID-19 pandemic and associated restrictions were in place during this period. This is of note in relation to home leave arrangements that were made during this time. It is recorded that Marcus’s MDT and family made decisions in relation to home leave, and this took the form of one week leave initially. Family remains resolute in their view that from their understanding and recollection this was in fact Marcus being discharged from hospital and not a period of home leave.

18.75 The initial leave period was driven by Covid protocols at the time, with the aim to minimise the risk of introducing the Covid virus into the hospital. Outside of Covid it would usually be a graded process starting with shorter periods of leave first. Given the restrictions in place and the requirements one week home leave was granted to include Crisis Team Support if needed.

18.76 The decision for home leave to Karen’s home address would appear to have been made with minimal input from other agencies. Probation was not consulted and consideration of the domestic abuse incidents that had taken place previously do not appear to have formed part of the risk planning discussions or assessments. The weeks leave took place with Marcus staying at his mother’s home. The Crisis Team attended and discussed longer term support options for Marcus with parents, Marcus refusing to speak with anyone from the team.

18.77 It is evident that during this period Karen fluctuates between wanting Marcus home and expressing her concerns about how things would be and what support would be available. Karen also saying she felt backed into a corner of having Marcus at home as the only housing options that were being offered at that time was floor space in a homeless provision. Which Karen felt was unacceptable for Marcus given the length of time he had been in hospital and the support he would need on discharge.

Learning Point

There appears to be little information around the multi-agency approach to the planning of home leave and subsequent discharge. It is acknowledged that Marcus's mental health had improved to the point where his MDT were of the view that he could be discharged from the Section. However, Marcus was still subject to probation orders, and it was the understanding of some professionals that a restraining order was in place restricting Marcus from attending the home address. This information did not feature in the discussions around the planning of home leave. There needs to be holistic discussion of all risk factors and previous issues of domestic abuse prior to consideration of home leave plans for all inpatients. All known agencies should be involved in these discussions prior to leave taking place.

18.78 The learning from this case needs to be disseminated across mental health service providers to highlight the importance of a multi-agency response when agreeing discharge plans, where it is known that other agencies, are involved with the individual concerned.

18.79 It appears that Karen felt unable to openly discuss her concerns and used individual private conversations with professionals to express her worries, this may have been in part not to upset Marcus. Given her primary desire was for her son to be well and return home it is understandable that she did not always express these concerns in formal meetings or forums where Marcus was also present.

18.80 Most of the recordings from all agencies reference conversations and discussions with Karen. We were able to establish that James was also present during meetings at the hospital and with professionals at Karen's home address. Professionals in all agencies should ensure that when recordings of contact with families are made that all those present are noted.

Learning Point

Lack of recording that identifies James being present during discussions and meetings with agencies.

18.81 Marcus also refused to engage with Headroom whilst on the ward and at home. Numerous attempts were made to engage Marcus whilst an inpatient, but Marcus refused to talk with workers.

18.82 During the first part of May 2020, there was confusion about the restraining order that had previously been in place and the impact this had on Marcus's housing situation if discharged from hospital. It took some time to establish that probation would not support Marcus being discharged to his mother's home address, however, by this time Marcus was already on home leave with his mother. It is clear that the confusion led to several conversations where the only option would have been for Marcus to be arrested for breaching conditions, however, parents felt this was unfair and unnecessary. Marcus returned to hospital until appropriate accommodation was found.

18.83 At the end of May 2020, a meeting took place to discuss discharge arrangements, Karen and James were present and stated that Marcus could not live at either of their homes. June 2020 a Pre discharge meeting also took place, the Probation Officer was not invited, this was reported to have been an oversight. The Probation Officer had provided their risk assessment and the conditions, these outlined that Marcus has been assessed as posing high risk of serious harm to his mother and they would not support Marcus being at his mother's address.

Learning Point

Significant oversight that key agencies involved with Marcus and family were not involved in key meetings/discussions when planning home leave and subsequent discharge.

Discharge from Hospital

18.84 Marcus was discharged from Section 3 on 4 June 2020. Discharge records state that during his first few weeks of admission Marcus displayed symptoms of psychosis including delusional beliefs and was unwilling to engage with staff. Marcus's behaviour and presentation improved in the weeks prior to his discharge, and he was deemed not to be displaying psychotic symptoms. Marcus was prescribed olanzapine and clonazepam. Part of his discharge plan was input from Headroom. Marcus was provided interim temporary accommodation until alternative accommodation could be identified as it had been established that Marcus could not stay at his mother's address.

18.85 Keyworker via the support element of the temporary accommodation was in place for Marcus along with regular contact being made by CPN from Headroom. Marcus consistently refused to engage with Headroom and would not communicate in any conversations or discussion about his mental health. Marcus signed forms for benefits such as PIP and other related forms as Jesus Christ and this compounded his ability to access benefits.

18.86 Marcus regularly stayed at his mother's address over the following months. Marcus superficially engaged with his mental health support and refused to discuss his mental health needs. There was discussion between the CMHT and Karen in relation to Marcus's medication and his compliance with medication. The CPN from Headroom maintained weekly contact but it was noted that Marcus's insight into his mental health needs remained poor.

18.87 Karen regularly advocated and requested support for Marcus and expressed her concern that Marcus's accommodation was unsuitable for him and he required a higher level of support. It was identified that there was limited availability for housing and that Marcus was required to engage in the assessment process for this type of housing which he continually refused to do.

18.88 Mental Health Services (Consultant Psychiatrist, CPN) met with both Karen and James a week before the tragic incident of which this review has referenced. Karen reporting that Marcus was regularly at her property, although he generally did not speak to her just asking to use things the shower and to do his laundry. It is recorded that both James and Karen were of the view that Marcus should not go back to hospital but required housing. It is recorded that Marcus was not regularly taking his prescribed medication. There appears to be an over reliance on Karen to manage Marcus's medication, with limited understanding of the impact of noncompliance and what to do should he refuse medication/relapse.

18.89 It was noted during this review that there were no reported incidents of domestic abuse following Marcus's discharge from hospital. It is known that Marcus spent a significant amount of time at his mother's address. Agencies acknowledge that Marcus's behaviour and presentation remained of concern, however, there was no specific reference to a plan for Marcus to return to hospital.

18.90 Karen has since informed this review that there were incidents where Marcus had hit her, damaged property and generally made her feel unsafe following his discharge from hospital. Karen reflects that she did not report these incidents to Police or any of the agencies involved with Marcus due to being worried that he would be criminalised.

18.91 Records indicate that Karen was offered a carers assessment from the Local Authority in recognition of the care and support she was providing Marcus. However, Karen states she didn't see herself as a carer and declined this assessment only wanting to ensure Marcus received the support he needed.

Learning Points

This review identified a varying practice approach and understanding of risk assessments across agencies. There is varying understanding of what risk is being assessed, the focus of the risk i.e., individual, family, wider community; what the risk assessment outcome mean and what actions take place as a result.

Over reliance on family members to support compliance and engagement with prescribed medication.

There were obvious barriers for Marcus accessing benefits and move on accommodation due to his lack of insight and refusal to engage with support worker and CPN.

Individual Organisational Learning

Probation Service

19.1 Where an individual is convicted of a domestic abuse index offence and assessed as high risk consideration to be given for a referral into MAPPA. This process was not in place at the time of this case.

Cardiff and Vale University Health Board (C&VUHB)

19.2 The following support and training is available to staff within C&VUHB. There is Group 2 VAWDASV training for all staff who have face to face contact with service users - this is approximately 11,000 staff . Health IDVA are in place, who visit patients at Hafan Y Coed (HYC) and also offer staff advice on DV and training. There is MAPPA Training / awareness for staff in Mental Health. MAPPA records on Paris for staff to be aware that a patient has been discussed, and that the team can be contacted for further updates. MAPPA process and updates are also shared at SSG. The Safeguarding Team is available to all UHB staff for advice on safeguarding concerns.

19.3 The family believe that the catalyst for Marcus's mental health was as a consequence of a knife attack assault upon him. That assault resulted in significant injuries to his foot rendering it impossible for him to take part in sport and the decline in his mental health. At that time, for incidents of this nature, there was no support in place either in a hospital or the community. It was acknowledged that had Marcus received support following the assault it may have prevented Marcus's health deteriorating.

19.4 Since this time there is a Violence Prevention Unit (VPU) in place in the Emergency Department (E D) in the hospital and any person subject of a similar incident now would be offered support as a victim of an assault and support for being part of a gang.

19.5 Marcus would have been seen and offered 1:1 support in the community Via Action for children as a victim of an assault. The service would have provided intensive support to Marcus. The service would be able to signpost and assist with any mental health or drug issues Marcus experienced following the incident, and support to attend services and encourage engagement in the community. The referral to Action for Children can only be accessed via referral from attendance at ED via VPU

Welsh Ambulance Service NHS Trust (WAST)

19.6 Mental Health - WAST has a dedicated Mental Health Team who have developed a Mental Health and Dementia plan 2021-2024, which has identified the following key objectives. These are:

- Appropriate Mental Health training is in place to equip staff to feel confident and competent in supporting patients with mental health concerns.
- Developing pathways and working with external agencies to provide ongoing support for our patients who are experiencing mental health issues. This is evident in the newly established NHS111 press 2 service, which utilises the platform (NHS111) of an all-Wales Service to enable patients/service users to access Mental Health support within their local Health Board area. Ensuring patients access the right support at the right time and when they need it most.
- Engaging with patients and service users, learning from their experiences.

- Supporting staff wellbeing and ensuring support services are in place for staff to access.

19.7 TerraPACE ePCR - The Covid 19 pandemic offered the opportunity to improve the digital opportunities available to staff, as all staff who worked within the Emergency Medical Service and Non-Emergency Patient Transport Service were supplied with iPads. This enabled the Trust to move away from paper patient clinical records (PCRs) to electronic patient clinical records (ePCRs) via the TerraPACE application. The ePCR is a digital form that WAST have been using across Wales since March 2022. It also is a contemporaneous document that provides a legible and accurate account of all assessments and treatments taken on scene. Another function of TerraPACE is the 'Historical Records' function. This enables staff to search the database for stored ePCRs and view a list of matched historical ePCRs for the patient they are currently assessing. This function is especially useful when managing patients with mental health concerns as it provides a picture of the number of contacts, the reason for the contact and previous management. Thus, providing staff with a much broader overview of the patient and their management plan and identifying escalation in behaviour and risk factors, so that the appropriate action can be taken.

Headroom – Psychosis Response Service

19.8 Cardiff and Vale UHB mental health services have changed the risk assessment method to the Wales Applied Risk Research Network (WARRN) a multidisciplinary formulation-based technique for the assessment and management of serious risk. For patients referred to mental health services including Headroom this would be the standard assessment and risk management tool.

South Wales Police

19.9 As a result of this and other cases, South Wales Police has implemented a trail of a new online live platform for Multi Agency Risk Assessment Conferences.

The online platform MANTA for MARAC has lifted MARACs into a live dynamic Safeguarding system, that shares information across all partners at the same time whilst also placing equal and immediate active management responsibility on all partner agencies.

This live time system is able to remove the administrative burden and volume demands from one agency and places it equally across all partners from the start.

As a result this fast time process provides total transparency to all agencies at equal levels of accountability and is speeding up engagement to actively build and implement multi agency risk management plans.

Once the agency has submitted their referral into the online MARAC platform it provides all agencies with an acknowledgement that a new referral has been received and it is instantly shared across all MARAC partners.

Agencies other than the Police have now also taken up the role of Chairing the MARACs on a rotation basis, which now provides a shared transparent level of accountability and responsibility at the appropriate senior manager grade.

Improving Systems and Practice (National, Regional and Local):
To promote the learning from this case the review identified the following actions and anticipated improvement outcomes:

Domestic Abuse

Learning Points

- The additional information provided by Karen identified the barriers that are faced by victims of domestic abuse in allowing them to discuss incidents of abuse, particularly within a family relationship and the need for Professionals to be proactive in seeking to discuss domestic abuse when engaging with individuals.

- Responsibility of Professionals following completion and submission of MARAC referrals in terms of verification of receipt of referral and responsibility around the management of risk until the MARAC referral is addressed.

- During the Learning Event information was shared on how the MARAC processes and discussion of domestic abuse incidents in a multi-agency forum had changed since this case. Practitioners stated there was now a focus on daily discussions taking place to ensure identified risks were responded to in a timely manner and that those cases risk assessed as high were then being progressed to MARAC.

- Practitioners at the Learning Event raised concerns, that in their opinion, there was a conflict of interest in that the Chair of the daily discussion meetings and MARAC were the same for the two processes. Practitioners also stated that they felt the MARAC Chair should be of a person whose role was Senior within their Organisation to oversee the discussions around the management of risk and allocation of resources to address that risk.

- Karen informed the Chair and Independent Reviewers that the physical abuse from Marcus, continued following his release from prison and in hospital. Whilst it was noted that there was lengthy interaction with Karen by professionals around the provision of support, there was no evidence that Karen was asked directly if the abuse was continuing, and without this focus the considerations of Ask and Act were not evident.

Recommendations

1. Agencies to understand the barriers faced by victims in discussing incidents of familial domestic abuse and need for Professionals to openly discuss domestic abuse during contact with individuals.

2. Agencies must learn from this case around the requirements on Professionals who refer cases to MARAC on seeking assurance that the referral has been received and their responsibility in the management of the risk.

3. Community Safety Partnerships in Cardiff and Vale need to seek assurance that the Multi- Agency Daily Discussions around Domestic Abuse Incidents that has been implemented is fit for purpose and sufficiently robust to identify the risks for victims and respond to the same in a timely manner. In addition where the risk is identified as high the case is progressed to MARAC.

4. Raise awareness of MAPPA and MARAC processes across agencies. Highlight referral pathways; eligibility and criteria for referral; purpose and risk management approaches of these processes.

Restraining Orders

Learning Points

- Knowledge on the application processes, notifications and expectations on interested parties in responding to requests for variance and/or discharge of Restraining Orders.

- Availability of support during application process and court hearings.

- Responsibility of Professionals in seeking verification of the existence of Civil Orders when assessing and managing risk.

Recommendations

5. The SUSR Coordination Hub to inform the Criminal Justice Board for Wales of the learning identified within this report and seek consideration of reviewing the process for responding to applications for variance and/or discharge of Restraining Orders. The review should consider –
    - how notifications are made to interested parties,
    - the expectation of those interested parties,
    - the support during the process to victims of domestic abuse. and
    - the communication and expectation of interested parties following the outcome of the court hearing.

6. Agencies to be made aware of the circumstances and processes in which a request can be made to the Court for variation and/or discharge of a Restraining Order. To include how interested parties can make representation to the Court during the application process.

7. Expectations on Professionals to confirm the validity of Civil Orders or other legal directions that have been implemented for the protection of victims and management of risk, prior to reviewing and implementing risk management processes.

Response to reduce risk offending

Learning Points

- Options for individuals convicted of offence related to familial domestic abuse to engage in specific offender management programmes.

- Probation have implemented changes for domestic abuse perpetrators assessed as high risk of serious harm in that they should be considered for MAPPA Level 2

Recommendation

8. The SUSR Coordination Hub to inform the Probation Service of the learning identified within this report and seek consideration of reviewing the availability of interventions for those who are convicted of familial domestic abuse and subject to Probation supervision.

9. Cardiff Community Safety Partnership seeks assurances and evidence from the Probation Service that this change is being implemented.

10. Cardiff Community Safety Partnership to raise awareness with agencies of their commissioned services that work with individuals and families in reducing violence, exploitation and other forms of abuse

Recording

Learning Point

- Lack of recording that identifies James being present during discussions and meetings with agencies. This review noted an absence of this in agency records.

Recommendation

11. Agencies to ensure that all those present and engaged in discussions are accurately recorded.

Substance Use & Mental Health

Learning Point

- Marcus self-reported daily cannabis use. There is little focus on how this level of cannabis use impacts either positively or negatively on Marcus's mental health and/or symptoms of psychosis.

Recommendations

12. Practitioners involved in assessing, risk management planning and providing support services, should be alert to individuals substance use and consideration of any correlation with presenting mental health issues, particularly taking into account cultural and religious beliefs.

13. Area Planning Board & Regional Partnership Board to review current service delivery and support, for individuals with co-occurring mental health and substance use needs. Work with agencies to implement identified/required improvements.

Learning Points

- Clear evidence that Marcus is not recognising he has any mental health related issues/needs. Marcus did not attend any of the appointments being offered by GP or CMHT. Issues balancing this degree of mental health deterioration/presentation (lower level than MHA intervention) with risks and concerns being expressed by those closest to him.

- Families' frustrations and lack of knowledge of mental health services and systems.

- There were obvious barriers for Marcus accessing benefits and move on accommodation due to his lack of insight and refusal to engage with support worker and CPN.

Recommendation

14. Health services should develop information which can be provided to family and parents in terms of availability of support for individuals who are experiencing mental health issues on
    - the process of assessment;
    - when intervention can take place;
    - understanding the legal framework
    - rights of individuals and
    - legality of information sharing and consent.

Learning Points

- There appears to be little information around the multi-agency approach to the planning of home leave and subsequent discharge. It is acknowledged that Marcus's mental health had improved to the point where his MDT were of the view that he could be discharged from the Section. However, Marcus was still subject to probation orders, and it was the understanding of some professionals that a restraining order was in place restricting Marcus from attending the home address. This information did not feature in the discussions around the planning of home leave.

- Over reliance on family members to support compliance and engagement with prescribed medication.

Recommendations

15. There needs to be holistic discussion of all risk factors and previous issues of domestic abuse prior to consideration of home leave plans for all inpatients. All known agencies should be involved in these discussions prior to leave taking place.

16. Health services to provide written information at the point of home leave/discharge to nearest relative/families on the circumstances of the leave/discharge and arrangements for support to be provided at that time.

Learning Point

- It was evident that Marcus did not attend follow up appointments with GP and/or Community Mental Health Services in the two years prior to him being detained in hospital under the Mental Health Act. The approach taken to engage Marcus was to offer follow up appointments or provide advice to family to contact GP if they were concerned. However, it was clear that Marcus would not engage with services in this way and this was a clear barrier to both Marcus and family. There was no opportunity to develop a professional understanding of Marcus's mental health needs in the community from a holistic perspective and no opportunity to build any relationship or level of understanding of Marcus's individual presentation and needs.

Recommendation

17. Health Services involved in the provision of mental health support should adopt a reflexive approach to follow up appointments. Considerations should be made as to how best to engage those in the community who will not attend appointments They should :

    - Create opportunities to understand how individuals are presenting from the perspective of those closest to individuals, in this case family members were consistently expressing their concerns/worries.
    - Be flexible in their approaches in how they engage those who are unwilling to engage.
    - Explore alternatives to in person appointments

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Dissemination
List of recipients who will receive copies of the Review Report (in line with guidance and due to the recommendations of this Report): Please copy and paste the appropriate number of instances.

Date circulated to relevant policy leads: 05/02/2025

Organisation	Yes	No	Reason
C&V University Health Board	☒	☐	Click or tap here to enter text.
South Wales Police	☒	☐	Click or tap here to enter text.
WAST	☒	☐	Click or tap here to enter text.
Cardiff Council	☒	☐	Click or tap here to enter text.
Cardiff Community Safety Partnership	☒	☐	Click or tap here to enter text.
Vale of Glamorgan Council	☒	☐	
National Safeguarding Team, Public Health Wales	☒	☐	
Cardiff RISE	☒	☐	
Police & Crime Commissioner's Office	☒	☐	
Safer Wales	☒	☐	
Velindre University NHS Trust	☒	☐	
National Probation Service	☒	☐	
His Majesty's Prison Service (HMPS)	☒	☐	
South Wales Fire & Rescue Service (SWF&RS)	☒	☐	
Barnardo's Cymru	☒	☐	
NSPCC Cymru	☒	☐	

Single Unified Safeguarding Review process

It is evidenced throughout the report that;

- The Cardiff and Vale Regional Safeguarding Board and Cardiff Community Safety Partnership has followed the SUSR guidance for the review. The agencies represented on the review panel are recorded within this report.

- Two Learning Events were held, one with practitioners and the other with managers. There was good agency representation at both events and attendees contributed well to identify learning.
- Family members were informed of the review, and they have engaged throughout the process. Their views were sought and represented at the learning event and feedback has been provided to them. The family attended a panel meeting where they were able to receive answers to questions that they posed to panel members concerning interaction with their family members. They have also had an opportunity to examine and comment on the report.

Final confidence check

This Report has been checked to ensure that the Single Unified Safeguarding Review process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication ☒

Does this Report include aspects which meet the following requirements of completing a Domestic Homicide Review? *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* If yes, upon completion and ratification by the Regional Safeguarding Board Chair, in consultation with the Community Safety Partnership Chair, the Single Unified Safeguarding Review Report needs to be forwarded to the Home Office Quality Assurance Panel.	☒

For Welsh Government use only

Date information received: Click or tap to enter a date.

Date acknowledgment letter sent to Board Chair: Click or tap to enter a date.

Date circulated to relevant inspectorates/Policy Leads: Click or tap to enter a date.

Agencies	Yes	No	Reason
CIW	☐	☐	Click or tap here to enter text.
Estyn	☐	☐	Click or tap here to enter text.
HIW	☐	☐	Click or tap here to enter text.
HMI Constabulary	☐	☐	Click or tap here to enter text.
HMI Probation	☐	☐	Click or tap here to enter text.

Statements of Independence

Statement of Independence by Reviewer(s): Please read and sign the following statement. Consider the section on independence in the SUSR Statutory Guidance before completing. [Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES]()
Reviewer 1: Carol Ellwood-Clarke
Statement of independence from the case *Final check statement of qualification* I make the following statement that prior to my involvement with this learning review: • I have not been directly involved in the case or any management or oversight of the case. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies. • I have read and understood the 7 Nolan Principles and will apply accordingly.
Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* *Guidance: Explain the independence of the Reviewer and give details of their career history and relevant experience. Confirm that the Reviewer has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:* **Carol Ellwood-Clarke was appointed as one of the Independent Reviewers. She is an independent practitioner who has chaired and written previous Domestic Homicide Review's and other safeguarding reviews. Carol retired from Humberside Police in 2017, after thirty years service. Prior to leaving the police she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews working with Child and Adult Safeguarding Boards.** **In January 2017, Carol was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison.** **Following retirement, Carol worked for two years on a Home Office funded project to establish a multi-agency response to perpetrators of domestic.** **Carol is an Associate Trainer for SafeLives delivering training to Police Forces on domestic abuse.**

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Carol has been an Independent Reviewer since 2018 and has experience of undertaking the following types of reviews – Local Child Safeguarding Practice Review, Safeguarding Adults Reviews; Multi-agency Public Protection Arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and has completed the Home Office online training for undertaking DHR,s. Carol is also completed accredited training for DHR Chairs, provided by AAFDA.

Carol has previously completed two Domestic Homicide Reviews for Cardiff Community Safety Partnership (DHR 08 & 09).

Signature:

Name: Carol Ellwood-Clarke
Date: 21/03/2024

Reviewer 2: Natasha James

Statement of independence from the case
Final check statement of qualification

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*

Guidance: Explain the independence of the Reviewer and give details of their career history and relevant experience. Confirm that the Reviewer has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:

Natasha James was appointed as one of the Independent Reviewers. She is a local authority safeguarding manager. Natasha is a qualified social worker with over 20 years' experience in safeguarding and child/adult protection. She has been involved in a number of safeguarding reviews as chair, reviewer and panel member. Natasha was part of the team that developed the Wales Safeguarding Procedures in 2019 and continues to support local, regional and national developments to safeguarding practice across Wales.

Signature:

Name: Natasha James
Date: 21/03/2024

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Statement of Independence by Chair of the Review Panel: Sue Hurley
Please read the following statement and sign below. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES

Final check statement of qualification

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

Where a Domestic Homicide has occurred, please set out below how you meet Section 4, paragraph 37 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Guidance: Explain the independence of the Chair of the Review Panel and give details of their career history and relevant experience. Confirm that the Chair of the Review Panel has had no connection with the Community Safety Partnership. If they have worked for any agency previously state how long ago that employment ended:

The Chair was employed by South Wales police retiring in October 2014 following 30 years policing Service. Their role at the time of retirement was a Detective Chief Inspector on the Public Protection Strategic Team with no connection to any Community Safety Partnership. During their 30-year policing career they had no connection with the Cardiff and Vale Community Safety Partnerships having never worked in that area of the Force.

In December 2014, the Chair took on the role of an Independent Protecting Vulnerable Person Manager in South Wales Police. This position was also within the Public Protection Strategic team with no operational responsibilities. Their role was to be the South Wales Police Panel Member in Adult and Child Practice Reviews as well as Domestic Homicide Reviews. The Chair has undertaken relevant training for the Welsh Government Practice Reviews as well as Home Office Domestic Homicide Reviews.

The Chair has experience of both chairing and reviewing Child Practice and Adult Practice Reviews, a position they held for 9 years. During this time, they were a panel member on a number of Domestic Homicide reviews in both Cardiff and the Vale area which had been commissioned by Cardiff and the Vale Community Safety Partnerships.

In the last 4 years of service, their area of responsibility was Rhondda Cynon Taff and Merthyr as well as Swansea Bay.

As part of their role and responsibilities, the Chair was involved in the working groups that were set up for the Single Unified Safeguarding Review project undertaking various pieces of work. This work was still ongoing at the time of retirement; however, their engagement in the Single Unified Safeguarding Review project has served to enhance knowledge in this area.

The Chair retired from South Wales Police in March 2023 and decided to utilise the vast experience they had gained and become a self-employed Independent Chair/Reviewer.

The Chairs of Cardiff and the Vale Safeguarding Board and Community Safety Partnerships were satisfied of the Chair's independence, given their previous roles and responsibilities and that their expertise within the Single Unified Safeguarding Review would be an asset to the review process.

Signature:

Name: Sue Hurley
Date: 21/03/2024

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

APPENDIX 1

Review Panel Members

Number of times the Panel met: 13

Role and job title	Agency	Confirm Independence
Operational Manager, Community Safety	Community Safety Partnership, Cardiff	☒
Senior Probation Officer	National Probation Service	☒
Deputy Director of Nursing for the Mental Health Clinical Board	Cardiff and Vale University Health Board	☒
Safeguarding Nurse Advisor	Cardiff and Vale University Health Board	☒
Consultant Nurse, Headroom	Cardiff and Vale University Health Board	☒
Independent Protecting Vulnerable Persons Manager	South Wales Police	☒
Senior Safeguarding Specialist	Welsh Ambulance Services, NHS Trust	☒
Operational Manager, Mental Health	Adult Services, Cardiff Council	☒
Operational Manager, Central Services	Children's Services, Cardiff Council	☒
Accommodation and Support Manager	Housing Services, Cardiff Council	☒
Improvement Project Manager, Gender Specific	Housing Services, Cardiff Council	☒
Domestic Abuse Coordinator	Housing Services, Cardiff Council	☒
Service Manager	Cardiff Rise	☒
SWP & Crime Commissioner Victims Lead	South Wales Police and Crime Commissioner's Office	☒

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

APPENDIX 2

Learning Event Attendees

Practitioners/Managers Learning Event

Agency
Community Safety Partnership, Cardiff
H.M. Prison and Probation Service, Cardiff
H.M. Prison and Probation Service, Swansea
National Probation Service
Cardiff and Vale University Health Board
Adult Services, Cardiff
South Wales Police
Young Men's Christian Association (YMCA), Housing Support Cardiff
Salvation Army
Llamau
Linc Cymru
Welsh Ambulance Services, NHS Trust

APPENDIX 3

Terms of Reference

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations, reviews or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources to establish what lessons are to be learned from the incident.
- Identify clearly what the lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
    - Apply these lessons to service responses including changes to the policies and procedures as appropriate;
    - Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
    - Contribute to a better understanding of the nature of domestic violence and abuse;
    - Highlight good practice.

In addition to the review process, to have regard to the following:

- Whether previous relevant information or history about the individual at risk and/or family members was known and considered in professionals' assessment, planning, and decision-making in respect of the adult at risk, the family, and their circumstances. How that knowledge contributed to the outcome for the individual at risk.
- Whether the actions identified to safeguard the individual at risk were robust, and appropriate for that person and their circumstances.
- Whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the individual at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the individual at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the Review Panel in accordance with guidance.
- Agree the time frame.
- Identify agencies, relevant services, and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis, and hypotheses.
- Plan with the reviewer/s a learning event/s for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft SUSR report to ensure that the Terms of Reference have been met, the initial hypotheses addressed, and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Regional Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Ensure the Review Panel completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government (and in cases of Domestic Homicide, the Home Office).
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored, and reviewed.
- Plan publication on Board website and SUSR Co-ordination Hub website.
- Agree dissemination to agencies, relevant services, and professionals.
- The Chair of the Board will be responsible for overseeing all public comment and responses to media interest concerning the review until the process is completed.

When the Single Unified Safeguarding Review includes and Domestic Homicide, please refer to the Terms of Reference guidance in the *Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)*[22].

[22] Multi-agency Statutory Guidance

Glossary

MARAC

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

EMERGENCY MARAC

One off bespoke meeting which can be called by any of the partner agencies, where the case is High risk and risks are such that it cannot wait for the date of the next scheduled MARAC meeting. As well as Domestic Abuse these can also be called for cases concerning Exploitation / Human Trafficking.

Domestic Abuse Daily Discussion Meeting

Daily partnership meeting which discusses Domestic Abuse cases which agencies have highlighted over the last 24 hrs. In the meeting the case circumstances are briefly discussed, and immediate actions / safeguards are agreed for partners to implement. After cases have been discussed they can also be listed for discussion of mention in the next MARAC meeting.

Public Protection Notifications

Mandatory for South Wales Police staff to submit for
For **ALL** children in custody or subject of voluntary attendance.
For **ALL** High-Risk missing children.
For **ALL** children looked after by the local authority who are reported missing, Missing Person & Child Protection Policy on BOB
For **ALL** Domestic Abuse (Inc HBA / Forced Marriage)
For **ALL** Child Concern / CSE / CCE / Vulnerable
For **ALL** Vulnerable Adults / Adults at Risk
For **ALL** Mental Health

Specialist Domestic Violence Court

Specially adapted magistrates court hearings designed to enhance the prosecution of domestic violence cases and improve victim safety satisfaction.

Section 62 Mental Health Act 1983

Section 62 of the Mental Health Act provided that treatment that is immediately necessary to save the patient's life or to prevent a serious deterioration of their condition can be given to a detained patient without the need for consent or a second opinion.

Section 117 Mental Health Act 1983

Section 117 after-care is intended to provide sufficient support for an individual who has been compulsorily detained so that they can leave hospital and return to their home, or other accommodation in a manner that minimises the risk of deterioration of their mental health and, the chances of them needing further hospital admission for treatment. A section 117 meeting would review the current aftercare arrangements and include the person affected by the section 117, their family, and the involved clinicians.

Ask and Act

Ask and Act" is a Welsh Government commitment to preventing violence against women, domestic abuse and sexual violence. It is a process of targeted enquiry to be practiced across the relevant authorities (as named in the Violence against Women, Domestic Abuse and Sexual Violence Act) to identify and take action violence against women, domestic abuse and sexual violence.

Dyfodol

Dyfodol are experienced substance misuse specialists who work in every setting in the justice system in Wales, working at police custody suites, courts, community hubs and prisons.