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Domestic Homicide Review
Overview Report
DHR 0113

Report into the death of a man on 7th October 2012

Report produced by Malcolm Ross M.Sc
Independent Chair and Author

June 2015

CONTENTS

List of Abbreviations

ABMUHB	Abertawe Bro Morgannwg University Health Board
A&E	Accident and Emergency department at Hospital
BAS	Bridgend Assessment Service
BCBC	Bridgend County Borough Council
BCSP	Bridgend Community Safety Partnership
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DHR	Domestic Homicide Review
GP	General Practitioner (Doctor)
HTT	Home Treatment Team
ICU	Intensive Care Unit in Hospital
IMR	Individual Management Review
Meow Meow	Street name for the drug Mephedrone
Ogwr DASH	Ogwr Drug and Alcohol Self-Help Group
PPD1	Police Public Protection Referral Form
SIO	Senior Investigating Officer (Police)
SWFRS	South Wales Fire and Rescue Service
WCADA	Welsh Centre for Action on Dependency and Addiction
Hospital (A)	A General Hospital
Hospital (B)	A General Hospital with a Mental Health facility

INTRODUCTION AND BACKGROUND

1.1 Introduction

1.1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 49 year old man, (the Victim) on 7th October 2012. His son (the Perpetrator) was arrested and charged with his murder. The Perpetrator appeared before the Crown Court and was convicted of manslaughter (diminished responsibility) and was made subject of a Hospital Order under Section 37/41 and Part 3 Mental Health Act 1983.

1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[2], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those 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; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

1.3 Process of the Review

1.3.1 South Wales Police notified Bridgend Community Safety Partnership of the homicide on 14th June 2013. Bridgend Community Safety Partnership Review Steering Group, a sub-group of BCSP, reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended to the Chair of BCSP that a Domestic Homicide Review should be undertaken. The Chair ratified the decision. There had been a delay in Crown Prosecuting Solicitors deciding whether to pursue a charge against the alleged perpetrator due to uncertainty about his mental health.

1.3.2 The Home Office was notified of the intention to conduct a DHR on 3rd July 2013. An independent person was appointed to chair the DHR Panel and a second independent person appointed to write the Overview Report. At the first review panel terms of reference were drafted. On 19th March 2014 the Community Safety Partnership Board approved the final version of the Overview Report and its recommendations.

1.3.3 Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[4] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

[3] Home Office Guidance 2013 page 15
[4] Home Office Guidance 2013 page 11

1.4.2 Bridgend County Borough Council (BCBC) decided that in this case to appoint both an independent chair and an independent author.

1.4.3 The Independent Chair, Mr Colin Turner, is an experienced County Council Chief Officer and is currently Head of Children's Services for BCBC. During his 30 year career in social care, he has authored a number of Serious Case Reviews and chaired a range of strategic and operational inter-agency safeguarding forums. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the initial meeting of the panel as Chair on a temporary basis this being Bridgend's first DHR. Following that the Independent Author chaired the remainder of the meetings.

1.4.4 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 DHR Panel

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Turner chaired the Panel and Mr Ross also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

o Representative	Head Safeguarding ABMU
o Representative	Adult Protection BCBC
o Representative	Welsh Centre for Action on Dependency and Addiction (WCADA)[5]
o Representative	ABMU Mental Health Mental Health Directorate
o Representative	South Wales Fire and Rescue Services (SWFRS)
o Representative	South Wales Police
o Representative	South Wales Police
o Representative	Bridgend Community Safety Partnership
o Representative	Business Support Officer Bridgend Borough Council
o Representative	Wales Probation

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

[5] Formerly West Glamorgan Council on Alcohol and Drug Abuse (WGCADA) until October 2013 when the name was changed to the Welsh Centre for Action on Dependency and Addiction (WCADA)

1.5.3 The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6 Parallel proceedings

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- BCSP advised HM Coroner on 27th July 2013 that a DHR was being undertaken.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with awareness of the issues of disclosure that may arise.

1.7 Time Period

1.7.1 It was decided that the review should focus on the period from 14th March 2005 (Perpetrator's 16th birthday) up until the time of death of the Victim, 7th October 2012, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

1.7.2 The review also considered any relevant information relating to agencies contact with the Victim and alleged Perpetrator outside the time frame as it impacts on the assessment in relation to this case.

1.7.3 This was Bridgend Community Safety Partnership's first experience of a Domestic Homicide Review. It was a complex case from the beginning with the involvement of Mental Health issues and uncertainty if the Perpetrator was going to be charged with any offence. In the event Crown Prosecution Service deliberated for some time as to whether the Perpetrator was to be arrested and interviewed. This caused a delay in the notification of the death to the Home Office. It is now however, appreciated by the CSP that the process needed to begin straight away and that lessons have been learned by the CSP and all associated agencies.

1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the BCSP to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies were advised accordingly.

1.9 Individual Management Reports

1.9.1 An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- Welsh Centre for Action on Dependency and Addiction (WCADA)
- Bridgend County Borough Council Adult Protection
- South Wales Police
- Abertawe Bro Morgannwg University Health Board (ABMUHB)

1.9.2 In addition, an information report was received from Ogwr Drug and Alcohol Self-Help Group (Ogwr DASH).

1.9.3 Guidance[6] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.9.4 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Overview Author and the Panel.

1.9.5 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

1.10 The area

1.10.1 The area where the Perpetrator and his family reside, is a coastal town in South Wales, home to a large caravan site, many hotels and guest houses. Tourism was once a significant element of the town's prosperity. The town has four primary schools, one large comprehensive school and two private schools. The 2011 census indicates that there are some 7,000 people living in the town, the majority of which are aged between 45 years and over 65 years of age. The percentage of households with one family and no dependent children is by far the largest percentage, with the next group being households with one adult resident. Over 50% of houses are either detached or semi-detached. Most people in the town are either fully employed or retired. Of those employed the majority hold professional or senior managerial positions. There is a very low unemployment rate in the town however there is a growing homeless population in the area.

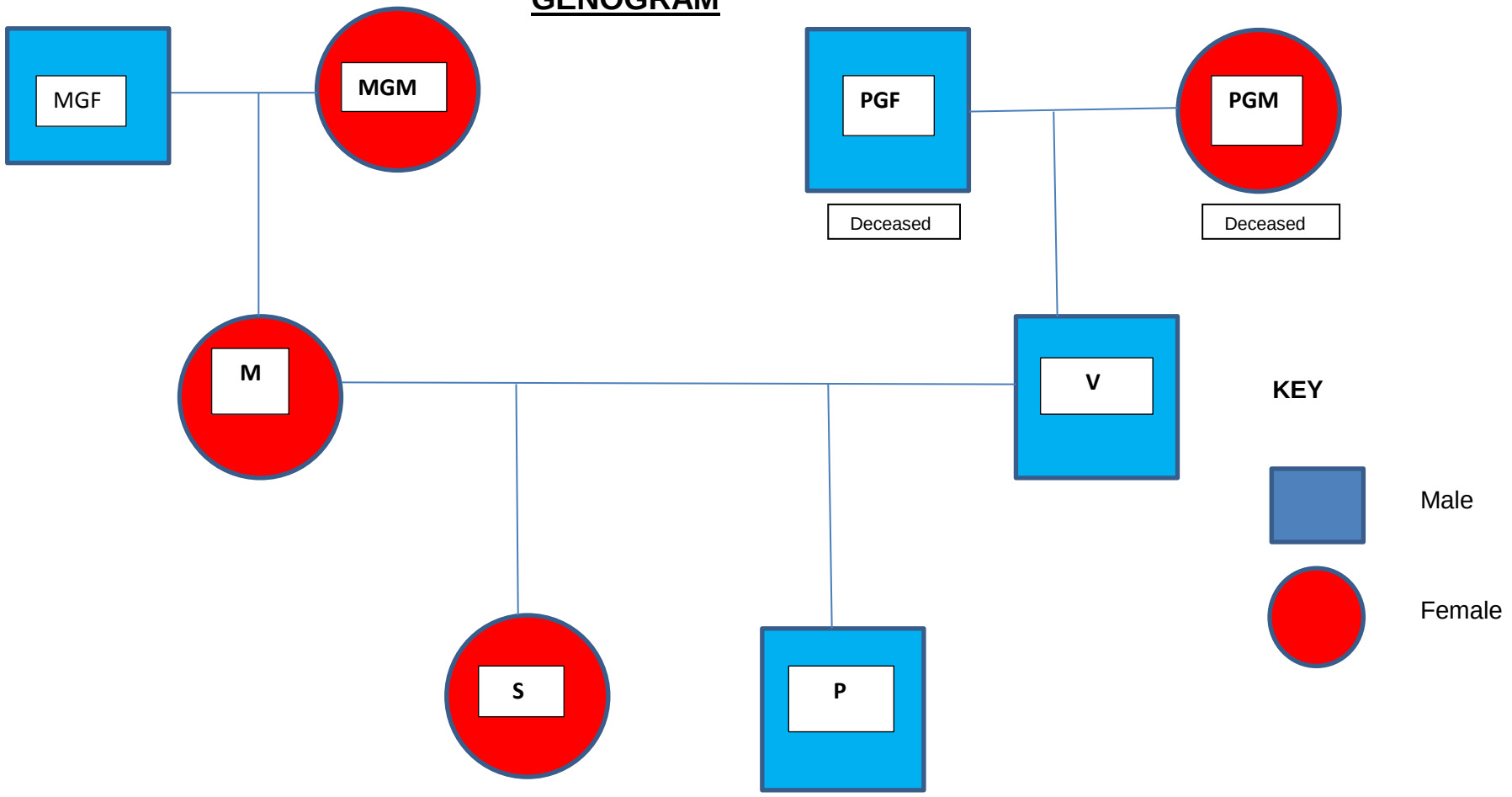
1.11 Family members concerned in this review

1.11.1 The following genogram identifies the family members in this case, as represented by the following key:

Victim	
Perpetrator	Male: aged 23 years at the time of incident – son of Victim and mother
Mother	Wife of Victim – mother of Perpetrator
MGM	Mother of wife – grandmother of Perpetrator
MGF	Father of wife – grandfather of Perpetrator
S	Younger sister of Perpetrator – daughter of Victim and mother

[6] Home Office Guidance 2013 Page 18

GENOGRAM



MGM – Maternal Grandmother **MGF** – Maternal Grandfather **PGF** - Paternal Grandfather **PGM** - Paternal Grandmother

V – Victim **M** – Mother **S** – Sister **P** - Perpetrator

2. Summary

2.1 The Victim was born in Wales in 1962 and was employed as a Steelworker at a large manufacturing company. He and his wife had two children, a son, the Perpetrator, being the oldest, followed by a daughter some 3 years later.

2.2 The wife, referred to as the Mother throughout this review, is employed in a senior position within local education. The family, who are all white European, reside in a privately owned house in South Wales. There is no Police record of Victim, Mother or Sister.

2.3 The Perpetrator, however, has come to the notice of the Police on several occasions mainly for offences involving drunkenness, public disorder and violence. Police have also had contact with him as a result of calls to the Emergency Services as a result of him overdosing on various drugs.

2.4 The Perpetrator disclosed to his family that he was first misusing drugs in 2010 and as a consequence he attended DASH on two occasions.

2.5 By June 2011 he reported hearing voices and having suicidal feelings. He called the Police imagining there were people in his house and on 27th June 2011, he was taken to hospital by the Police having taken mephedrone. Whilst at hospital he assaulted a male nurse. He was arrested by the Police and cautioned. He was subsequently admitted to an acute psychiatric ward for treatment. He was admitted and remained there for three weeks before being discharged.

2. During 2012, there followed several incidents where he was arrested and/or taken to hospital where he was usually discharged after a short period of treatment. Throughout 2011 and 2012 he had several changes of accommodation.

2.7 On 7th October 2012 the Perpetrator was disturbed at home by a noisy party at nearby neighbours. His parents were at home at the time and around midnight the Perpetrator took a knife threatening to kill someone. His parents attempted to calm him down and disarmed him but he managed to get hold of two more knives. His father locked the front door to prevent his son leaving the house, while his mother summoned assistance from the Police by telephone. He was anxious to find the door keys and his father again disarmed him. He then appeared wrapped in a bed sheet saying he was going to hang himself.

2.8 The Perpetrator then walked into the hallway with a third knife and stabbed his father, which proved a fatal stab wound. He retrieved the keys from his father's pocket and left the house, wandering around the street calling at various houses. He returned to his own house where he found his mother in the hallway. He assaulted his mother and stood on her. A neighbour banged on the door of the house which distracted his attention and gave his mother an opportunity to move into a downstairs toilet and lock herself in whilst she called again for assistance. It was then that the Perpetrator stabbed himself several times.

2.9 The Police were quickly on the scene, forcing entry into the house finding the Perpetrator injured and his father seriously injured, later to be pronounced dead.

2.10 The Perpetrator was taken to hospital suffering from serious wounds to his body and was detained for some 4 weeks. He was transferred to a medium secure Psychiatric Unit and eventually arrested, cautioned and interviewed. He was charged with the murder of his father on 11th June 2013 after advice from Crown Prosecution Service.

3. Terms of Reference for the Review

The aim of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those 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; and

- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.1 Process

3.1.1 An Independent Chair/Author has been commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel will include representatives from relevant agencies.

3.2 Time Period

3.2.1 The DHR should therefore focus on events from 2005 (Perpetrator's 16th birthday) up to the date of the death of the Victim 07.10.2012 unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

3.2.2 The review should also consider relevant information relating agencies contact with the Victim and alleged Perpetrator outside that time frame as it impacts on the assessments in relation to this case.

3.3 Individual Needs

3.3.1 Home Office Guidance[7] requires consideration of individual needs and specifically:

[7] Home Office Guidance page 25

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

3.3.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

3.3.3 The review gave due consideration to all of the Protected Characteristics under the Act.

3.3.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

3.3.5 In particular the review took into account the Perpetrator's young age as a person with a diagnosis of a serious and enduring mental illness, together with the Victim's gender, his relationship with the Perpetrator, his caring responsibilities and vulnerability. Also the fact that during the time scope of this review, the Perpetrator lived for periods of time with his parents, his grandparents, his girlfriend and had his own flat. He was employed in several jobs and was also unemployed during the same period of time.

3.3.6 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

3.7 Family Involvement

3.7.1 Home Office Guidance[8] requires that:

> "Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the Victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the Victim and Perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
>
> and:
>
> "Consideration should also be given at an early stage to working with Family Liaison Officers and Senior Investigating Officers involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

3.7.2 The 2013 Guidance states[9]:

[8] Home Office Guidance page 15
[9] Home Office Guidance 2013 page 16

> 'The Review Panel should recognise that the quality and accuracy of the review is likely to be significantly enhanced by family, friends and community involvement. The panel should therefore make every effort to include these parties and, to ensure that when approaching and interacting with these parties, the Review Panel follows best practice.'

3.7.3 In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage. Contact with the family was initially made by a letter sent via the Police Family Liaison Officer, to the Mother explaining the review process and inviting her and her family to contribute to the review should they wish to do so.

3.7.4 The Mother was seen by the Chair and the Author at their family home initially on 21st August 2013. She was in the company of her daughter and her mother and father. They all indicated that they wished to be part of the review process and after a lengthy conversation, they were left to consider in what way they wished to contribute.

3.7.5 The Author visited them again on 8th October 2013, when a more detailed conversation took place about their concerns which are explained and included within this report. The Author has been in contact with the family on several occasions since October 2013. The family have been provided with an anonymised copy of the both the Overview report and the Executive Summary.

3.7.6 Consideration was given to including the views of the Perpetrator's girlfriend but the Perpetrator's Mother has lost contact with the girlfriend after all of this time. The Mother stated that the relationship was only a matter of months old and thinks that the girlfriend would have little to offer to the review.

3.7.7 On Thursday 11th September 2014, the Author of this report, visited the wife and daughter of the deceased to explain that the report had been accepted by the Community Safety Partnership Board of Bridgend and the next step was to forward it to the Home Office. The Author went through the Overview Report and the recommendations with the family members who expressed their approval of the contents and outcome of the review. It was explained that they would receive an anonymised copy of the Overview Report and the Executive Summary before the Overview Report, Executive Summary and Action plan were published on the Community Safety Partnership web site.

4. Summary of Key Events and Analysis of Agency Iinterventions

4.1 The Perpetrator was born in 1989. He has a younger sister. His father, the Victim was employed as a Steelworker at a large local manufacturing company and his mother holds a senior position in education. He received a local education and attended a local college where he attained 10 GCSE certificates. There appeared to be no concerns about his general health or his mental health other than he had developed asthma.

4.2 On leaving school, he joined the military aged 18 and spent two years in HM Forces. He was an active athlete and Judo champion. He was medically discharged from the military due to his asthma. He returned home and secured employment at a local security company and later at a Call Centre where he stayed until he was admitted to

hospital in March and June 2011. At the time of his arrest he was employed at the Call Centre.

4.3 His family describe how he developed resentment towards his father over a family issue that arose some time ago.

4.4 Prior to the dates set in the scoping for this review, i.e. 2005 (the Perpetrator's 16th birthday) until 7th October 2012, none of the family came to the notice of any agency for anything significant.

4.5 It was 29th December 2007 that the Perpetrator first came to the notice of the Police. A fight occurred outside a late night food outlet and a man was knocked to the ground by three men. Police released CCTV footage of the incident and the Perpetrator surrendered to the Police with his solicitor. Papers were submitted to the Crown Prosecuting Service, who decided that there was insufficient evidence to support a conviction and No Further Action was taken.

4.6 On 15th August 2010 the Perpetrator called the Police saying that a man had been vomiting for the last couple of hours at his address. The Police passed the call to the Ambulance Service who attended and found the Perpetrator in a drunken state and having overdosed on Ephedrine tablets. He was taken to hospital, treated and discharged.

4.7 On 19th March 2011, the Perpetrator overdosed on a drug called 'Meow Meow' (mephedrone) giving him suicidal thoughts. He attended at the Emergency Department of hospital A and was treated and referred to the Crisis Team.

4.8 On 11th April 2011, the Perpetrator's GP sent a letter of referral to the Community Mental Health Team, indicating that the Perpetrator was having increasing problems with his mental stability over the last few weeks and that he needed to be seen urgently. The history given at that time was that the Perpetrator had been using Mephedrone for some time but in recent weeks he had experienced hallucinations and was having delusions of misidentification. He was also becoming increasingly aggressive and asking for money from both his parents and grand-parents. He had told his GP that he wanted to kill himself and that he had made plans to do so but declined to outline those plans to the GP. The GP had requested an urgent assessment.

4.9 The Perpetrator's Mother, in conversation with the Author, stated that nothing was heard about the urgent assessment, despite numerous telephone calls, so his Mother and Grand-father went to the offices of the Social Worker within the Community Mental Health Team who confirmed that a referral from the GP had been received but there had been nothing received from the hospital at that stage.

4.10 The following day, 19th April 2011, the Perpetrator was seen by a Mental Health Speciality Doctor, who made a referral to WCADA. The GP was notified by letter on 26th April 2012. The Doctor also made recommendations that the Perpetrator has a weekly prescription of fluoxetine, seeks guidance from the Citizen's Advice Bureau regarding his debt problem and he was also referred to a youth counselling service to 'avoid idleness'. It was determined that the risk of harm to himself and others was low to moderate. It does not appear that there was any input from the family into this decision or risk assessment.

4.11 An appointment was made for the Perpetrator at an Assessment Service, but he failed to attend. A letter was sent informing the Speciality Doctor from the Community Mental Health on 16th May 2011

4.12 There was no contact with the Perpetrator by any agency until he called the Police late on the evening of 26th June 2011, stating that there were people hanging around outside his house and looking through the windows. He stated that he recognised them but didn't know their names. The Police arrived an hour and 10 minutes later, to find no one in the area. At this time the Perpetrator lived alone in his own house. The officers spoke to the Perpetrator and as there were no offences disclosed there was no further requirement for Police action.

4.13 At just after 10am the following morning, 27th June 2011, the Perpetrator again called the Police stating that he didn't feel safe in his house, people were ganging up on him and shouting abuse at him. The officer noted that the Perpetrator was sweating profusely, he was agitated and explained that he had not slept for two days and had binged on drugs. He was expressing suicidal thoughts. The officers were so concerned that he took the Perpetrator to a local hospital and was placed in the care of the hospital staff.

4.14 However, whilst in the Emergency Department of the Hospital A, the Perpetrator became aggressive and impatient, resulting in him assaulting a male nurse by grabbing him around the throat. A call was made for a Mental Health Liaison Nurse to attend as the Perpetrator was running round the Emergency Department causing a disturbance.

4.15 The Police were called and on arrival they arrested the Perpetrator for assaulting the nurse. He was taken to the local Police Station where he admitted taking Mephedrone. As a consequence of this, a mental health assessment was carried out by a Forensic Medical Examiner at the Police Station, which determined that he was unfit to be detained and it was requested that he be returned to Hospital A for a further assessment. On arrival at the hospital another assessment by Emergency Department staff concluded that he was fit to be detained and he was again returned to the Police Station.

4.16 On returning to the Police Station another Doctor, the on call Consultant Psychiatrist, made an assessment in the custody unit and concluded that the Perpetrator needed a further mental state assessment.

4.17 This whole incident of the Perpetrator being transferred between the Police Station and Hospitals is indicative of the problem area between diversion and justice where violent offences and mental illnesses are concerned.

4.18 He was returned to Hospital A where a Consultant Psychiatrist re-assessed the Perpetrator, which by now was some 10 hours after he had first arrived at the Emergency Department. The result of this assessment declared he was unfit to be detained and arrangements were made for him to be transferred to a Mental Health Ward at a second local Hospital B where he would be admitted to Psychiatric Intensive Care Unit as a voluntary patient, but there was no bed available so he was admitted to a general ward back at Hospital A, where he was placed on one to one observations. It was recommended that whilst he was at Hospital A, a Forensic Psychiatric Assessment should be undertaken but in his transfer those recommendations were lost and he was treated for a medical psychosis which was incorrect.

4.19 During all of these transfers to and from hospitals and police stations, all of the time the Perpetrator being under arrest, the Police bailed him to return to the Police Station on 28th July 2011.

4.20 From the family's view, the Mother was informed of her son's detention at the Police Station and the circumstances of and reasons for his arrest. His Mother and Grand-father attended the hospital and spoke to the Doctors, who told them that the Perpetrator would be in hospital for six or seven weeks in order that extensive assessments could be carried out. Mother describes how the family were relieved that at last something positive seems to have been done.

4.21 The Perpetrator agreed with this action and stated that he realised he needed help. Later that day the Consultant Psychiatrist stated that their assessment of the Perpetrator was:

- Pre Morbid Personality – Usually upbeat without street drugs
- Mental state examination – Depressed and suicidal paranoid
- Diagnosis – Paranoid psychosis

4.22 His treatment plan was to prescribe anti-psychotic drugs, to remain in hospital and to undergo random drug testing.

4.23 The Perpetrator was transferred to a general ward at the Hospital B and Mother describes how, thereafter, she was afforded no further opportunity to speak to Doctors about her son. She describes how she approached staff on the ward regarding the assessments to be carried out, and she was told that the staff were unaware of the need for any such assessments.

4.24 Later that same day, 28th June 2011, the Perpetrator was tearful, still hearing voices telling him to harm his associates with whom he used drugs. He was later transferred to another ward and a CPA risk assessment and a nursing assessment was completed. It was determined that he was possibly showing the symptoms of early schizophrenic illness. His treatment plan was amended to include a reduced observation level, continued medication and to be reviewed within a few days. On a ward round the Perpetrator told the medical staff:

- He is unwilling to engage with the Community Drug and Alcohol Team (CDAT)
- He takes mephedrone to suppress voices and hallucinations.
- He has debt problems but a management plan to deal with it.
- His parents are unwilling to have him in their home.
- He is still hearing voices telling him to kill himself.
- He has no thoughts of harming himself but he fears he may harm others.
- He is happy to stay on the ward.

4.25 He requested to go to the shops within the hospital, and this was allowed with supervision of a member of staff or his parents.

4.26 During July 2011, the Perpetrator responded well to the treatment and his mental state improved. On 4th July 2011, he disclosed to a nurse that he had problems with his father regarding domestic issues, which he considered his father had caused some time ago. This caused him and his father to fight and argue. He found it difficult to have anything to do with his father. He also stated that while he had been in hospital, his parents had discovered that he was in significant debt. While discussing this at the hospital in the presence of his parents, the Perpetrator became angry and

walked out of the room. It is stated that it was thought that the Perpetrator had unresolved anger with regard to his father.

4.27 On 5th July 2011, when his condition had improved, his daily intake of drugs was reduced and arrangements were made for him to have contact with CDAT team. A CPA risk assessment was completed. His risk was now measured as low in relation to suicide and risk to himself. He no longer had homicide ideations. It is noted however, that he had by now a larger debt which his parents were trying to help him with. This was also regarded as a low risk factor. He was assessed as being medium risk in relation to aggression and violence.

4.28 On 10th July 2011, the Perpetrator was allowed out of hospital for a few hours to see his grand-parents with no problems being recorded.

4.29 Later on the following day, 11th July 2011, a decision was taken to discharge the Perpetrator.

4.30 The Perpetrator's Mother states that at this time she received a call from the hospital to the effect that he was about to be discharged with medication and with a list of telephone numbers to contact should he feel the need. She states that there were no discussions with the family and they were not told any details of any named professional who would take control of her son's care, no details of a care plan or any after care and no involvement with the Community Mental Health Team. He was however, supplied with Outpatient appointment arrangements. The Perpetrator's parents stated that they thought it was wrong for him to be discharged and that he was not ready to be discharged. There is no mention in the Mental Health IMR of any assessments or carers being undertaken as per the CPA guidance.

4.31 On 25th August 2011, at an Outpatients Clinic, the Perpetrator disclosed that he had declared himself bankrupt, had sold his flat and was now living with his parents. His financial troubles had reduced significantly and he was sleeping and feeling better.

4.32 His Mother told the Author of this report, that in January 2012, the Perpetrator started to work for a window company and at the same time commenced a relationship with a woman, which at first was fine but he soon found that he was unable to cope with the emotional upsets caused by his girlfriend's uncertainty, which, his Mother considers, was the cause for his arrest later in June of 2012.

4.33 His Psychiatric Outpatients appointment in February 2012 disclosed no problems and saw him improving. He was asked to return in four months.

4.34 However, an entry in the Health IMR indicates that on 2nd June 2012, he presented to the Emergency Department after self-harming. His Mother states that on that day the Perpetrator had confided in his younger sister that he was feeling unwell and had stopped taking his medication as he wanted to 'be normal'. His sister took him to the Emergency Department where his prescription was changed and he was again referred to the CMHT. There is nothing from the family to suggest that he self-harmed on this occasion. The Perpetrator told the hospital staff that he was waiting for an appointment to be seen by the Home Treatment Team (HTT). The Emergency Department Doctor recommended that the HTT visit should be expedited and arrangements were made for him to be seen the following day.

4.35 Attempts were made by the HTT to contact the Perpetrator the following day but without success.

4.36 On 4th June 2012, a HTT member called at the house to see the Perpetrator. His parents explained that he had argued with his father that morning and had gone to live with his grandparents. His Mother was upset and the note states there was 'lots of high emotions'. Arrangements were made for the HTT to see the Perpetrator at his grandparents address later that week. On the same day the Perpetrator telephoned the HTT and stated that he had started to take his medication again and he felt better. He was happy to meet with the HTT but didn't see the need to do so.

4.37 The following day 5th June 2012, his Mother called the HTT, specifically asking that the Perpetrator was not made aware of her call. She was concerned that he wouldn't see the HTT but was reassured that arrangements were in place to see him. The HTT were unable to contact him that day.

4.38 On 6th June 2012, the HTT spoke to his grandmother, who stated that she would leave a message for him to contact them. She described the situation as 'tricky'. On this day his paternal grandfather, who he was very fond of, died. He also finished with his girlfriend, but she maintained text contact which caused him some anxiety.

4.39 On 7th June 2012, the Perpetrator saw the HTT at his maternal grandparent's home. He stated that he was taking his medication and denied using illicit drugs. He did admit to drinking alcohol at weekends. He was given telephone numbers to contact should he feel the need and the HTT discharged him from their care.

4.40 His mother's account of this visit is that two female social workers attended at his grandparent's house and after speaking to them, spoke to the Perpetrator. His grandparents expressed concern about the effects his medication was having especially with regard to him getting up in the morning.

4.41 His Mother states,

> 'Their solution was to have a hot shower and drink a few cups of coffee.'
>
> and
>
> 'He was discharged from the HTT due to the fact he was working and that he was well cared for and that he had no need for follow up or for a social worker.'

4.42 There was however, a psychiatric appointment pending. The Perpetrator's GP was notified of the discharge from the HTT by letter on 11th June 2012.

4.43 On 30th June 2012, Police were called to a disturbance involving the Perpetrator arguing with the occupants of a vehicle. As the Police approached him he became aggressive and declined to calm down. He was arrested for Public Order Offence and taken to the Police Station. After disclosing his mental illness and the medication he was taking he was seen by a Doctor. The Doctor deemed him fit to be detained and interviewed. The Perpetrator was charged and bailed to Magistrates Court where, two weeks later, he pleaded guilty and was fined.

4.44 The Police IMR indicates that this process involving a person with a mental health history may have warranted the submission of a referral form to other agencies, (PPD1). In this case the officer chose not to submit the form. He/she did not record the rationale for not doing so. The officer has been advised accordingly.

4.45 On 12th July 2012, the Perpetrator was seen by the Consultant Psychiatrist at an Out-patient's appointment. He explained to the Consultant that he was now living with his

grandparents as his relationship with his father was not good. He was taking his medication but was feeling high one moment and low the next. He explained that his paternal grandfather had died and the relationship with his girlfriend was over. He was in full time work, smoking 10 cigarettes per day and only drinking at weekends. He was advised about binge drinking.

4.46 His medication was reduced by stopping the citalopram (antidepressant), but he remained on quetiapine (antipsychotic).

4.47 On 20th July 2012, Police were called to a public house where there was a disturbance. They found the Perpetrator in a very drunken condition trying to fight everyone. He explained that he had attended the wake of his grandfather. The Police warned him about his behaviour and took him home to his parent's house. Within 40 minutes Police were called to a different public house where again they found the Perpetrator wishing to fight everyone. This time the Police issued him with Section 27 notice under the Violent Crime Reduction Act 2006, which directed him to leave the area and not to return within 48 hours. The officers then took him to an address some five miles away.

4.48 On 5th August 2012, the grandparents of the Perpetrator, found him collapsed in his bedroom at their house. It appeared that he had taken an entire month's supply of his medication. An ambulance was called and he was taken to hospital where he was quickly ventilated and transferred to ICU at a nearby hospital. The Perpetrator's mother describes his care in A&E and ICU as excellent.

4.49 On 7th August 2012, the Perpetrator had a mental health assessed following his overdose of amphetamine, alcohol and Mephedrone. He reported that his grandfather had died 10 days previously and he had split from his girlfriend. He had also started a new job. An assessment tool was used to measure his suicide intent which scored low. He was referred to psychiatric outpatients department.

4.50 His mother's account of this period in hospital is somewhat different. She recalls that her son was discharged primarily because he had an outpatients appointment booked already. There were no discussions with his family regarding his discharge. His mother was informed that he was going to be discharged and she attended the hospital, where she discussed his future need for medication with the ICU Sister. The Sister contacted the Community Psychiatric Nurse and arranged for a prescription to be dispensed at the hospital pharmacy.

4.51 His mother's comments are recorded as:

> '(The Perpetrator) was discharged from hospital having made a serious attempt at suicide, no attempt was made to discuss risk or medication arrangements with the family – it was simply left to the family and (her son) to cope. No care plan. No Risk assessment. No named personnel to contact, just a list of numbers once again. There was no further contact from the CMHT following discharge.'

4.52 Weekly prescriptions were introduced by the GP and the grandparents took responsibility for collecting them. The Perpetrator's mother assumed responsibility for administering the medication.

4.53 During the early hours of 26th August 2012, the Perpetrator was again taken to hospital, this time by his parents, having taken an overdose of mephedrone. He stated that he wanted to harm himself and he had suicidal thoughts. Again his

mother's opinion of the treatment her son received in A&E was excellent. She asked if she could see her son but she was told not until 0900.

4.54 During the course of the day, the Perpetrator was assessed in hospital. A detailed history was obtained from him during which, he repeated his suicidal thoughts, but said he had no plans to harm himself. He explained that he believed that people were conspiring against him. The primary risks identified were those of mephedrone misuse, alcohol and he was in a low mood, his life not being worth living. The outcome of the assessment was that he was to be discharged with an outpatient's appointment on 10th September 2012.

4.55 Mother's account of this was that she was contacted by telephone by the CPN, who expressed disappointment to see the Perpetrator back in hospital. Mother expressed her concerns about him being discharged and asked if she could go to the hospital to speak to the CPN. She was told that the CPN was busy with other people and that her son was 'vulnerable but not the worst she had seen.' Mother explained her position to the CPN about the suicide watch the family had to manage. The CPN explained that support would be offered through counselling and WCADA. No other advice or support was offered.

4.56 In her account of events, Mother explains that she was deeply concerned and sought advice from a Mental Health Specialist at a local surgery, who expressed concerns that the Perpetrator, it appeared, had not been 'properly diagnosed.' He suggested that the Perpetrator attend his next Psychiatric appointment and then return to see him.

4.57 On 5th September 2012, an appointment was made for the 27th September 2012, for the Perpetrator to attend for a drug and alcohol assessment.

4.58 On 10th September 2012, the Perpetrator attended at an outpatient's appointment with his grandparents. They expressed concerns about the events of the recent weeks and said that they felt the Perpetrator was very depressed. On examination, the Perpetrator agreed that he felt depressed on occasions. His medication was changed and another appointment for 6 weeks-time was made.

4.59 The assessment took place on 27th September 2012, and the Monitor and Assessment Officer from an Alcohol Advice Service looked at all areas of risk, which included suicide, neglect, violence and aggression, accidental overdose, child care issues, road and machinery safety, child protection and vulnerable adult risk. To a question regarding suicide, the Perpetrator indicated that he had considered suicide by hanging. The outcome of the assessment was there were 'no current concerns.' It was identified that the Perpetrator used recreational drugs and he had a dependency towards alcohol. Questions about domestic abuse were not asked during the assessment which is the usual practice during the first part of the dependency assessment. He was not asked if a substance misuse is identified, which in this case was alcohol. Both of these questions however, are included as part of the substance misuse assessment and therefore should have been asked.

4.60 The assessment also identified that there were no vulnerable adults resident with the Perpetrator. The definition used to determine a vulnerable adult is the 'No Secrets'[10] definition:

[10] No Secrets Department of Health March 2000

> 'A vulnerable adult is a person over the age of 18 years who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him/herself, or unable to protect him/herself against significant harm or serious exploitation.'

4.61 This assessment was conducted at a time when the Perpetrator was living with or had significant contact with his grandparents, both of whom are in their 70's. The Carers Assessment was not completed as there was no proper care plan which would have taken into account the parents and grandparents ability to manage the Perpetrator's medication and capacity to adequately care for him.

4.62 The result of the assessment was a referral to WCADA.

4.63 WCADA received the referral on 27th September 2012, and a letter arranging an appointment for the Perpetrator on 11th October 2012, was sent to him on 2nd October 2012.

4.64 However, during the late evening of 7th October 2012, the Perpetrator armed himself with a knife whilst at home with his parents. He had been troubled by a noisy party at a neighbour's house. His parents disarmed him. His father locked the front door of the house to prevent his son leaving. In the ensuing struggle, the Perpetrator fatally stabbed his Father. He also attacked and injured his mother and finally stabbed himself several times in his stomach.

4.65 The Perpetrator was taken to hospital seriously injured, and was detained for several weeks being treated for his physical injuries. He was eventually interviewed by the Police. The case was referred to Crown Prosecution Service who eventually gave the Police permission to charge him with the Murder of his father.

4.66 The Perpetrator subsequently appeared before the Crown Court and pleaded guilty to an offence of Manslaughter on the grounds of diminished responsibility and was made subject to a hospital order with restrictions under Section 37/41 and Part 3 Mental Health Act 1983. At the time of the offence the Perpetrator was found to have been suffering from a serious mental illness namely, paranoid schizophrenia. He continues to receive treatment for his mental health condition under conditions of medium security.

5. Analysis and Recommendations.

5.1 This Domestic Homicide Review concerns a family broken by the unlawful killing of the father and the severe mental illness of the Perpetrator, the eldest child who was formally a member of the armed services and an athlete. It is considered that there was a missed opportunity to offer the Perpetrator additional support by not signposting him to the Veteran's Mental Health Service. This should have been considered by the NHS Mental Health Services.

5.2 Only the Perpetrator was known to Mental Health and Criminal Justice agencies, and it is clear that his misuse of illicit drugs and alcohol fuelled both his mental illness and his offending behaviour.

5.3 The Perpetrator had extensive contact with Mental Health professionals over the period between 2010 and 2012. He was detained in hospital on several occasions for treatment. Throughout this period he had the constant support of his immediate family as well as his maternal grandparents.

5.4 He did, however, hold a grudge against his father over a domestic related issue from some years before, which caused animosity between the two.

5.5 His contacts with the police were generally in accordance with guidance regarding dealing with those who show signs of, or disclose mental illness. There is a comment within the report to the effect that on his arrest for a Public Order Offence on 30th June 2012, the officer could have submitted a referral form (PPD1) which may have brought the incident to the attention of other agencies after a series of contacts with the police. The officer has been advised about this by supervisors and it is thought there is little need to make a specific recommendation about that issue.[11]

5.6 The facts of the case, however, do highlight some short comings within the Health and Mental Health arena especially with regard to the compliance with the Care Programme Approach (CPA) guidance for the treatment of mentally ill patients.

5.7 The Mental Health IMR, which is very candid in its comments, points out that the treatment of the Perpetrator concentrated on his drug/alcohol problems and states:

> '(The Perpetrator) received several tentative diagnoses, but appears to have been mainly treated as if suffering from drug induced psychosis. At an early stage consideration was given to the possibility of an emerging enduring mental illness, but there was no coordinated formulation that took account of the risks associated with his early presentation of acting on paranoid delusional beliefs with a violent assault on a nurse nor the combination of paranoid beliefs about his father and a reported history of conflict with his father. There was a lack of follow through on early recommendations that a forensic psychiatric opinion be obtained.'

5.8 The IMR indicates that there were concerns about his moods, debts and his relationship with his father, but there does not appear to have been any mention or exploration to the risk of violence within the family home.

5.9 The Perpetrator was advised to communicate with the HTT. The HTT contacted his parents and grandparents and on 7th June 2012, the HTT saw him at his grandmother's home. The Perpetrator told the HTT that he was taking his medication, only drinking at weekends and denied taking illicit drugs. On this information the HTT discharged him from their care, after only one short meeting.

5.10 The Mental Health IMR states:

> 'There appeared to be little in the way of liaison between the outpatient psychiatric clinic and the crisis intervention home treatment team, and no evidence of attempts to review the care and treatment plan in light of repeated presentations to accident and emergency.' and
>
> 'The follow up by the home treatment team was not fully consistent with the National Confidential Inquiry[12] recommendations about seven day follow up following discharge from A & E after overdoses. However, appointments were

[11] Since this incident NCALT (National Computerised Aided Learning Training) for all Police Forces in the UK have introduced a mandatory training 2 hour learning package for all officers particularly front line officers regarding recognising and dealing with Mental Health issues. There is also, jointly with Caswell Clinic Bridgend, an ongoing liaison and review of a memorandum of understanding when dealing with persons suspected of murder and/or manslaughter where it is suspected mental illness is present, which is the first of its kind in the UK.

[12] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness University of Manchester July 2013.

> offered to fit in with his work schedule and there was some consultation with family members. ‘

5.11 During the Author’s visits to the family, the Mother of the Perpetrator mentioned that she was aware of the document Delivering the Care Programme Approach in Wales, (Interim Policy Implementation Guidance) and indeed produced copies of that document (July 2010) as well as the review of the Care Programme Approach in Wales 2009. The documents also include the more recently passed Mental Health (Wales) Measure 2010 and 2012.

5.12 Mother mentioned in her interviews with the Author, that there was no contact with the family regarding the continuous treatment or care plan, and no mention of who her son’s Care Co-ordinator was on the occasions that he was discharged from hospital.

513 Delivering the Care Programme Approach in Wales states:

> ‘Planning for discharge should be in place from early on in the individual’s contact with secondary mental health services, and such planning should involve the service user, their family and the health and social care professionals working with them.’
>
> and
>
> ‘The Care Co-ordinator is central to the effective delivery of the CPA: they are responsible for ensuring a care treatment plan is developed and delivered, and where necessary reviewed and revised.’
>
> and
>
> ‘Care Co-ordinators should ensure that any service user discharged from hospital but who will be remaining in secondary care, is seen within five working days of discharge by a mental health professional.’

5.14 If there was a care and treatment plan and/or a Care Co-ordinator, the family were not made aware of the details. The Health IMR states:

> ‘He was not provided with an enhanced care programme approach care and treatment plan and there appears to have been an expectation that the drug and alcohol service would be better placed to meet his needs, despite evidence that his risk of violence was at least partially associated with delusional beliefs. There is no evidence of any attempt to understand his presentation in a longitudinal manner that might reveal more about the pattern and fluctuations in his symptoms and the ongoing risk of violence.’

5.15 Delivering the CPA in Wales document states:

> ‘Copies of the care and treatment plans should be provided to the service user, members of the care delivery team and other relevant parties as soon as it is made and in any case within seven days of being agreed.’

5.16 Issues around risk assessment are cause for concern throughout this review.

5.17 Mention has been made above about the Perpetrator being discharged into the care of his elderly grandparents. There does not appear to have been any consideration of the risk involved should he become violent in the home settings whilst under the care

of his grandparents. The Mental Health IMR comments about the lack of communication between the Police and Mental Health Services when the Perpetrator was arrested for violent offences after the death of his grandfather. This is acknowledged by the Police and the officer who failed to submit a PPD1 referral form has been suitably advised. None the less, the comments made by Mental Health that such a referral if it had been submitted may have influenced subsequent risk assessments.

5.18 The Mental Health IMR identifies three major factors in the Perpetrator's risk of violence that were not fully linked together in his care and treatment plan. They were the history of assault, the presence of delusional beliefs about homicide and the history of substance misuse that appeared to be linked with psychotic symptoms.

5.19 Research conducted for the National Confidential Inquiry into Suicides and Homicides report that in Wales, of the perpetrators of homicides annually, 11% had an abnormal mental state, of which 20% had symptoms of psychosis at the time of the offence. 11% of perpetrators were identified as being patients who had been in contact with Mental Health services within the previous 12 months prior to committing the offence. 21% of offenders had a history of co-morbid drug and alcohol misuse and severe mental illness.

5.20 It appears that a totally holistic view of the Perpetrator's history was not made when assessing risk. A pilot study[13] published in June 2013 states that Risk Assessment and Management should not ignore past history and should be individual to each patient, assess current risk factors and past history and include a management plan that follows on from the risk assessment.

5.21 CPA (Wales) states:

> 'Where appropriate, criminal justice agencies can provide support to the risk assessment process and should be consulted as part of a holistic assessment. Mental Health Service providers (such as Local Health Boards and Local Authorities) should consider introducing and delivering a standardised approach to risk assessment. Such an approach should seek to minimise the potential for: Harm, to self, (including deliberate self-harm), suicide, harm to others (including violence) self-neglect, adverse risk associated with abuse of alcohol or substances and social vulnerability'[14].

5.22 The Mental Health IMR makes the very useful comment:

> 'However, whilst there appears to have been a lack of foresight in this case, in terms of risk of future violence, the presenting picture would not have led to a prediction of homicide. The fact that his symptoms appeared to abate quickly and that [the perpetrator] appeared capable of maintaining employment, had little in the way of an offending history, showed no signs of antisocial personality traits, and that the assault on the nurse did not result in prosecution possibly mitigated against him being considered a high risk of future serious violence'.

[13] Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study June 2013 Healthcare Quality Improvement Partnership

[14] Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study June 2013 Healthcare Quality Improvement Partnership

5.23 It is considered that these factors clearly influenced any assessment of risk that the Perpetrator may have posed to anyone other than himself. The fact that the Health IMR states that the Perpetrator was not prosecuted is somewhat negated because he received a formal police caution for that offence which is considered as him being 'prosecuted.'

5.24 There has been much said about the failings of implementing the Care Programme Approach guidance. Since this incident the Care Programme Approach has been subsumed into the new Mental Health (Wales) Measure 2010 which has changed the manner in which patients are cared for. However, it has to be stressed that at the time of this homicide, the Care Programme Approach was the standard by which the Perpetrator was cared for.

5.25 The Mental Health (Wales) Measure part two steering group involves the patient's council as well as the local authority which has responsibility for regular audit of the care and treatment planning process and the allocation of Care Co-ordinators.

5.26 In this case, it is accepted by Mental Health professionals that staff were not doing what they were supposed to be doing, albeit at that time the Perpetrator would have been still subject to CPA rather than MHM. He was receiving care at a time when psychiatric outpatient clinics sat outside of CPA but the clinics were in the process of being integrated into part 2 services.

5.27 Concern was raised by the Panel regarding the amount of times the Perpetrator attended at the Emergency Department of hospitals for various reasons and the question was raised as to whether there is a structure in place to identify those people who are frequent presenters and who have some degree of mental illness.

5.28 There exists an interagency structure, chaired by the Police, called Mental Health Liaison Meeting. The first Mental Health Liaison Meeting[15] was set up in July 2011 followed by others around the police force area until 2012.

5.29 There are currently four police, health and social service liaison meetings across the four police basic command units (BCU'S) held on a monthly basis. These meetings allow for information to be shared on appropriate persons who present a potential risk to themselves and that of the general public at large, as a result of their mental health. Should a person present as a frequent caller or concerns are viewed relating to the safety of the individual a further strategy meeting is convened to discuss an action plan to resolve both that persons safeguarding and/or risk they may pose. In the event that a service user requires a review of their mental health, any of the agencies concerned can immediately convene a strategy meeting to discuss the individual, it need not wait until the next scheduled police liaison meeting.

5.30 Each BCU Police liaison meeting has their own defined terms of reference, mainly due to the individualities of the co-ordinating Health Boards. However, sitting above the groups individual terms of reference are the overarching terms of reference constituted by the Mental Health Criminal Justice Planning Forum.

5.31 The meeting is chaired by a Detective Inspector from Public Protection Department and attended by the following persons:

- Crisis team manager
- Clinical service managers from the psychiatric hospital concerned

[15] Mental Health Criminal Justice Planning Forum Meeting Guidance South Wales Police 2011

- CMHT managers
- Community drugs and alcohol misuse managers
- Criminal justice liaison nurse
- Staff development and service provision officer
- Lead social worker or their representative
- Learning disabilities representative
- Missing person coordinator

5.32 Whilst this system has been in place since 2011, its implementation force wide took some time and during the period of this review it was in its infancy. The Perpetrator did not benefit from the system that is in place today.

5.33 A recommendation has been made for the Community Safety Partnership to organise a Learning Event once the Overview Report has been accepted by the Community Safety Partnership Board. This will enable practitioners involved in the case to come together and be made aware of the issues identified and together, learn how to avoid such issues and failings occurring in the future.

5.34 The following recommendations are made:

Recommendation No 1

ABMU Health Board should give assurance to the Community Safety Partnership that all individuals, including their carers where appropriate, who are entitled to and requesting a care and treatment plan under the Mental Health Measure should have one in place and care coordinators will inform the person and / or their carer of the minimum level of contact they can expect.

Recommendation No 1 is designed to capture all of the failings identified under the Care Programme Approach in one recommendation.

Recommendation No 2

The Local Mental Health, Learning Disabilities and Criminal Justice Planning Group for the South Wales Area should review the multiagency training needs related to psychiatric assessment of fitness for police interview and diversion from custody of people detained on suspicion of any violent offence who have or appear to have serious mental ill health where the person has a need that may require a joint response from health / social care and the criminal justice system.

Recommendation No 3.

ABMU HB should give assurance to the Community Safety Partnership that, where a history of violence is noted in any person requiring care and treatment planning under part two of the Mental Health Measure, a validated violence risk assessment tool will be completed and a violence risk formulation and management plan included in the care and treatment plan.

Recommendation No 4.

Bridgend Community Safety Partnership considers organising a 'Learning Event' involving practitioners involved in this case once the Overview report has been presented and accepted by the Community Safety Partnership Board, in order that the recommendations and learning from this review can be disseminated.

6. Conclusions

6.1 The Perpetrator in this case became severely mentally ill over a period of time. His family noticed changes to his personality. He suffered numerous significant events in his life, a personal rift between himself and his father, the death of his grandfather and the break up from his girlfriend. At the same time he was misusing alcohol and illicit drugs and becoming involved in criminality, mainly connected to his alcohol misuse.

6.2 His parents and grandparents became increasing concerned and sought medical and mental health assistance. At that time his mental health care fell under the guidance of the Care Programme Approach (since changed to Mental Health (Wales) Measures). That CPA demanded a certain level of care, which included the involvement of his carers (parents and grandparents), the creation of a care plan and the appointment of Care Co-ordinators. In all of these areas the Mental Health failed to provide the level of care required.

6.3 The involvement of the family in this case highlighted the frustration that the Perpetrator's mother and grandparents experienced when they described how they repeatedly requested that the Perpetrator remain in hospital as they knew he was too unwell to be discharged. When he was discharged he was discharged into the care of his aged grandparents. Family members were expected to assume responsibility for the monitoring of his medication.

6.4 For some reason on that night in October 2012, the Perpetrator became violently aggressive and attacked his father, fatally stabbing him. He then injured his mother and stabbed himself so seriously that he remained in hospital for several weeks.

6.5 Whilst his overall mental condition worsened, albeit with temporary periods of improvement, there were no signals to raise concerns that he was in danger of attacking his family members. He had antipathy towards his father but that had never manifested into acts of violence. Nor had he showed any aggression towards the remainder of his family. His aggression had resulted in violence towards others in drink and street scenarios.

6.6 The assessment of the risk he posed to himself and others varied in degrees of usefulness. Each time a risk assessment was completed it was done without a holistic view of the Perpetrator's lifestyle and antecedents.

6.7 It can be seen that during his treatment for his mental ill health, there may have been issues relating to the understanding of the role and expectations of substance misuse services and general mental health services, which may prevent a holistic understanding of the connection between mental health and substance misuse in users with dual diagnosis. The focus of his treatment tended to concentrate on his substance misuse rather than his mental illness as a whole.

6.8 Whilst the treatment the Perpetrator received from Mental Health Services left a lot to be desired a prediction that he would take the life of his father could never have been made.

6.9 His father died as a result of trying to deal with the Perpetrator's outburst of aggressive behaviour at a time when he was so mentally unwell he did not know what he was doing, which is reflected in the outcome of the criminal court hearing.

6.10 It is the view of the Author and Panel members that the attack on his father had nothing to do with their relationship. The Panel consider that anyone who got in the way of the Perpetrator that evening was likely to become a victim. Enquiries with the Police Senior Investigating Officer confirms this view and further states that the Perpetrator, in his confused state, stated that he was going to 'kill someone.'

6.11 It would be difficult to suggest that the death of the Perpetrator's father could have been predicted or prevented. The Perpetrator developed a degree of animosity towards his Father so the possibility of some physical conflict between them at some stage may have been predicted. It would have been impossible to predict the death of his Father being the result. The Panel however, are of the opinion that there were missed opportunities to manage his mental health in a different manner which may have led to an alternative outcome.

Recommendations

Recommendation No 1

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DOMESTIC HOMICIDE REVIEW
DHR 01/13

ACTION PLAN

Pen-y-bont ar Ogwr
Mwy Diogel
Safer Bridgend
www.saferbridgend.org.uk

PART ONE: RECOMMENDATIONS FROM THE DHR PANEL INTO THE DEATH OF A MAN ON 7TH OCTOBER 2012

Overview Report Recommendations						
Overview Recommendation 1: ABMU Health Board should give assurance to the Community Safety Partnership that all individuals, including their carers where appropriate, who are entitled to and requesting a care and treatment plan under the Mental Health Measure should have one in place and care coordinators will inform the person and / or their carer of the minimum level of contact they can expect.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	ABMU will comply fully with the requirements of the Mental Health (Wales) Measure 2010	Service Manager Adult Mental Health (ABMU HB)	Immediate and ongoing	All individuals entitled to assessment and a care and treatment plan under the Mental Health (Wales) Measure and their carers where appropriate will be provided with such. The services to be provided will be set out in the care and treatment plan	Audit of compliance with Mental Health (Wales) Measure 2010 standards	Reporting to Wales Government on audit of care and treatment plans

Overview Recommendation 2: The Local Mental Health, Learning Disabilities and Criminal Justice Planning Group for the South Wales Area should review the multiagency training needs related to psychiatric assessment of fitness for police interview and diversion from custody of people detained on suspicion of any violent offence who have or appear to have serious mental ill health where the person has a need that may require a joint response from health/social care and the criminal justice system.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
2	South Wales Police Area Mental Health, Learning Disabilities and Criminal Justice Planning group (SWMHLDCJP) to develop multiagency training plan for section 135/136	Head of offender health policy, Welsh Government (SWMHLDCJP group member)	Immediate and ongoing	Agencies can provide assurance that staff are receiving consistent training in s136 that includes awareness of the roles and responsibilities of all the agencies involved.	SWMHLDCJP to receive updates on progress from Lead Officer.	Implementation of training across the South Wales Police area evidenced to the SWMHLDCJP Training evaluations completed by participants
	Arrangements for fitness for interview assessments and the training needs of staff will be reviewed by the South Wales Police Area Mental Health, Learning Disabilities and Criminal Justice Planning Group.	General Manager, Adult Mental Health (ABMU HB) (SWMHLDCJP group chair)	October 2014 and ongoing	All agencies can provide assurance that staff have the necessary competencies related to assessing fitness for detention in police custody and police interview.	SWMHLDCJP to receive updates from agencies.	Criminal justice liaison services provide feedback to SWMHLDCJP

	Criminal Justice liaison teams operate across the South Wales Police Authority area and provide specialist mental health advice and support in relation to suspects detained in police custody.	General Manager, Adult Mental Health, (ABMU HB) (SWMHLDCJP group chair)	Immediate and ongoing	Mapping and gapping exercises related to criminal justice liaison mental health services are ongoing. Health Boards share good practice through the SWMHLDCJP group.	Regular reports from agencies to SWMHLDCJP group	Increased consistency of services provided across the South Wales Police Area
Overview Recommendation 3: ABMU HB should give assurance to the Community Safety Partnership that, where a history of violence associated with mental illness is noted in any person requiring care and treatment planning under part two of the Mental Health Measure, a validated violence risk assessment tool will be completed and a violence risk formulation and management plan included in the care and treatment plan.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
3	All secondary mental health care assessments to include a query about history of violence or violent ideation and where violence is associated with mental illness a formal violence risk assessment tool will be used.	Service Manager, Adult Mental Health (ABMU HB)	Immediate and ongoing	Individuals with histories of violence will have a violence risk assessment and formulation included in their care and treatment plan	Audit of care and treatment plans	Evidence of violence having been assessed in assessments for care and treatment plans.

Overview Recommendation 4: Bridgend Community Safety Partnership considers organising a 'Learning Event' involving practitioners involved in this case once the Overview report has been presented and accepted by the Community Safety Partnership Board, in order that the recommendations and learning from this review can be disseminated.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
4	Multi-agency review/refresh learning event.	CSP Manager	October 2014	**Opportunity**; to raise awareness of the Domestic Abuse, Gender-based Violence Domestic Abuse and Sexual Violence (Wales) Bill; (so far key links for Health and local authorities to work on local strategy) Raise awareness of domestic abuse definition; Raise awareness of other domestic abuse services available. 'Ask and Act'; Raise awareness around sharing of information and knowledge of PPD1 referral pathway; Raise awareness care plans; Raise awareness concerning the ability/capacity of families to support care plans.	Multi-agency core group to oversee progress of DHR1 action plan; including key recommendations. Updates provided by the partnership manager at CSP Executive Group meetings; chaired by the Leader of BCBC; held every two months.	• Number of agencies who attended the event; • Number of operational staff; • Number of managers; • Number of actions completed; • Number of recommendations implemented; • Number of new agreed actions; • Opportunity to gain commitment from partners around future training etc.

Wellbeing / Adult Safeguarding Report Recommendations						
Recommendation 1: Documentation used during the assessment process should be subject of review. This is to ensure that the assessment process captures the current circumstances of the person subject of the referral and all avenues are explored to their fullest extent. Should the assessment document be completed in its entirety or only mandatory fields completed?						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	Matter is subject of review by the Information Management & technology team. (Regional Area Planning Group – substance misuse services , Western Bay Area) PARIS substance misuse assessment tool will be redeveloped and validated – now circulated and known as W.I.I.S.M.A.T	SG (Swansea Borough Council)	Development work undertaken – to be subject of validation and ratification Document now rolled out to 3 specific areas in South Wales. Integrated teams now using the W.I.I.S.M.A.T assessment tool	PARIS substance misuse assessment tool will be redeveloped and validated. This will ensure that staff utilising the tool will have conducted an adequate assessment of the presenting issues and needs of the individual based upon current and past circumstances 'Risk Assessment' is now an integral part of this assessment tool and is incorporated within the document Clarity within the document relating to issues of 'Domestic Abuse'. Section within the assessment tool relating specifically to 'Domestic Abuse' together with guidance notes.	Will be monitored on a quarterly basis within the IMT Group Will be subject of monitoring by the area planning board & also manager of the Bridgend CMHT and other managers of Integrated teams using the W.I.I.S.M.A.T assessment tool	Monitor effectiveness of the redevelopment of the document. Quality assurance checks of the new assessment tool Feedback from relevant agencies re referrals – increase/decrease in number of referrals to agencies

Recommendation 2: Clear policy and procedure or guidance should be provided to practitioners in respect of how the assessment process (within Bridgend Assessment Centre and other similar service areas) should be progressed and how documentation should be completed.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
2	Above group have produced Policy & Procedure as guidance for staff. New Policy & Procedure proposed is based upon the Swansea experience of using the new assessment tool Matter will also be subject of training development of staff within CMHT team	SS	Immediate & Ongoing at this time.	Quality of completion of assessment tool will be improved 'Risk' within the assessment toll is identified and shared where necessary	Will be monitored on a quarterly basis within the IMT Group Will be subject of monitoring by the area planning board & also manager of the Bridgend CMHT and other managers of Integrated teams using the W.I.I.S.M.A.T assessment tool	Monitor effectiveness of the redevelopment of the document. Quality assurance checks of the new assessment tool Feedback from relevant agencies re referrals – increase/decrease in number of referrals to agencies

Recommendation 3: The common assessment form utilised during the assessment of the alleged perpetrator should be subject of review. In particular the use of 'closed questions' should be questioned. When closed questions are used, then if required further 'open' questions need to be asked to identify intentions or any proposed actions of the person being assessed. This will enable any risks to be identified and if need be concerns can then be shared with relevant agencies.

REF	Action (SMART)	Lead Officer	Target Date for Completion	Desired Outcome	Monitoring Arrangements	How will Success be Measured?
3	Matter is subject of review by the Information Management & technology team. (Regional Area Planning Group – substance misuse services , Western Bay Area) PARIS substance misuse assessment tool will be redeveloped and validated – now circulated and known as W.I.I.S.M.A.T	SG (Swansea Borough Council)	Development work undertaken – to be subject of validation and ratification Document now rolled out to 3 specific areas in South Wales. Integrated teams now using the W.I.I.S.M.A.T assessment tool	PARIS substance misuse assessment tool will be redeveloped and validated. This will ensure that staff utilising the tool will have conducted an adequate assessment of the presenting issues and needs of the individual based upon current and past circumstances 'Risk Assessment' is now an integral part of this assessment tool and is incorporated within the document Clarity within the document relating to issues of 'Domestic Abuse'. Section within the assessment tool relating specifically to 'Domestic Abuse' together with guidance notes Assessment tool now allows for free text to be included where necessary and therefore allows frequent use of 'open questions'.	Will be monitored on a quarterly basis within the IMT Group Will be subject of monitoring by the area planning board & also manager of the Bridgend CMHT and other managers of Integrated teams using the W.I.I.S.M.A.T assessment tool	Monitor effectiveness of the redevelopment of the document. Quality assurance checks of the new assessment tool Feedback from relevant agencies re referrals – increase/decrease in number of referrals to agencies

Recommendation 4: Section relating to 'Domestic Abuse' in assessment process should be completed in all cases. In particular if identified that person subject of assessment is dependent on substance then the question should be asked how this may be impacting upon home or social circumstances/ environment.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
4	Matter is subject of review by the Information Management & technology team. (Regional Area Planning Group – substance misuse services , Western Bay Area) PARIS substance misuse assessment tool will be redeveloped and validated – now circulated and known as W.I.I.S.M.A.T	SG (Swansea Borough Council)	Development work undertaken – to be subject of validation and ratification Document now rolled out to 3 specific areas in South Wales. Integrated teams now using the W.I.I.S.M.A.T assessment tool	PARIS substance misuse assessment tool will be redeveloped and validated. This will ensure that staff utilising the tool will have conducted an adequate assessment of the presenting issues and needs of the individual based upon current and past circumstances 'Risk Assessment' is now an integral part of this assessment tool and is incorporated within the document Clarity within the document relating to issues of 'Domestic Abuse'. Section within the assessment tool relating specifically to 'Domestic Abuse' together with guidance notes 'Domestic Abuse' section is now a mandatory field which must be completed by the author of the assessment document.	Will be monitored on a quarterly basis within the IMT Group Will be subject of monitoring by the area planning board & also manager of the Bridgend CMHT and other managers of Integrated teams using the W.I.I.S.M.A.T assessment tool	Monitor effectiveness of the redevelopment of the document. Quality assurance checks of the new assessment tool Feedback from relevant agencies re referrals – increase/decrease in number of referrals to agencies

Recommendation 5: Section relating to Dependency – consideration for this section to be fully completed in relation to both the main substance and also the substance misuse checklist						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
5	Matter is subject of review by the Information Management & technology team. (Regional Area Planning Group – substance misuse services , Western Bay Area) PARIS substance misuse assessment tool will be redeveloped and validated – now circulated and known as W.I.I.S.M.A.T Assessment document amended which will now ensure that assessment relating to 'dependency' will be fully completed	SG (Swansea Borough Council)	Development work undertaken – to be subject of validation and ratification Document now rolled out to 3 specific areas in South Wales. Integrated teams now using the W.I.I.S.M.A.T assessment tool	PARIS substance misuse assessment tool will be redeveloped and validated. This will ensure that staff utilising the tool will have conducted an adequate assessment of the presenting issues and needs of the individual based upon current and past circumstances 'Risk Assessment' is now an integral part of this assessment tool and is incorporated within the document Clarity within the document relating to issues of 'Domestic Abuse'. Section within the assessment tool relating specifically to 'Domestic Abuse' together with guidance notes Assessment document amended which will now ensure that assessment relating to 'dependency' will be fully completed.	Will be monitored on a quarterly basis within the IMT Group Will be subject of monitoring by the area planning board & also manager of the Bridgend CMHT and other managers of Integrated teams using the W.I.I.S.M.A.T assessment tool	Monitor effectiveness of the redevelopment of the document. Quality assurance checks of the new assessment tool Feedback from relevant agencies re referrals – increase/decrease in number of referrals to agencies

WGCADA Report Recommendations						
Recommendation 1: When a referral with a high priority status is received, where possible telephone contact should be made with the client to discuss their immediate support needs.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	Referrals with high priority status telephone contact should be made with the client to discuss their immediate support needs. This should take place within 2 working days of receiving the referral. If a telephone contact number is not provided, high priority referrals should be offered an appointment within 5 working days.	WCADA Team Leader	Implement with immediate effect.	High priority referrals to be offered appropriate and timely support.	WCADA Team Leader and Administrative Officer to discuss high priority referrals and appropriate action. Adherence to timescales monitored through staff supervision process.	Contact timescales being met. High priority referrals being offered and engaging in appropriate and timely support.

ABMU Report Recommendations						
Recommendation 1: Changes to care and treatment plans on handover or transfer between services should be properly recorded with rationale in patients' healthcare records.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
1	Changes to care and treatment plans on handover of care or transfer of patients between services should be properly recorded with rationale in patients' healthcare record	Service Manager, Adult Mental Health (ABMU HB)	Immediate and ongoing	Transfer of care documentation is in place	Audit of healthcare records	Number of healthcare records sampled that meet standard.

Recommendation 2 Model of care for acute inpatient wards should specify the role of allied health professionals (psychology and OT) particularly in relation to informing risk assessments, and following through findings from assessments into care and treatment plans.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
2	Model of care for acute inpatient wards should specify the role of allied health professionals (psychology and occupational therapy) particularly in relation to informing risk assessments and following through assessments into care and treatment plans	Service Manager Adult Mental Health (ABMU HB)	Immediate and ongoing	Inpatient wards have operational policies / role and function documents that include the role of psychologists and occupational therapists as part of the ward team.	Review ward operational polices or role and function documents on a specified basis	Number of inpatient wards with operational policies or role and function documents Number of operational policies or role and function documents that include reference to the roles of psychologists and occupational therapists where these professions are included in the ward

Recommendation 3: Formal violence risk assessment tools should be used in all cases where violence / violent ideation are indicated.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
3	All secondary mental health care assessments to include a query about history of violence or violent ideation and where violence is associated with mental illness a formal violence risk assessment tool will be used	Service Manager, Adult Mental Health (ABMU HB)	Immediate and ongoing	Individuals with histories of violence will have a violence risk assessment and formulation included in their care and treatment plan	Audit of care and treatment plans	Evidence of violence having been assessed in assessments for care and treatment plans.
Recommendation 4 Service users presenting with violence / violent ideation associated with mental illness should have a relapse plan included in their care and treatment plan.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
4	Where an individual is identified as having a history of violence associated with mental illness a relapse prevention plan and contingency plans regarding violence will be included in their care and treatment plan.	Service Manager, Adult Mental Health (ABMU HB)	Immediate and ongoing	All care and treatment plans are completed fully and include relapse indicators and relapse contingency plans	Audit of care and treatment plans	Relapse plans are included in care and treatment plans

Recommendation 5 (ABMU): A carers assessment should be completed for patients presenting with violence / violent ideation associated with mental illness and living with family.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
5	Where an individual is identified as having a history of violence associated with mental illness the need for a carers assessment and assessment will be recorded	Service Manager Adult Mental Health	Immediate and ongoing	The need for carers assessments are fully documented and where necessary	Audit of care and treatment plans	The need for carers assessment is evidenced in care and treatment plans and where indicated, the carers assessment is present
Recommendation 6: For patients presenting with violence / violent ideation associated with mental illness, a specific risk assessment and risk management plan concerning family members should be completed.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
6	For patients presenting with violence / violent ideation associated with mental illness, risk of violence to family members is recorded in care and treatment plans.	Service Manager, Adult Mental Health	Immediate and ongoing	Care and treatment plans include violence risk assessment and risk of violence to family members is recorded	Audit of care and treatment plans	Violence risk to family members is recorded in care and treatment plans

Recommendation 7: All qualified staff within the mental health directorate should receive training in dual diagnosis substance misuse and mental illness						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
7	A training needs analysis for both mental health staff and drug and alcohol service staff in relation to psychosis and substance misuse will be completed. A programme of joint training will be developed to address the need.	Service Manager, Adult Mental Health	Immediate and ongoing	A dual diagnosis strategy group will develop and implement a dual diagnosis and mental illness strategy across the ABMU mental health directorate	Reports to Directorate Board	Numbers of staff trained in dual diagnosis
Recommendation 8 (ABMU): Substance misuse and adult mental health services should be integrated to support accessible and acceptable services from the point of view of service users.						
REF	**Action (SMART)**	**Lead Officer**	**Target Date for Completion**	**Desired Outcome**	**Monitoring Arrangements**	**How will Success be Measured?**
8	Dual diagnosis strategy group to review access points for service users with dual diagnosis	Service Manager, Adult Mental Health	Immediate and ongoing	Service users requiring both substance misuse and mental health services can access both with the services to be provided included in their care and treatment plans. Care coordinators liaise between mental health and substance misuse services	Dual diagnosis strategy group to receive reports from service providers and care coordinators	Numbers of Individuals with dual diagnosis that have care and treatment plans in place detailing both services

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KE
Business Support Officer
Bridgend County Borough Council

21 May 2015

Dear Ms E,

Thank you for submitting the Domestic Homicide Review (DHR) overview report for Bridgend to the Home Office Quality Assurance (QA) Panel. The report was considered at the April Panel meeting.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report and I am pleased to tell you that it has been judged as adequate by the QA Panel. The QA Panel would like to commend you on the compilation of a sensitive and honest report demonstrating an understanding of the dynamic of domestic violence. The Panel felt that the report might benefit from consideration of the following points prior to publication:

Adherence to DHR guidance:

- Please provide clarification around the timescales of this review. As stated in the guidance, as soon as the need for a DHR is established by the CSP, the DHR must be conducted expeditiously so that lessons are able to be drawn out which can then be acted upon as quickly as possible. [16]
- Future reviews should invite views from IMR authors to bring focus to the issues identified in IMRs.
- The DHR guidance states that prior to sending the final review to the Home Office, a completed version of the review should be shared with the family. Please clarify why it is intended to only provide a redacted version of the Executive Summary to the family and not the whole overview report.[17]
- Please clarify the independence of the Panel Chair of this review.
- Please clarify why there is no intention to publish the Overview Report and the Action Plan.

[16] Ref page 15:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf
[17] Para 50. H, Pg 17:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

Engagement:

- Please clarify if attempts were made to engage with the perpetrator's ex-girlfriend as the Panel felt that she may be likely to be able to offer some insights into the perpetrator's behaviour.
- The report does not indicate the employment status of the perpetrator. Please clarify if the perpetrator was in employment and if so, what attempts were made to engage with the perpetrator's colleagues.
- It was agreed by the Panel that future reviews should always seek input from the friends of the victim and the perpetrator.

Other substantive issues:

- The report states that it was difficult for this domestic homicide to be predicted or prevented however other areas of report suggest violence was predictable and that the perpetrator had demonstrated animosity towards family members. The Panel agreed that it was important to ensure that the dynamics of domestic violence are clearly demonstrated in the report, as the comments around the predictability of the murder may be deemed as inconsistent with the unstable state of perpetrator (Refs: Pg. 28 para 6.11, OR and Page 12 ES).
- Please clarify when the perpetrator was diagnosed with paranoid schizophrenia and whether this was before or after the domestic homicide took place.
- The report states that the perpetrator's contact with police was generally in accordance with those who disclose mental illness, (though a referral could have been made) and so a recommendation in this area was deemed unnecessary. Consider whether it is still useful learning to have a recommendation around how the police should respond to those disclosing mental illness. (Ref para 5.5, page 22 OR).

Technical issues:

- Please ensure that the recommendations from the Action Plan are included in the Overview Report.
- You may wish to consider altering the genogram on page 9 to remove the cross from the icon representing the victim as this was taken by some members of the Panel as inappropriate.
- Consider replacing word subject with the term person. Alternatively consider the use of pseudonyms.
- The Action Plan could include a matrix for measuring the success of training effectiveness.

The Panel does not need to see another version of the report, but we would ask you to include our letter when you publish the report.

I would like to thank you once again for providing this report for consideration by the Home Office Domestic Homicide Review Quality Assurance Panel.

Yours sincerely,

Christian Papaleontiou, Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Public Protection Team