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EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

of a

Domestic Homicide Review
Overview Report
DHR 0113

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

Independent Author

Malcolm Ross M.Sc

June 2015

Introduction

For the purposes of this report and to protect the identity of those involved a key will be used throughout the report as follows:

The victim - The deceased and father of perpetrator

The perpetrator - The son of deceased

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 pleaded guilty to an offence of manslaughter (diminished responsibility) and was made subject of a Hospital Order under Section 37/41 and Part 3 Mental Health Act 1983.

The Perpetrator was 23 years of age at the time of the incident that resulted in the death of his father. At the time the Perpetrator was living at home with his parents and his younger sister. He was employed at a Call Centre but had been suffering for some time from mental illness. He was known to misuse illicit drugs as well as alcohol. He had come to the notice of the police on a few occasions prior to the attack on his father, mainly with regard to alcohol related matters.

The Perpetrator had once served in the armed forces but had been discharged due to ill health. He had found employment in various jobs in and around the area where he lived. His last job was as a Call Taker, but he had previously been employed in the security industry.

Both of his parents were professional people. His father worked in a senior position in the steel industry and his mother holds a senior post with Education.

The Perpetrator's mental illness had progressively become worse and he had been admitted to hospital on several occasions. He had been discharged into the care of his parents and also on occasions into the care of his elderly grandparents,

Having been admitted into Hospital, his care was stipulated by the guidance of the Care Programme Approach (Wales), which has since been amended by the Mental Health Measures. That guidance sets out criteria for the Mental Health Services to care for patients and this review has found that that guidance was not adhered to in many respects.

On 7th October 2012, whilst at home in the evening and being disturbed by the noise from a party nearby, the Perpetrator armed himself with a kitchen knife stating that he was going to kill someone. Both parents attempted to intervene and his father disarmed him, but he soon found another knife. His father locked the front door to prevent the Perpetrator leaving the house and a struggle ensued in the hall way during which the Perpetrator stabbed his father. His father died at the scene from his wounds.

The Perpetrator then attacked his mother who managed to escape when a neighbour banged on the front door and distracted him. His mother locked herself in a downstairs toilet and called for help. Before the police could attend and break into the house, the Perpetrator had stabbed himself causing serious wounds that required his admission in hospital and treatment for several weeks.

The Perpetrator was subsequently arrested and charged with his father's murder. He appeared before the Crown Court and pleaded guilty to Manslaughter.

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[1] on 13th April 2011, establishes the statutory basis for a Domestic Homicide Review.

Under this section a 'Domestic Homicide Review' means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

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

In compliance with the Home Office Guidance,[2] South Wales Police notified the circumstances of the death in writing to the Community Safety Partnership (CSP) for Bridgend. The CSP accordingly notified the Home Office of the circumstances.

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Head Safeguarding ABMU
- Adult Protection BCBC
- Welsh Centre for Action on Dependency and Addiction (WCADA)[3]
- ABMU Mental Health Board, Mental Health Directorate
- South Wales Fire and Rescue Services (SWFRS)
- South Wales Police
- Bridgend Community Safety Partnership
- Business Support Officer Bridgend Borough Council
- Wales Probation

None of the panel members had any direct dealings with the Perpetrator or his family.

The Panel was chaired by an experienced Independent Chair and the Overview Report and this Executive Summary was compiled by an experienced Independent Author. Neither the Author nor Chair had any dealings with the Perpetrator or his family prior to being involved with this review.

Time Period

It was decided that the review should focus on the period from 14th March 2005 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] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Home Office Guidance page 8
[3] 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)

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.

Individual Management Reports

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)

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

Process of the Review

South Wales Police notified Bridgend Community Safety Partnership (BCSP) 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 regarding the Perpetrator's mental health.

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.

Home Office Guidance[4] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

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

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;

[4] Home Office Guidance 2013 page 15

- 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.

Family Involvement

Home Office Guidance[5] requires the family, friends and colleagues who have details or knowledge of the Victim or Perpetrator to be given the opportunity to contribute to the review process. In this case the Overview Author had frequent contact with the Victim's wife (mother of the Perpetrator), the Perpetrator's sister and grandparents. All had significant comments to make and contributed considerably to the process. Their views were faithfully recorded and are included within the Overview Report. The family have been provided with an anonymised copy of the Overview Report, the Action Plan and the Executive Summary

Summary of Events

The Perpetrator lived with his parents and his younger sister. He had a close relationship with his maternal grandparents and he was close to his paternal grandfather. He had served in the Armed Forces and once discharged through medical problems, he sought employment in his home town in a call centre. He formed a relationship with a woman but that was described as being unsettled and eventually that relationship was terminated. At about the same time his paternal grandfather died, which affected the Perpetrator badly.

The Perpetrator came to the notice of the police in December 2007, when he was involved in a fight outside a public house. On that occasion the Crown Prosecution Service decided to take no further action.

By March 2011, the Perpetrator was taking the illicit drug Mephedrone, and during this month he overdosed. He was taken to hospital and a referral was made to the Mental Health Crisis Team.

His parents became increasingly concerned about their son's mental stability and they took him to the family GP who decided that he required an urgent mental health assessment. The Perpetrator's Mother reported to the Review Author that nothing was heard about the urgent assessment until she and her mother went themselves to see a Community Mental Health Team Social Worker who confirmed that the referral had been received from the GP but nothing had been received from the hospital so the assessment could not take place.

The Perpetrator was seen by a Mental Health Speciality Doctor in April 2012 and another referral was made for him to be seen by an Alcohol and Drug Advisory Service. He had been expressing suicidal tendencies and by this time he was in debt. Without any consideration of

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

the family's views, the risk the Perpetrator posed to himself and others was determined as low to moderate.

It was June 2011 that the Perpetrator called the police saying that there were people outside his house where he lived that concerned him. Police attended but found no one there. He told them he had been taking drugs. The officers were so concerned about his mental health that they took him to hospital. Whilst in the Emergency Department of the hospital he became agitated and aggressive. He assaulted a male nurse. The police were called back to the hospital and the officers arrested the Perpetrator for that offence. He was taken to the police station where his mental state was assessed by a Forensic Medical Examiner, who deemed him not fit to be detained. He was returned to hospital, where he was examined whilst in casualty by casualty staff who stated that he was fit to go to the police station.

Officers took him back to the station, where he was assessed again, this time by a Consultant Psychiatrist who determined that he needed to be re-assessed for his mental health. This time he was declared unfit to be detained at the police station and he was taken back to hospital where he was assessed again, this time in need to being transferred to a different Mental Hospital where he would be detained.

Here it was decided that the Perpetrator required a Forensic Psychiatric Assessment, but there were no beds available so he was sent back to the original hospital. In all of the transfers from one hospital to another the request for a Forensic Psychiatric Assessment was lost and such an assessment was never completed. He was treated for a medical psychosis which was inappropriate. The focus of his treatment was on his drug and alcohol misuse rather than his underlying mental illness.

His family were informed that it was likely that he would be admitted for six or seven weeks for treatment, at which the family were relieved that at last something positive was being done for him.

Once settle in hospital a Care Programme Approach (CPA) form was completed. The CPA was guidance that then, determined the standard of care patients should receive whilst in hospital under these circumstances. This guidance has since been subsumed into the Mental Health (Wales) Measures 2010. It was determined that he was showing signs of early schizophrenic illness in June 2011. He told the ward staff that:

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

He later disclosed that he had a problem with his father over a family matter that occurred some-time before, but this was causing him was anxiety. He also disclosed that his debt was a significant size debt which was also causing him anxiety.

By 5th July 2011, the Perpetrator was feeling better, his drugs were reduced and he was referred to Community Drug Advisor Team (CDAT). Another CPA risk assessment showed him to be of a low risk of both suicide and to himself. He was assessed as medium risk in relation to aggression and violence. On 11th July 2011, he was discharged from hospital.

The Perpetrator's mother recalls this period very well. She describes how there were no discussions with family members regarding his discharge, nor was she informed about any arrangements for post discharge care, the identity of his care co-ordinator or any care plan, and no details of any further involvement with the Community Mental Health Team. The family were all agreed in their view, that he was not well enough to be discharged. There is no mention in the Mental Health reports of any CPA Carer's assessment being conducted, that is to say that no enquiries were conducted as to whether the family members were either in a position to care for the Perpetrator, or indeed were fit people to take on that role, which usually involves the supervision of the administration of medication.

In August 2011, the Perpetrator was involved in a road traffic collision, in which he sustained injuries to his head requiring hospital treatment. During the same month he declared himself bankrupt. In January 2012, the relationship with his girlfriend terminated, causing him some anxiety.

The Perpetrator attended at an outpatients appointment with his Psychiatrist and nothing significant was noted. He was asked to return four months later.

In June 2012, his sister took him to the Emergency Department of the hospital, complaining that he felt unwell. His medication was changed and an appointment made for him to see the Community Mental Health Team. He informed the hospital that he was waiting to see the Home Treatment Team (HTT) and arrangements made to bring that appointment forward.

A few days later the Perpetrator had an argument with his father and he left home to live with his grandparents. Mother described the situation at home as being full of 'lots of high emotion'. He was seen a few days later by the HTT and he stated that he felt better, had continued to take his medication, he was only drinking at the week-ends and was not taking any illicit drugs.

Mother's version of this visit was that the HTT spoke to the grandparents who expressed concerns about the effects drugs he was taking was having on him especially regarding to his getting up in the morning. Mother reports that the response from the HTT was to have a hot shower and a few cups of coffee which would help. As he appeared to be properly cared for by family members, the HTT discharged him from their service, after one short visit. His GP was notified of that decision.

At the end of June 2012, the Perpetrator was arrested for being involved in a disturbance, for which he was fined for a Public Order offence.

In July 2012, the Perpetrator told his Consultant Psychiatrist that he was living with his grandparents and that the relationship between him and his father was 'not good' and that his paternal grandfather died, causing further anxiety. At that stage he was in full time employment.

On 20th July 2012, Police were called to a disturbance at a Public House and found the Perpetrator to be very drunk, saying that he had just come from his grandfather's funeral. He was taken to his parent's address but within a short time the Police were called to a similar call at another public house. This time the Perpetrator was issued with a notice barring him from the area for 48 hours.

Two weeks later his grandparents found him collapsed on the floor of his bedroom having taken an overdose of amphetamine, alcohol and mephadrone. He was taken to hospital where his suicide risk was measured as low. He was given an outpatients appointment.

Mother has a somewhat different recollection of this incident. She recalls the reason for the Perpetrator's discharge was that he already had an appointment at outpatients booked and

again there was no consideration of the family's views about his discharge. She makes to comment:

> '(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.'

Weekly prescriptions were introduced by the GP. The grandparents took responsibility for collecting them and the Mother responsibility for administering them.

The following month, August 2012, the Perpetrator again overdosed on illicit drugs and was admitted to hospital. He repeated his suicidal thoughts to hospital staff but stressed that he had no intention to harm himself. He was assessed again and discharged to yet another outpatients appointment.

Mother again expressed her concerns about her son being discharged and asked to speak to the Community Psychiatric Nurse at the hospital, but was told that the nurse was busy and that her son's condition was that he was 'vulnerable but no worse than had been seen before'.

Not being satisfied with that explanation, Mother made arrangement for her son to be seen by a Mental Health Specialist at a local surgery who was of the opinion that the Perpetrator had not been 'properly diagnosed' and made arrangements for him to be seen again for a drug and alcohol assessment.

That assessment took place on 26th September 2012, when the Perpetrator was assessed in all areas of risk including suicide, neglect, violence and aggression, accidental overdose, child care issues, and vulnerable adult risk. The result was that there were no current concerns.

The assessment also identified that there were no vulnerable adults resident with the Perpetrator, albeit, at the time of the assessment he was with his aged grandparents.

Because there was no care plan identified, a Core Assessment was not completed, which would have considered the capacity of his parents and grandparents to adequately manage his care.

The Perpetrator was referred to a Local Council managed Alcohol and Drug advice centre and an appointment made for him to attend on 11th October 2012.

However, during the very late evening of the 7th October 2012, before he had an opportunity to attend the centre, the Perpetrator was disturbed by the noise from a neighbour's party near to his parent's house where he was staying. He armed himself with a knife saying he was going to kill someone. His parents disarmed him and he re-appeared with a sheet expressing his intention to hang himself. That was removed from him. His father locked the front door to prevent him leaving the house while assistance was summoned. The Perpetrator took another knife and in the ensuing confrontation with his father over the keys to the front door, he fatally stabbed his father. He recovered the door keys and went to the house of a neighbour who was well known to his family. After disturbing them he returned home where he attacked his mother in the hallway. He was disturbed by a neighbour banging on the locked front door and his mother managed to lock herself in a downstairs toilet and call for assistance.

The Perpetrator turned the knife on himself, seriously stabbing himself several times. The police arrived and broke through the front door. Ambulances were summoned and the Perpetrator was taken to hospital where he was admitted for treatment to his wounds.

After several weeks in hospital, the Perpetrator was formally arrested and subsequently interviewed by police. He was charged with the homicide of his father and subsequently 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.

Analysis and Recommendations

Given the Perpetrator's previous military experience, the Review Panel identified that once he had been recognised as a person with mental illness, there was a missed opportunity to provide him with extra support through the Veteran's Mental Health Service. This should have been considered by the NHS Mental Health Services.

Of the family members, only the Perpetrator was known to the police and Mental Health Services. Other family members were professional people each holding senior positions in their respective professions.

Examining his contact with the police on 30th June 2012, it appears that officers may have considered submitting a referral form to other agencies, which possibly would have alerted other agencies, Mental Health for instance, of his behaviour and therefore an exchange of information may have taken place. This issue has been raised with officers concerned and advice given but this is acknowledged to be a considered opinion for the officers concerned and no hard and fast rules apply.

Comment has been made regarding the application of the then, Care Programme Approach Guidance that pertained at the time that Mental Health Services were engaged with the Perpetrator. This guidance was introduced as a standard by which patients receiving Mental Health Services were cared for. It sets out the manner in which the patient and the patient's family/carers should be involved in the treatment and care of the patient.

In this case, an examination of the application of the Care Programme Approach found serious failing to comply with the guidance.

Once admitted to hospital and then discharged there was no assessment of the ability and capacity of the carers to provide adequate care for the Perpetrator. Often he was discharged into the care of the his aged grandparents. The administration of his medication was also left to his family to supervise.

The CPA requires a care plan to take the treatment of the patient forward especially after discharge and a Care Coordinator to supervise that process. There is no evidence of either a Care Plan or Care Coordinator being used.

It is clear from the IMR of the Mental Health Service that the focus of the treatment the Perpetrator received was on addressing his alcohol and drug misuse rather that the holistic mental health problems that he had. There was no recognition that the animosity between the Perpetrator and his father was seen as a risk factor, when conjoined with the rest of his mental illness and social problems.

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.

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

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.

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.

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
- 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

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.

There were a number of occasions that the voice of the family was ignored. The Perpetrator's parents voiced their opinion on several occasions that their son was not fit to be discharged from hospital but their comments went unheeded. It wasn't until the parents sought specialist opinion from their GP's surgery that they found that their son had not been properly diagnosed and arrangements made for him to see a specialist for an assessment, but that was too late. Events of the 7th October 2012 overtook all arrangements for further treatment.

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.

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.

Conclusions

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.

His parents and grandparents became increasingly 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 coordinators. In all of these areas the Mental Health failed to provide the level of care required.

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.

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.

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.

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.

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 holistic mental illness.

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.

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.

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'.

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.

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 executive summary 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 a redacted copy of the Executive Summary before the report was published on the Community Safety Partnership web site.

On 4th April 2015, the Home Office DHR Panel considered the report and found that it was adequate. A letter was received by the CSP on 21st May 2015 requesting a few minor amendments which were completed by the Independent Author. The letter from the Home Office is attached to the Overview Report.

Malcolm Ross

Independent Chair and Author
Domestic Homicide Reviews

June 2015

DOMESTIC HOMICIDE REVIEW
DHR 01/13

ACTION PLAN

Pen-y-bont ar Ogwr
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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