Cwm Taf Partneriaeth Diogelwch Cymunedol
Community Safety Partnership

Diogelu Gwent
Gwent Safeguarding

Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

Domestic Homicide Review
using the
Adult Practice Review Methodology
(Pilot)

"Rose"

Reviewers and Authors of this report:

Ann Hamlet, Head of Safeguarding, Aneurin Bevan University Health Board

Mary Ryan, Head of Corporate Safeguarding, Newport City Council

1. Brief Outline of the Circumstances Resulting in the Review

1.1 Legal Context

1.2 In 2011, Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). A "Domestic Homicide Review" is required in circumstances where 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/she was related or with whom he/she was or had been in an intimate personal relationship, or

(b) a member of the same household as him/herself,

1.3 Overall responsibility for establishing a Review rests with the local Community Safety Partnership (CSP) or Public Service Boards (PSBs) who will establish a multi-agency Review Panel to undertake the review. Reviews are held with a view to identifying the lessons to be learnt from the death.

1.4 In October 2017, Assistant Chief Constable Liane James commenced a secondment to the Welsh Government to undertake work on the Violence Against Women Domestic Abuse and Sexual Violence agenda. A particular focus was to "Assess the effectiveness of the Welsh Government, Community Safety Partnership and other public services responses to Domestic Homicide Reviews and make recommendations as to how they might be fully acted upon by Welsh public services". This work has been informed by Robinson et al. (2018) Findings from a Thematic Analysis of Reviews into Adult Deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews, Cardiff University, available at http://orca.cf.ac.uk/111010

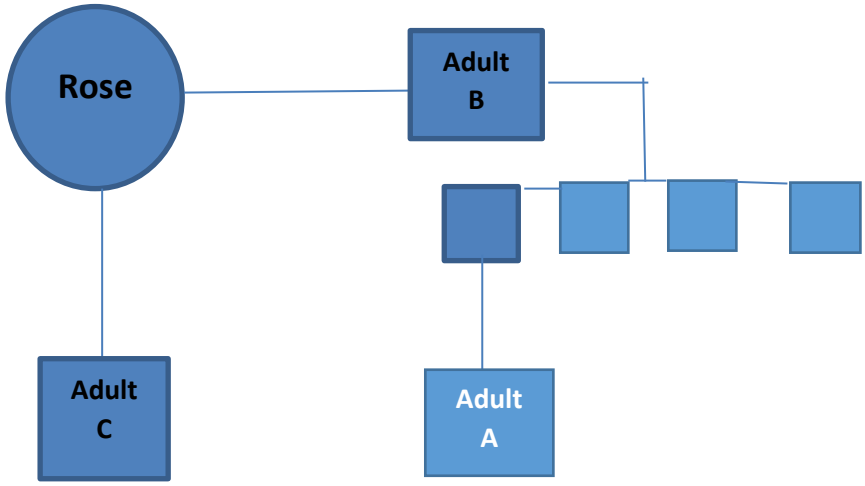
1.5 This DHR was conducted using the Adult Practice Review (APR) methodology. This was the second Pilot carried out in agreement with the Home Office, Cwm Taf Community Safety Partnership (CSP) and Welsh Government, as a result of their review findings. The first pilot using this methodology was completed in the Gwent region and to ensure consistency in testing the methodology the same reviewers have been used for the second pilot using this methodology in agreement with Cwm Taf.

2. Circumstances Resulting in the Review

2.1 This DH-APR concerns a grandson and his step-grandmother. For the purposes of this report, he will be referred to as Adult A and she will be

referred to as Rose. Rose was a name chosen by her family. Rose was a 59 year old, white Welsh woman living on a small estate in a Welsh village.

3. Genogram



3.1 Rose lived with her son, (Adult C) who was a baby when she started a relationship with Adult B, who she married. Adult B had 4 children from a previous relationship who lived with their mother. Adult A was the grandson of Adult B. Adult A lived with Rose and his grandfather (Adult B) from when he was a few months old, this was due to domestic violence and drug issues within his parents' relationship

3.2 Adult C viewed Adult B as his father and Adult A as a brother. Adult C was a teenager when Adult A (as a baby) moved into the family home.

3.3 In June 2017, Adult A, who was in his 20s, assaulted Rose at home causing life threatening injures from which she died the following day in hospital. He was arrested on the day and subsequently convicted of manslaughter by virtue of diminished responsibility. He remains detained under Section 37/41 of the Mental Health Act (1983).

3.4 The Police referred the case to the CSP and it was agreed that this case met the criteria for a DHR. The first Panel meeting was held on 5th October 2017 where it was agreed that the DHR process would be suspended to allow the criminal process to be concluded. The Domestic Homicide process reconvened in July 2018 and reviewers were identified, with further meetings held in September 2018 and January 2019. In January 2019, discussions

were held with Gwent Safeguarding Business Unit and PSB partners following the completion of the first Gwent D-APR pilot and support was requested.

3.5 It was agreed that when reconvening the DHR it would be concluded using the APR methodology with Independent Reviewers from Gwent supporting. This was agreed in partnership with the Home Office, Cwm Taf CSP and Welsh Government.

3.6 The first meeting of the reconvened process was in June 2019 and the Learning Event held in September 2019.

3.7 In line with APR methodology, the time period for the review was agreed as from 12th June 2015 to 12th June 2017. Information was obtained prior to June 2015 to inform the review.

3.8 The reviewers met with the family and discussed the review process, the methodology of the review for practitioner learning and how the family would like to be involved was established. The family had a good relationship with the Family Liaison Officer (FLO) and they were provided with leaflets and information regarding specialist advocacy services to assist them through the review process. They acknowledged the additional resource and were aware that could be referred at any point in the review process. The internal family support was very strong and resilient and open to challenge the panel and reviewers when they wanted to.

4. Rose as Described by Her Son and Nieces

4.1 In line with Home Office guidance, the Reviewers wanted to ensure that the Review was conducted through the lens of Rose as the victim by reviewing the records and hearing her voice through her family.

4.2 Rose had lived in the area all of her life and was very well known as a strong character in the community, with a large network of friends, neighbours and intergenerational family.

4.3 Rose had a huge capacity for caring for all her large extended family and frequently had various family members stay with her, for example, when they had fallen out with their parents. Rose was non-judgemental and would allow them all to stay for significant amounts of time when needed or requested. The wider family accepted that Rose offered the younger members a safe place when needed.

4.4 Rose was a prominent member of the community and was known by everyone including all the bus drivers, as her home was on a bus route with a

stop outside her door. On occasions, the drivers would carry her shopping in to her home for her. The information suggests that Rose would use the bus stop as somewhere to go when she needed to avoid conflict in the home with Adult A.

4.5 Rose and her husband (Adult B) had a relationship that her family described as like 'Jack and Vera' from Coronation Street. There was a lot of bickering and conflicting opinions between the two of them which sounded to the family as 'squabbling', however, the family never felt that this was ever with malicious intent or unkind but a natural way that they communicated to one another.

4.6 The family described a relationship between Rose and Adult B as one of continual minor arguments and disagreements. The family described language full of 'effing and jeffing' from Rose towards Adult B about everything and anything. They stated that they were not aware of the arguments ever resulting in physical violence. This was an accepted method of communication and any colourful language would be forgotten about two minutes later.

4.7 Rose was a strong and passionate woman who was not afraid to stand up for herself, to her husband or family when required. She was the matriarch of the family with all going to her for support, guidance and help when required. The family agreed that Rose had a complete devotion to support and care for Adult A. They were aware of Adult A's drug taking that started when he was a teenager and latterly his poor mental health, but Rose was always there for him and would not have a word said against him.

4.8 Rose's financial situation was put under a lot of pressure when her husband died in March 2014. He was her main support emotionally, even though he was very physically unwell for the last year of his life. Rose nursed her husband at home and Adult A was in and out of the home throughout that period.

4.9 Her son (Adult C) worked abroad for most of the year but the family referred to him as Rose's golden boy. Rose was very proud of her son and his achievements. He would often get her out of financial difficulties and support her from afar when needed.

4.10 The family recognise that there were pressures on Rose at times, concerning her ability to cope with her husband's physical needs, financial pressures and Adult A's erratic mental health.

5. Background

5.1 Rose was known to Mental Health services and had been supported by the Crisis Team. The Crisis Team would normally offer an assessment of an individual's mental health and short-term intervention. For Rose, these were usually brief interventions made up of telephone contact, assessment and home visits when Rose felt she needed support. Rose had no sustained involvement with professionals.

5.2 There were domestic abuse incidents reported to the Police between Rose and Adult A that resulted in Police Public Protection Notices (PPNs) being shared with specialist Domestic Abuse services and the local Community Mental Health Team. Rose was contacted and offered specialist Domestic Abuse services and support but declined further input.

5.3 Rose and Adult A were not referred to the Multi Agency Risk Assessment Conference (MARAC) during the period of the timeline due to the level of risk assessed at that time as medium and not high.

5.4 Rose was referred to MARAC outside the period of the review. MARAC minutes on 22nd May 2015 detail statements from Adult A about Rose, when it suggests he was hearing voices stating – "told by God to kill Rose as a white witch". Rose was offered Independent Domestic Violence Advocate (IDVA) support, but she declined.

5.5 The records show that the Police recognised Rose as a victim of domestic abuse and that they had warning markers for her address, which included Rose as being a high-risk repeat victim of domestic abuse from her grandson. Both Rose and Adult A had markers for suicide and the need for an immediate response. Adult A had police markers for mental health and violence. This level of understanding of Rose as a victim of domestic abuse is not evident from Health and Social Care records. At the time of the review, Mental Health services did not attend MARAC routinely and the lack of shared information between agencies had a significant impact on the formulation of risk.

5.6 During the period of the review and the preceding years, Adult A had multiple admissions to Mental Health wards. His status in regard to the Mental Health Act 1983 was often fluid involving periods of detention under the Mental Health Act 1983 as well as informal admissions. There were however, frequent calls to the Police from in-patient staff concerning Adult A's behaviour on the ward, when he was expressing violent behaviour towards staff and other patients.

5.7 Rose considered Adult A as her son, having lived with them since a baby and this afforded Adult A, a level of protection and permanent refuge and continual acceptance of a safe place to be within Rose's home. As a teenager Adult A

struggled with friendship groups in school and started to spend sporadic time with his estranged father. The relationship with his father was not positive or protective and started to impact on Adult A's mental health and his introduction to recreational drugs. Adult A started a journey into drugs and mental health services never acknowledging the impact his relationship with his father had on his mental health or relationships with Rose and the wider family. Adult A has an extensive history with psychiatry of inpatient and community support by mental health services, Psychiatric admissions for Adult A all have an element of drugs use and deterioration in his mental health.

5.8 Adult A had been subject to a Community Treatment Order (CTO). A CTO (Section 17a Mental Health Act 1983, amendments 2007) provides the possibility of a recall to hospital for assessment if any of the conditions are not adhered to and if there is a significant risk of deterioration in the individual's mental state that requires treatment in hospital.

5.9 Rose's family reported that they and Rose felt a level of protection was afforded through the CTO to which they believed Adult A was subject.

5.10 Rose's family and professionals described a complex relationship between Rose and Adult A. There would be times when things were difficult, usually linked to Adult A's mental health and his misuse of illicit substances.

5.11 Agency records support a strong recognition by Rose and professionals of what the triggers for relapse were for Adult A's mental health. The records also evidence that Rose often identified relapses in Adult A's behaviour/mental health and would seek the support of Mental Health services at these times.

5.12 At times of relapse, Rose would struggle to manage Adult A's behaviour. This was recorded when he was at home with her and when he was in hospital. Hospital staff witnessed his rejection of her on the ward, where he would be verbally abusive and at other times ignore her. On these occasions of high expressed emotion, Rose would ask for alternative accommodation for him. Adult A would then view this as Rose rejecting him and the complex pattern within the relationship would continue, with Adult A returning to Rose.

5.13 Although at times professionals would start the discussion of looking at independent accommodation for Adult A, the crisis within their relationship would dissipate and Rose would agree for his return. On occasion, Adult A would just turn up at her home and she would never turn him away.

5.14 The family said they were aware that Rose hid some information and the stress she endured living and caring for Adult A, and they have interpreted their relationship as a co-dependant relationship. No one in the family predicted the actions of Adult A towards Rose or considered it as domestic abuse.

5.15 The financial pressures for Rose once her husband died did directly have an impact on her relationship with Adult A. Rose started to ask the family for money for household bills. Initially they were assisting but realised it was to give to Adult A for purchasing drugs.

6. Protective Factors in Rose's Life

- Rose had a large family, with whom she had daily contact by phone and in person.
- Rose would at times leave her house and go to her friends to calm down when Adult A's behaviour was stressful and demanding. Many neighbours and friends, who were aware that Adult A had mental health issues and were aware of the stress within the household at times, supported Rose; they welcomed her when she needed refuge.
- Adult A and Rose were both known to Mental Health services.
- Adult A and Rose were well known to the Police and were part of Police Watch. Rose was well supported by local Police Officers. She had a good rapport with Community Police Officers and would contact them directly if needed.

7. Barrier Factors for Rose

7.1 Rose accepted Adult A's behaviour towards her at personal cost to her on a regular basis, not just financial but the level of verbal abuse and tension he displayed when in the home.

7.2 Rose would hide the reality of life with Adult A from her family at times of heightened stress between them both, out of a sense of responsibility, love and acceptance of who Adult A was.

7.3 Agencies need to recognise the emotional factors within all family relationships and work with family members to acknowledge negative physical and emotional impacts in relationships. Services need to be open to challenge with support individuals such as Rose when the impact of the relationship was acknowledged.

8. Learning Event for Practitioners

8.1 As part of this DH-APR, a Learning Event was held, engaging practitioners involved with Rose and Adult A.

8.2 The Reviewers would like to thank all those who attended the Learning Event and for their contribution to the learning identified in this Review.

8.3 The discussions and suggested learning from the event reflected the thinking of the Panel.

9. Themes and Learning Points

9.1 There were three overarching themes identified which have informed the learning points from this Review.

9.2 Theme 1 – Recognition of Domestic Abuse and specifically Coercion and Control in the relationship between Rose and Adult A

9.3 The Panel were mindful that coercive control is a significant factor in predicting DHRs and as such, wanted to ensure that this was considered and explored by the Panel and practitioners at the Learning Event.

9.4 The recognition of the Panel to be open to considering all aspects of Rose's relationship with Adult A enabled the practitioners at the Learning event to review how as service providers, they considered the emotional, controlling and coercive nature of the co-dependent relationship.

9.5 The Learning Event discussed the exploration of whether or not services involved with Adult A ever considered the relationship between the two of them as coercive and controlling, or emotionally abusive towards Rose. Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. For the purposes of this offence, behaviour must be engaged in 'repeatedly' or 'continuously'. As described above Rose would always allow Adult A to return to her.

9.6 It was clear from records that the relationship between Rose and Adult A was complex, co-dependent and at times emotionally aggressive. It was clear that this complex relationship was emotionally and financially exploitive for a number of years towards Rose.

9.7 Another aspect and separate element of the Serious Crime offence is that it must have a 'serious effect' on someone and one way of proving this is that it causes someone to fear, on at least two occasions, that violence will be used against them. The emotional violence recorded both in hospital and community files record frequent exchanges of verbal aggression and threats of harm towards Rose by Adult A. There is no specific requirement in the Act

that the activity should be of the same nature. Any prosecution should be able to show that there was intent to control or coerce someone. (https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship).

9.8 Rose was clear she was responsible for Adult A, as a step-grandmother (who had looked after him virtually from birth) therefore the relationship was not the 'usual' step grandmother relationship, but a deep maternal connected one.

9.9 An example of the tensions between Rose and Adult A can be found in the referral to MARAC in 2015. Adult A at that point wanted to return to his father's address after a hospital admission and referred to Rose's comment on not wanting him to return to her home as 'you don't love me'. This appears to indicate the level of emotional control from Adult A towards Rose, At this point he would talk of returning to his father's home as a rebuttal to Rose, but the reality was that he always returned to Rose.

9.10 Within the Health and Social Care records for Adult A, the above is well recorded and repeated on many occasions. When Adult A's mental health deteriorated, Rose would tell professionals that she was afraid of him and there were incidents of domestic abuse recorded by the Police. However, services did not consider the impact of their relationship through a domestic abuse lens and therefore did not pose the question of whether the impact of his behaviour was seen as one of coercion and/or control.

9.11 The family did not talk about the relationship between Rose and Adult A as one of domestic abuse, but recognised the relationship as complex. At the Learning Event and from records, it is evident that it was not just the family but also professionals that accepted it was a complex relationship but not a domestic abuse issue.

9.12 The National Training Framework, within the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) legislation (2014) is the start of mandatory training and raising awareness of this agenda in Wales. However, it is not enough on its own and requires agencies to develop explicit training of this specialist agenda to fully understand, raise awareness and give practitioners the skills and knowledge to recognise, question and put into practice.

9.13 Learning Point 1

9.14 Practitioners' understanding of domestic abuse and coercion and control in all family dynamics requires attention when understanding family relationships.

9.15 Mental Health practitioners are familiar with the complexities of family working but they do not always consider these families through the domestic abuse lens. Practitioners focused on the presenting behaviours and the immediate impact, but did not consider if there was an underlying coercion and control that may require different action.

9.16 Completion of the National Training Framework (NTF) under the VAWDASV Act is a mandatory requirement for public authorities to report annually to the Welsh Government on the number of staff who have completed the Ask and Act training. The groups of the NTF requiring completion is dependent on the role of the professional within an organisation but clearly mandates all levels to complete Group 1 (E learning). Further consideration needs to be given to more specific training in regards to coercion and control.

9.17 Mental Health Practitioners need to understand the pathways into MARAC and understand how information is shared/analysed to identify the risks posed to an individual.

9.18 Theme 2 – Recognising Rose as a Carer with her Own Needs

9.19 At the Learning Event, it was clear that professionals described a complex relationship between Rose and Adult A and this is supported in agency records. Professionals knew the triggers for relapse for Adult A and Rose would make Mental Health services aware when she was concerned about his mental health. On the day that Rose was assaulted, she left her house and went to a friend where she contacted Mental Health services requesting a visit. She asked whether Adult A remained under a CTO. Rose was told that the Care Co-ordinator responsible for Adults A's Care and Treatment plan was not available, but she was offered a visit by another professional or for the Care Co-ordinator to call the following day. Rose was of the opinion that it would not be good to send an unknown professional, for fear of upsetting or antagonising Adult A.

9.20 Staff accepted the information Rose provided and did not seek any points of clarification, for example where she was phoning from and if she felt safe. Professionals accepted that Rose was able to make the decision to delay a visit from the Care Co-ordinator. There was no consideration that given Adult A's presenting symptoms, with known triggers that this was a clinical decision to be made as part of a risk assessment.

9.21 The complex relationship within this family requires professionals to be aware of the possibility of tunnel vision within their practice. There was evidence of an over reliance on the narrative presented to them by both Rose and Adult A and therefore a lack of professional curiosity and ownership of the risks associated with Adult A. When Rose presented her concerns to professionals,

there was a focus on responding to that incident and not identifying the long established pattern of behaviour.

9.22 On the day that Rose was assaulted, she asked if Adult A was still subject to the CTO but this information was withheld, as there was confusion as to Rose's status. Within the records, Rose was recorded as Step-grandmother, Carer, Nearest Relative (within the Mental Health Act 1983) or Next of Kin. Rose's status throughout Adult A's involvement with Mental Health services changes throughout his records.

9.23 It is clear that Adult A consistently displayed 'hoodwinking' behaviour towards professionals. He was able to consistently hide or manipulate people and situations, agreeing to attend services to address his illicit substance misuse and work/training but never actually completing any engagement. Professional, competent and confident practitioners needed to identify and challenge disguised compliance with Adult A.

9.24 Evidence of the triggers for when Adult A relapsed were established and known to the wider Mental Health team and to Rose. However, when Adult A was in the community it appears that Rose was the decision maker in terms of his presenting behaviour and addressing the risks he posed towards her and himself. This therefore raised her status in terms of risk management and daily management of Adult A.

9.25 On the day that Rose was fatally assaulted, there was no evidence of an objective risk assessment being undertaken to evidence a formulated response. Staff asked what the presenting behaviours were but then left it to Rose to risk assess and manage the situation. The reliance of professionals to assume that Rose 'knew best' requires further clarity and would have received further enquiry if the complex co-dependent relationship had been viewed through a domestic abuse lens. This requires an understanding and recognition of the complex relationship, and can be seen from a number of viewpoints. Good practice would require that professionals listen to Rose, as carer/step-grandmother and to her thoughts and wishes in terms of what would be best for Adult A on that day, in the spirit of collaboration and voice of the family. However, when the relationship has elements of control, such as Rose minimising the distress she was experiencing and witnessing Adult A's behaviour, then the knowledge of professionals cannot be underestimated in assessing risk in the context of the emotional detachment required for robust formulation of risk assessments.

9.26 Professionals recognised that Rose knew Adult A and his vulnerabilities. Agencies did not take into account her needs as a carer and victim of domestic abuse. There was no escape for Rose when Adult A was unwell or deteriorating and requiring additional support unless he was in hospital. Rose

was his main carer throughout, and this added additional stress within their relationship.

9.27 Throughout the period of the Review, Adult A had multiple admissions to hospital both informal and formal under the Mental Health Act legislation. Some of these were for a day or two and others for a longer period. His discharge destination was discussed on occasion and on some admissions, his own accommodation was considered but this was never pursued and he was always discharged to Rose. From the records, it is clear that Rose asked on more than one admission that Adult A not be discharged back to her. The records do not reflect that this was ever explored in detail as an option.

9.28 Good Practice

9.29 All professionals and carers recognised that Rose and Adult A had a complex relationship.

9.30 Learning Point 2

9.31 The formulation of risk assessments in Mental Health and Social Care need to ensure the full family dynamic is considered as central to the plan. The voice of the carer/family is equally vital as the voice of the Service User when a plan is determining the risk and especially for recognition of any deterioration or changes in presentation.

9.32 Sharing this risk assessment and plan is also required to ensure all are aware of thresholds and concerns when deterioration in mental health occurs. This recognises the status of the family, and Rose in particular was viewed as a protective factor for Adult A, but there is a requirement of Rose's needs to be accounted for and addressed within the risk formulation and care planning. As a carer, Rose was entitled to support and an assessment of her care and support needs.

9.33 Theme 3 – Record Keeping and Communication

9.34 As members of an integrated team for Mental Health, there is an assumption that practitioners have access to Health and Local Authority records. However, there were many recording systems at the time of the fatality and this has posed problems within the review process, ensuring all recording systems were accessible to the Panel. Some records acknowledged the stress in the relationship and others not. An example of this were the PPNs, which are shared with the Community Mental Health Team (CMHT) and are held within those records but the assertive outreach team and in-patient team did not have access to this information as they used a different recording system.

9.35 The relationship between Rose and Adult A was critical in understanding his needs and Rose as a carer when in the community. Community teams and inpatient records are reliant on accurate information and communication to ensure robust care plans and risk assessments are in place for individuals and family members.

9.36 Adult A was previously subject to a Community Treatment Order (CTO) (Section 17a Mental Health Act 1983, amendments 2007), which requires multi-agency planning and agreement with the individual about the care plan and conditions when discharged to the community. The Responsible Clinician can end a CTO when they are of the professional opinion that it is no longer required. However, the Mental Health Act Code of Practice suggests that this should be a multi-agency decision. The communication of the discharge of the CTO for Adult A appears not to have had any multi-agency discussion or oversight. Adult A was no longer subject to the CTO when he assaulted Rose.

9.37 The family were not aware that Adult A was no longer subject to a CTO and have not been able to reconcile with the fact that this was not communicated to them or Rose.

9.38 Good Practice

9.39 The development of community 'problem solving meetings' which at the time of the incident were quarterly, are now monthly. These are part of the wider public safety agenda and include police, health, social services, housing, and community safety partners.

9.40 The introduction of the All Wales recording system is currently rolling out with the result being that all Health and Social Care records will be on one system for community services.

9.41 Rose had a strong relationship with the Community Police Officers. Since December 2018 the Police have implemented a mental health triage system which, if it had been in place during this time, could have supported Rose further.

9.42 Learning Point 3

9.43 The Health Board to agree best practice principles for record keeping. Record keeping and communication is an issue within every review, going forward the implementation of the Wales Community Care Information System (WCCIS) as a single point of record keeping will enable improved communication but not entirely. As multi-agency services attention to communication is always key in risk formulation.

9.44 Learning Point 4

9.45 Mental Health services to consider the single agency perspective ending certain Orders such as the Community Treatment Order. Good practice would require mandatory multi-agency, voice of the individual and family being party to the decision making process to end the Order. The analysis of the decision making needs to be clearly recorded and communicated with the individual and family.

9.46 Mental Health practitioners need to be mindful of the Code of Practice with regard to discharging Community Treatment Orders as single agencies. Consideration of ending certain Orders such as the Community Treatment Orders would require mandatory multi-agency, voice of the individual and family been party to the decision making process to end the Order as good practice. The analysis of the decision-making needs to be clearly recorded and communicated with the individual and family.

10. Improving Systems and Practice

10.1 In order to promote the learning from this case the review identified the following actions for the CSP/SB and its member agencies and anticipated improvement outcomes:-

10.2 For each learning point, the following actions have been identified:

10.3 Learning Point 1

1. Ensure that mental health practitioners have access to training in relation to domestic abuse and coercive control and that this training is incorporate into the annual social care training calendar
2. Training to include pathways to MARAC where an escalation in risk has occurred
3. Share the learning from this report widely to remind mental health practitioners of the need to recognise domestic abuse and specifically coercion and control in family relationships

10.4 Learning Point 2

4. The Health Board and Local Authorities to provide assurances that mental health practitioners are using the Wales Applied Risk Research Network (WARRN) tool when assessing risk to ensure that the voice of the carer/family member is included
5. The Health Board and Local Authorities to provide assurances that there is adequate training in risk assessment/ risk management and contingency planning for all mental health practitioners.

6. The Health Board and Local Authorities should be asked to review policies and procedures in relation to risk assessments, risk management and contingency planning and undertake audit work to ensure that the correct procedures are being followed

10.5 Learning Point 3

7. The Health Board to be asked what the plans are in relation to the implementation of WCCIS and, in the meantime, provide details of how mental health practitioners will have access to both health and local authority records and systems
8. Share the learning from this report widely to remind mental health practitioners of the importance of multi-agency planning and information sharing

10.6 Learning Point 4

9. The Health Board to be asked to lead on a review of the Community Treatment Order Policy, in conjunction with the local authorities to incorporate the learning from this review
10. Following the review, relaunch the CTO Policy to raise awareness amongst practitioners
11. Carry out an audit to establish whether the changes to the policy have been adequately adopted.

11. Statement by Reviewers

REVIEWER 1	Ann Hamlet	**REVIEWER 2**	Mary Ryan
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	Ann Hamlet	**Reviewer 2** *(Signature)*	Mary Ryan.
Name *(Print)*	Ann Hamlet	**Name** *(Print)*	Mary Ryan
Date		**Date**	

12. DH-APR process

12.1 **Independent Reviewer:** Ann Hamlet, Head of Safeguarding, Aneurin Bevan University Health Board

Independent Reviewer: Mary Ryan, Head of Corporate Safeguarding, Newport City Council

Independent Chair of Panel: Steve Jones, Deputy Unit Nurse Director, Abertawe Bro Morgannwg University Health Board Stephen Jones: (Mr Jones' Mental Health specialist knowledge was acknowledged and he worked for a

different Health Board and had no connection with the Cwm Taff Health Board or Mental Health Services)

12.2 The services represented on the panel consisted of:

- Sue Hurley, Protecting Vulnerable Person Manager, South Wales Police
- Louise Mann, Deputy Head of Safeguarding, Cwm Taf Morgannwg University Health Board
- Fiona Davies, Safeguarding Specialist, Welsh Ambulance Service Trust
- Natalie Bevan, Team Manager, Wales Community Rehabilitation Company
- Director Public Health Protection & Community Services, Rhondda Cynon Taf
- Jonathan Tumelty, Community and Safety Manager, Trivallis (Housing Provider)
- Jackie Neale, Service Manager Adult Safeguarding, Rhondda Cynon Taf
- Jean Harrington, Manager, Treatment & Education Drug Service
- Deb Evans, Regional Advisor, Violence Against Women Domestic Abuse Sexual Violence
- Elspeth Wynn, Operations Manager, Cwm Taf Youth Offending Service

12.3 The Panel met regularly from June 2019 in order to review the multi-agency information and provide analysis to support the development of the report.

13. Learning Event

13.1 A Learning Event took place in September 2019 and was attended by 16 practitioners from the following agencies:

- South Wales Police
- Barod (Substance Misuse support)
- Taf Ely Community Mental Health Team
- Housing Provider - Trivallis
- Ward Staff, Mental Health Unit Cwm Taf Morgannwg Health Board

13.2 There was no attendance from Mental Health Psychiatry or Responsible Clinician at the learning event.

14. Family Members

14.1 Rose's son and two nieces were part of this review process and initial questions that they required an explanation and answers to at the beginning of the review were reported back to respective agencies. When reviewers met

with the family to share the report, the family confirmed that all answers and queries had been answered by health services directly with them.

15. Terms of Reference

15.1 These Terms of Reference set out the scope of this pilot which intends to carry out a Domestic Homicide Review (DHR) using the Adult Practice Review (APR) process. Therefore, these Terms of Reference represent a hybrid of DHR and APR methodologies which will guide the pilot process and will be used to inform the development of future review procedures.

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

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

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

15.3 Held with a view to identifying the lessons to be learnt from the death. (Home Office, Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016)

15.4 The above criterion for a Domestic Homicide Review needs to be satisfied in order for a case to qualify to be reviewed using the Adult Practice Review process.

15.5 Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the relevant Board. Procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Consider whether family and friends are prepared to participate in the review.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Assess whether the perpetrator had any previous history of abusive behaviour or coercive/controlling towards Rose, or any previous or current partner and whether this was known to any agencies.
- Review any barriers experienced by the family in reporting abuse or concerns, including whether they (or Rose) knew how to report domestic abuse had they wished to.

- Review any previous concerning conduct or a history of abusive or coercive/controlling behaviour from Adult A and whether this was known or acknowledged by agencies.
- Assess whether it would have been possible to conduct a Multi-Agency Risk Assessment Conference.
- Review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.
- Take account of any parallel investigations or proceedings related to the case. Hold a learning event for practitioners and identify required resources.

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

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

15.7 Specific tasks of the Review Panel

- Were discharge planning decisions and arrangements from the psychiatric unit in respect of the perpetrator being properly made in accordance with existing discharge protocols?
- Are disengagement protocols for mental health service users robust and properly applied?
- Is there clarity about the responsibilities on the duty officers in responding to telephone contacts by the family of mental health service users?
- Produce a merged timeline with an initial analysis and hypotheses.

- Plan with the reviewers a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with family members prior to the event.
- Ensure that advocacy options are offered to family members, including a 'consent to share' option. Even if not accepted, this will attempt to ensure that family members are fully aware of what is available to them at every stage of the review process. To review the offer of these advocacy options regularly throughout the review process.
- Receive and consider the draft Domestic Adult Practice Review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Review best practice in respect of protecting adults from domestic abuse.
- Draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse at local, regional and national levels.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

15.8 Relevant panel member agencies were:

- Sue Hurley, Protecting Vulnerable Person Manager, South Wales Police
- Louise Mann, Deputy Head of Safeguarding, Cwm Taf Morgannwg University Health Board
- Fiona Davies, Safeguarding Specialist, Welsh Ambulance Service Trust
- Natalie Bevan, Team Manager, Wales Community Rehabilitation Company
- Director Public Health Protection & Community Services Rhondda Cynon Taf
- Jonathan Tumelty, Community and Safety Manager, Trivallis (Housing Provider)
- Jackie Neale, Service Manager Adult Safeguarding, Rhondda Cynon Taf
- Jean Harrington, Manager, Treatment & Education Drug Service
- Deb Evans, Regional Advisor, Violence Against Women Domestic Abuse Sexual Violence
- Elspeth Wynn, Operations Manager, Cwm Taf Youth Offending Service

15.9 Governance

- Home Office

- Public Service Board (Cwm Taf Community Service Partnership) – as a governing body. Pilot progress will be reported to CSPs by CSP Coordinator who is a panel member.
- Cwm Taf Morgannwg Safeguarding Board

15.10 Tasks of the Community Safety Partnership

- Consider and agree any learning points to be incorporated into the final report or the action plan.
- Send to relevant agencies for final comment before sign-off and submission to Home Office.
- Confirm arrangements for the management of the multi-agency action plan, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication of the report
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the CSP will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

END