7 Minute Briefing

Single Unified Safeguarding Review / CV SUSR 01/2021

Background

STEP 01

In October 2020, the Police attended at Karen's home address following a call from a neighbour. Her partner James was found lifeless inside the property with several stab wounds to his body and was pronounced deceased at the scene. Karen was found with several stab wounds to her body and was given life sustaining treatment at the scene, which saved her life. Their son Marcus was subsequently arrested.

Marcus was known to a number of agencies including Mental Health services, Probation and Police, having previously served a custodial sentence for Domestic Abuse towards his parents, which included physical assault and criminal damage and previously been sectioned under the Mental Health Act.

In July 2022 Marcus pleaded guilty to the manslaughter of James and to the attempted murder of Karen. Marcus received a Section 41 Hospital Order (Mental Health Act 1983) and was detained without limit of time.

Context

STEP 02

James defined as a spiritual Rastafarian and the family were brought up within the spiritual Rastafarian culture, beliefs and values.

The family lived with multiple risk factors (domestic abuse, mental health, substance use)

Marcus was subjected to a violent knife assault in 2017 and it is felt by family that this was the start of his mental health decline.

There were a number of opportunities to safeguard the family members through robust risk assessment processes however these opportunities were not consistently explored and utilised.

A significant feature of the review was the barrier to seeking support in relation to Domestic Abuse and consistent non engagement with Mental Health support.

Organisational Learning

STEP 03

- Barriers for victims' reporting domestic abuse.
- Consistent application of the Ask & Act principles
- MARAC referral process
- Restraining Order processes
- Provision of domestic abuse perpetrator's programmes for familial abuse.
- Impact of substance use on mental health.
- Key agencies to be involved in discussions for planning home leave from hospital for those subject to section.
- Alternate ways of providing follow up mental health appointments
- Recording all interested parties at multi-agency discussions
- Consistent approach to application, understanding and mitigating risk amongst professionals using risk assessments.

Recommendations for improving systems and Practice

STEP 04

Recommendations

1. Agencies to understand the barriers faced by familial DA victims and the need to openly discuss DA during contact with individuals.
2. Professionals submitting safeguarding referrals to confirm it has been received.
3. Community Safety Partnerships in Cardiff and Vale to seek assurance that the Multi- Agency Daily Discussions process is fit for purpose and that High-risk cases proceed to MARAC.
4. Raise awareness of MAPPA and MARAC processes across agencies and the risk management approaches of these.
5. The SUSR Coordination Hub to inform the Criminal Justice Board of the learning identified within this report and seek consideration of reviewing the process for responding to applications for variance and/or discharge of Restraining Orders.
6. Agencies to be made aware of the circumstances and processes around variation and/or discharge of a Restraining Order. To include how interested parties can make representation to the Court during the application process.

Recommendations Continued

STEP 05

7. Professionals to confirm the validity of Civil Orders or other legal directions prior to reviewing and implementing risk management processes.
8. SUSR Coordination Hub to inform the Probation Service of the learning identified and seek a review of the convicted familial DA perpetrator interventions for those subject to Probation supervision.
9. Cardiff Community Safety Partnership to seek assurances and evidence from the Probation Service that this change is being implemented.
10. Cardiff Community Safety Partnership to raise awareness of their commissioned services that work with individuals and families in reducing violence, exploitation and other forms of abuse
11. Agencies to ensure that all those present and engaged in discussions are accurately recorded.
12. Practitioners involved in risk management planning and providing support services, to consider the impact of substance use and any correlation with presenting mental health issues, particularly taking into account cultural and religious beliefs.
13. Area Planning Board & Regional Partnership Board to review current service delivery and support, for those with co-occurring mental health and substance use needs and to work with agencies to implement identified/required improvements.
14. Health services should develop information which can be provided to family and parents in terms of availability of support for individuals who are experiencing mental health issues.

Recommendations Continued

STEP 06

15. There needs to be holistic discussion of all risk factors and previous issues of domestic abuse prior to consideration of home leave plans for all inpatients. All known agencies should be involved in these discussions prior to leave taking place.
16. Health services to provide written information at the point of home leave/discharge to nearest relative/families on the circumstances of the leave/discharge and arrangements for support to be provided at that time.
17. Health Services involved in the provision of mental health support should adopt a reflexive approach to follow up appointments. Considerations should be made as to how best to engage those in the community who will not attend appointments.

STEP 07

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