Mental Health Homicide Review
SUSR 01/2022

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

1 Background

In November 2021, 'John' murdered June in her own home. Prior to the incident there was no relationship between June and John with the first point of contact occurring at the time of the incident. At the time John was a student at a University in Wales and was under the care of Adult Mental Health Services in Cwm Taf Morgannwg Health Board and had previous contact with South Wales Police.

The Review predominantly focusses on the agencies who had contact with John as June was unknown to services prior to her murder. The timeline has been extended to cover the period following the incident as there were areas of learning identified during the review. As this was a mental health homicide a review was commissioned by Cwm Taf Safeguarding Board on 9/3/2023 using the pilot Single Unified Safeguarding Review process

2 Learning Theme 1 Communication

There were limits to the flow of information between all agencies, and between agencies and John and John's family. The sharing of information was limited by practice and process at the time. In other instances, problems with information sharing were based on misunderstanding about when information can be shared, and assumptions about where information goes and how much information is held by partner agencies. When all the pieces of the information jigsaw were brought together, a different picture emerges of John's needs that would perhaps have invited more concern and more targeted support.

It is recommended all agencies review and amend their information sharing arrangements to improve communication.

3 Learning Theme 2 The use of statutory processes to aid care

There were missed opportunities to utilise statutory and standardised processes to aid care. There were also significant limits to the application of evidence-based care.

The Community Mental Health Team processes did not allow for the timely or robust provision of care and treatment.

It is recommended that The Health Board should review & update 2018 MH36 policy "Mental Health Measures Parts 2 and 3 Care and Treatment Planning (CTP) and that The Health Board should review & update CMHT Operational policy

4 Learning Theme 3 The provision of evidence-based care including the involvement of significant others

NICE Guidelines indicate the need to offer family intervention as a frontline intervention alongside individual Cognitive Behavioural Therapy. This did not happen in this situation.

It is recommended that the Health Board review its capacity to provide evidence-based care consistent with NICE Guidelines for all patients and respective family and develop an action plan to remedy any shortfalls.

5 Learning Theme 4 Working across localities

There is no identified mechanism for sharing information or delivering shared care when a person moves into another health board on a temporary basis.

It is recommended that a protocol is developed between Health Boards to facilitate the sharing of information and the continuation of care when a person moves to another Health Board on a temporary basis.

6 Learning Theme 5 Confidence in services

For people experiencing distress and disturbance of mental state, but especially for young people experiencing a first episode of psychosis, it is crucial to feel that services can be trusted and that such services are well trained, skilled and able to offer hope.

It is recommended that the Health Board consider their principles of co-production. This could ensure that services, interventions and communication are developed in partnership with those that use them. This, coupled with increasing access to evidence-based care and reporting on improvements, can increase confidence and trust in services.

Increasing access to evidence-based intervention should be a key priority and the Health Board should audit its current position and form an improvement plan

7 Learning Theme 6 Managing post-vention

Whilst the events and experiences in the immediate aftermath of the homicide were not part of the terms of reference, these were shared with practitioners to honour the families' and the community's accounts and to facilitate learning outside of the designated timeline.

An immediate response group (IRG) was not convened for this incident and, as such, there was no multi-agency response to manage threat, risk, harm in relation to a group of individuals. Many of the difficulties and distress could have been minimised or managed using the IRG process.

It is recommended that The Safeguarding Board should review the "*Protocol for an Immediate Response to Critical Incidents"* to ensure a consistent understanding across multi agency partners of the type of incident for which the protocol should be invoked, the purpose of the Immediate Response Group (IRG) and agreement on the recording of decision making as to whether an IRG should be held.

Once agreed, all agencies should be reminded of their roles and responsibilities in respect of this protocol.