The Isle of Man Safeguarding Board

Board Response to Serious Case Management Review – Family K

This Serious Case Management Review (SCMR) concerns the homicide of Mrs K and a serious assault to her husband Mr K in January 2021 by their son Mark. Mark has been in secure psychiatric care since the homicide. He was convicted for manslaughter of his mother. The Court determined that Mark was mentally unwell at the time of the incidents. His mental illness was not known at the time of the offences, but he was later diagnosed with schizophrenia.

This SCMR was commissioned in 2021 by the Isle of Man Safeguarding Board in line with the 2019 Safeguarding Together Guidance and Safeguarding Board Act 2018.The purpose of a SCMR is to identify learning and apply this to improve safeguarding systems and practice. The Board commissioned Sylvia Manson an experienced independent reviewer to complete this SCMR.

The review process consisted of agencies providing reports of their involvement with the family and a practitioner event. The review process is supported by a panel of senior staff from involved agencies that can provide necessary context on organisational policies and practice.

The agencies involved in the process were:

Isle of Man Constabulary

Department of Education Sports and Culture

Manx Care- Health & Social Care

Mr K had been dependent upon Mrs K and their son, Mark for his care throughout Mark's teenage years. Mrs K had a long-term depressive illness. She and Mr K were described by professionals as having chaotic lifestyles secondary to alcohol use, however neither of them accepted they had problematic alcohol use. There were repeated concerns regarding domestic abuse in the family home and Mr and Mrs K's relationship

At the time of Mrs K's death, she was caring for a relative, and Mark was also relied upon to provide care too.

In the weeks leading up to the homicide, Mrs K and a friend of Mark's had contacted mental health services, concerned about his behaviour. Mark did not engage in an assessment.

The report and its recommendations were agreed and accepted by the Isle of Man Safeguarding Board. The report has been published by the Safeguarding Board along with this Board response. The publication follows the outcome of a police investigation and conclusion of the judicial process.

The report noted that this homicide could not have been predicted or prevented, despite the areas of identified learning to reduce risks in the future.

The review identified learning points in the following areas:

- Understanding any issues that may be impacting both victims and perpetrators of domestic abuse, is key to examining opportunities to intervene to support the victim and reduce risks from the perpetrator.

- All practitioners need to consider the risks and vulnerabilities of all people within the household, particularly children and young people and ensure there is robust information sharing and multi-agency responses – Think Family approach:
- Domestic abuse needs a multi-agency strategic approach. Legislation needs to be accompanied by specialist services; shared risk assessment tools; effective multi-agency communication and protection planning. Schools can play a vital role in mitigating against Adverse Childhood Experiences.

The review also found many aspects of good and expected practice from services including consent gained to make referrals to Adults Social Care. The family had declined any offers of support on a number of occasions.

Recommendations

1) The IOMSB should assure itself that there are robust measures in place for responding to incidents of domestic abuse, including considering the risks and vulnerabilities of all people within the household, particularly children and young people.

2) Manx Care Social Care should lead an awareness raising campaign about being a young carer. The campaign should target key services for children and young people and provide:

- Information on the impact of being a young carer
- Guidance on the difference that agencies can make to the young carer
- Tools and aids to help agencies generate support plans and signpost to support services

3) DHSC, working in partnership with Manx Care, should assure there are robust processes in place to correctly identify the adult/child's registered GP. Assurance should also be sought that GP's are involved as key multi-agency partners in responses to safeguarding and domestic abuse concerns and that information is shared in line with the permissive provisions of GDPR, IOMSB policies and professional guidance

4) The review recommends this review is shared with the IOM Department of Home Affairs to inform the implementation of its Domestic Abuse strategy and the following components that should be factored into the IOM Department of Home Affairs implementation planning:

- Strategic forum for multi-agency senior leadership to drive forward the strategy
- Specialist and dedicated support services including IDVAs
- Adoption across agencies of a shared, evidence- based risk assessment tool e.g. Safe Lives DASH risk checklist, and agencies building chronologies of incidents
- Establish structures for multi-agency risk management meetings

Actions Taken to Address the Learning and Recommendations.

There have been a number of actions taken to improve systems and practice and are as follows:

- The Isle of Man Justice Reform Act 2021 includes provision that enhances information sharing that supports the prevention of crime and safeguards the welfare of the person. The Domestic Abuse Act 2020 also received Royal Assent. This will provide police with more powers in response to domestic abuse. However, at time publication, the Act had not been implemented and the statutory guidance and secondary legislation behind the Act was still to be completed
- The Department of Home Affairs (DHA) has been developing a Domestic Abuse strategy to support the new powers in the Act as well as the broader objectives to reduce harm and

improve the recognition and reporting of domestic abuse. Plans are being progressed to set up a Community Safety partnership to oversee the DHA implementation plan. The plan references the requirement for all parts of Government to work together and commits to developing a stable framework for domestic abuse services to be delivered, including engagement with stakeholders. A Domestic Abuse Strategic Coordinator has been appointed in February 2022, to lead the Domestic Abuse Strategy and implementation plan.

- Manx Care is in the early stages of developing a single Manx Care record that will improve integrated care and information sharing across the Manx Care services.
- Timely access to psychological therapies such as Cognitive Behavioural Therapy is a fundamental component of effective mental health treatment for individuals experiencing common mental health problems such as depression and anxiety. The Integrated Mental Health Service has received significant additional funding in order to substantially increase the volume of therapists available to deliver psychological therapy.
- Manx Care is establishing an Integrated Wellbeing Partnerships in each of the Isle of Man's geographic areas. These have been established in the West, South and North and work now being undertaken to create a Wellbeing Partnership for the East of the island. The hubs are multi-disciplinary and ensure that information and decision making happen in real time to ensure the individual gets the right support, in the right place and at the right time. They will act as 'one stop shop' approach to support individuals and communities on a locality basis.
- Manx Care has, from the 1 November 2022, established an Integrated Safeguarding Team, to ensure that safeguarding resources and practice is consistent and are effectively utilised across Manx care. This is the first step to then creating the Multi Agency Safe Hub (MASH) which will also bring in colleagues from the IoM Constabulary. The MASH is being developed over the coming months and will be collocated at Murray House.
- The Isle of Man Safeguarding Board has developed an information sharing protocol that will govern information sharing between agencies. The Board have also developed comprehensive information sharing guidance, to support professionals to effectively share information and a helpful guide "The Myths of Information Sharing". These are all available on the Isle of Man Safeguarding Board website here.

The Safeguarding Board have developed an action plan based on the recommendations and the progress of actions will be monitored and assurances about progress sought from partner agencies. The Safeguarding Board has developed a Quality Assurance and Scrutiny Framework which will test the impact of the actions taken, to ensure they are leading to improved safeguarding practice and improved outcomes for Isle of Man citizens.