SAFEGUARDING BOARD
ISLE OF MAN

IOM Safeguarding Board Learning Brief

Serious Case Management Review 'Family K'

THE REVIEW

The Isle of Man Safeguarding Board (IOMSB) will convene a Serious Case Management Review (SCMR) in circumstances where:

a. there is cause for concern about how the Safeguarding Board, it's partner agencies or any other relevant body have worked together to safeguard the vulnerable adult, and

b. a vulnerable adult has died or suffered serious harm and

c. where abuse or neglect is known or suspected.

This SCMR concerns the homicide of Mrs K and a serious assault to her husband Mr K by their son Mark. Mark was mentally unwell at the time of the incidents. He was convicted for manslaughter of his mother, and the attempted murder of his father. Mark is now detained in secure psychiatric care through a Hospital Order imposed by the Court.

BACKGROUND

Family K experienced multiple life stress factors and Mark grew up within difficult family dynamics. Mr K had a physical disability and an acquired brain injury from a work injury. At that time Family K had debt problems and were under threat of eviction. Mr K was described as having mood swings and aggressive behaviour. There were repeated incidents of domestic abuse from Mr K to Mrs K. Mr K received support from Adult Social Care but was reliant on care from Mrs K and Mark. Mr and Mrs K were heavy users of alcohol. Neither acknowledged they had problematic alcohol use and they declined any support from alcohol services. Mrs K had a long-term depressive illness and spent a lot of time off island, leaving Mr K to be cared for by Mark who was a young teenager at that time.

Mark's school record noted that he was a young carer but there were no details about what this meant for him or what support he may need. The school were not aware of other adverse childhood events – they were unaware of Mr and Mrs K's alcohol use and of the domestic abuse incidents although this was known to Adult Social Care and Children's Social Care.

When Mark left home to go to University, the incidents of domestic abuse from Mr K to Mrs K continued. Mrs K was assessed by mental health services due to her continued anxiety and depression. She talked about the domestic abuse incidents but did not want to pursue prosecution. This information was not passed onto her GP.

Shortly after Mark returned home from University, Mrs K and Mark's friends contacted the mental health Crisis team, concerned about his mental health. Mark was thought to be using cannabis at the time. He did not want to see mental health services and was not thought to be a risk to himself or others. The Crisis Team advised Mrs K to take him to his GP. Mark never attended his GP. It transpired that he was no longer registered with a GP in the IOM. This was not known to the Crisis Team at that time. The team sent information to Mark's previous GP to inform them of the concerns. In the following weeks, Mrs K and his friend made four further calls to the Crisis team, concerned about Mark's increasingly erratic, paranoid and threatening behaviour. Again, Mark declined to have any follow up from mental health services. There were insufficient concerns to warrant calling for a Mental Health Act assessment. Advice to see his GP was not followed up.

During this period agencies were also involved with Family K, due to a Safeguarding Adult Enquiry relating to a relative who was temporarily living with the family. There were concerns about how Family K were able to care for this family member's needs arising from dementia and diabetes. The Safeguarding Adult Team made a home visit. They were not aware of the concerns about Mark's mental health. Information about family members had not been comprehensively drawn together.

Ten days later, the fatal incident occurred. The day before, Mark had become agitated and hit Mrs K around the head. Neither Mrs K nor Mr K reported this incident to the police or the Crisis Team. During the early hours, Police were contacted by the family relative to report that Mark had tried to strangle Mr K and when attending the property had found Mrs K in bed and deceased. Mark was charged with murder and detained for psychiatric assessment. Mark was subsequently diagnosed as having schizophrenia. The Court determined that he was mentally unwell at the time of the offences.

The review concluded that the homicide could not have been predicted or prevented. Nonetheless the review highlighted areas of learning and made recommendations to reduce risks to other

KEY MESSAGES FOR PRACTITIONERS

1. 'Think Family' is a key message in working with domestic abuse. 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. *[Recommendation Arising]*
2. Schools can play a vital role in mitigating against Adverse Childhood Experiences (ACEs). Their ability to make a difference is reliant upon (i) sharing information between agencies and (ii) schools using that information proactively in a support plan.
3. GPs play a key role in safeguarding and working with adults and children affected by domestic abuse. Working in partnership is key share information and involve GPs in support plans.

KEY MESSAGES FOR STRATEGIC DEVELOPMENT

1. There is emerging research from Domestic Homicide Reviews in the UK, that can aide understanding of prevalent factors for victims and perpetrators, including factors relevant to this review relating to adult family violence. Ensure this learning is used to develop practice responses to Domestic Abuse.[1]
2. Assure there are robust processes in place to correctly identify an adult or child's registered GP. *[Recommendation Arising*]
3. Develop an awareness raising campaign about the needs of young carers. *[Recommendation Arising*]
4. The IOM lacks the basic infra-structure required to respond to Domestic Abuse. This constrains the ability of practitioners to support victims and disrupt perpetrators. Domestic abuse needs a multi-agency strategic approach with adequate systems and resources. *[Recommendation Arising*]

You are encouraged to read the whole review. The full review is available here