Single Unified Safeguarding Review Report

Learning from the Past to Make the Future Safer

Name of Regional Safeguarding Board: **Cwm Taf Morgannwg**
Case Reference Number: SUSR 01/2022
Pseudonym 1: The perpetrator is referred to with the pseudonym John. All affected individuals (including the victim) have chosen to be referred to by their given names.
Date of incident which led to the Review: If unknown, please state this. 21st November 2021
Date of death where applicable: If unknown, please state this. 21st November 2021
Review's start date (commissioned): 09/03/2023 **Review completion date (approved and signed off):** **Publication date:** There has been a delay in the completion of this report. Due to unforeseen circumstances, there was a change in the Chair of the panel and delays were incurred while this process took place.

Background In November 2021, 'John' murdered June; an adult female that was unknown to him until this point. June was murdered in her own home. John was a student at a University in Wales, had some contact with South Wales Police and was also

under the care of Adult Mental Health Services in Cwm Taf Morgannwg Health Board.

Tribute to June

This review had a victim focus and, as such, it is important that the victim in this case is held in mind throughout. The victim's family have paid tribute to her and have chosen to use her real name in this report.

"June was a mother, grandmother and great grandmother and loved spending time with her extended family. She adored her children and grandchildren, and although she set high standards for us, she would do anything to support and encourage us. She spent many hours teaching her grandchildren various skills including baking, gardening, knitting & crafts, and telling them stories of the 'good old days' from her childhood.

"June was a vibrant lady, extremely hard working, determined and very resilient after overcoming many challenges throughout her life. She lived life to the full every day. She had a wicked sense of humour, and an infectious laugh. June had a huge heart and would welcome anyone with open arms into her home and was always prepared to share her advice or experiences to help anyone around her. She was a traditional lady who also had a love of nature, gardening, and animals.

"June was generous, if anyone had a problem, she would do anything in her power to help you – which makes it so much harder to accept that in November 2021 she was taken in such a cruel way for no reason and before her natural time. June was our family, friend, rock and safe space and we will feel this loss for the rest of our lives."

Rationale for SUSR

As outlined in the guidance for Single Unified Safeguarding Reviews (SUSR; issued under section 139 of *The Social Services and Well-being (Wales) Act 20146),* the criteria for conducting a Single Unified Safeguarding Review consist of several inter-related parts, as laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 20157*, the *Domestic Violence, Crime and Victims Act (2004)*8 and *section 24 of the Police, Crime, Sentencing and Courts Act 2022 and the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 20229*. The key criterion of the need for multiagency learning was met as well as criterion in section 3.5a:

- A homicide is committed, and the alleged perpetrator has been in contact with primary, secondary, or tertiary Mental Health services within the last year.

In this instance, 'contact' may include an assessment or intervention. Specific consideration must also be given to the Mental Health (Wales) Measure 201020 which defines the provision of mental health services to patients in specific situations.

As a result of these criteria being fulfilled, a SUSR was commissioned by Cwm Taf Morgannwg Board on the recommendation of the Case Review Group in accordance with the Guidance. It was agreed that the current review would be conducted under the auspices of a pilot given that the SUSR process has not yet been formally approved and adopted. For this reason, an addendum report outlining learning from the pilot methodology has been completed.

A panel was convened by Cwm Taf Morgannwg Safeguarding Board in order to inform this review. There was representation from Health Board (primary and secondary mental health care services), the Local Authority, the University, South Wales Police. The terms of reference (TOR) agreed by this panel can be found in annex one. As part of the TOR, agencies were asked to provide timelines for the period from time of first contact with mental health services in the Health Board (26th March 2019) until the index offence (21st November 2021). Through interviews with those affected by the homicide, the reviewers were party to additional information relating to events that fell outside the period of the review (e.g. mental health care provided in the previous University in England and help available in the immediate aftermath of a homicide in a community). For completeness of context, this information was shared with panel and the learning event and informs our recommendations.

John was subject to criminal proceedings. John pleaded not guilty to murder which was accepted by the Crown Prosecution Service. He pleaded guilty to manslaughter by diminished responsibility and was made subject of a hospital order under section 37 of the Mental Health Act for an indefinite period. The pre-sentencing report undertaken by a psychiatrist indicates that John has a diagnosis of Paranoid Schizophrenia.

The reviewers met with John virtually on the 5th July 2023 and relayed his views during the learning event.

A learning event took place on the 17th July 2023 which reviewed the combined timeline and provided areas of clarification.

Policies relating to the care and support provided and relating to the incident were taken into consideration as part of the review.

Equality and Diversity:

In respect of John there were no specific areas of note in respect of the key characteristics.

Whilst June was an older person at the time of her death, there were no specifics in respect of the equality act and access to services. This was a stranger homicide and June had no need to access services. The panel did have conversation about the protected characteristics of disability and sex. In regard to disability, panel recognised that on occasion this characteristic did not constitute a barrier to services. Panel did note, however, that there was limited consideration given to the risk of violence towards

women and girls in light of some of John's behaviour and therefore the protected characteristic of sex was relevant in discussions.

Involvement of family, friends, work colleagues, neighbours and wider community:

A number of people were affected by June's murder. Those people that were contacted and seen as part of the review process are outlined below. The victim's family were invited to choose who they wished to attend the meeting with the reviewers. The victim's son and older daughter did not wish to attend. June's youngest daughter attended with the very close family friend that discovered June's body. This adult is considered by the victim's family to be a surrogate sister and had a very close relationship with June. Initial contact with those directly affected with or involved with the murder was made by those that had existing links (e.g. family liaison officer) with subsequent contact for arrangements being via email and telephone with the reviewers. Terms of reference were provided. Loose agenda were set for meetings with a brief introduction to the SUSR process and a focus on learning. All contacts were asked to share whether they felt there was any learning from their unique perspective. All contacts were informed that confidentiality was not protected as learning would be shared with panel members and would inform the final synthesis presented in the report.

Contact	TOR shared	Advocate	Dates of Contact	Reviewers
June's daughters*	✓	X	21/7/2023 7/5/2024 8/7/2024	Liz Andrew & Angela Edevane Sue Hurley & Barbara Firth Sue Hurley & Barbara Firth
June's son	✓	X	01/08/24	Sue Hurley
June's close family friend	✓	X	21/7/2023 7/5/2024 8/7/2024	Liz Andrew & Angela Edevane Sue Hurley & Barbara Firth Sue Hurley & Barbara Firth
John's mother and father	✓	X	13/7/2023 10/5/2024 11/7/2024	Liz Andrew & Angela Edevane Sue Hurley & Barbara Firth Liz Andrew, Sue Hurley & Barbara Firth
RCTCBC Ward Member 1	X	X	14/7/2023	Liz Andrew & Angela Edevane
RCTCBC Ward Member 2	X	X	14/7/23 Ward Member UTA	Liz Andrew & Angela Edevane

*one daughter declined but has been kept informed

Family declined involvement

John's sister and June's son chose not to attend meetings with reviewers and chairs but were informed of the review. As above, June's eldest daughter chose not to meet the reviewers but has been kept informed throughout. June's son requested a meeting following completion of the report (July 2024).

Family History and/or Contextual Information:

At the time of the index offence, John was 25 years old. He was described as having an unremarkable childhood being brought up by his birth family in South Wales. His parents shared that he was an able young man who was capable academically and socially; he was interested in sport and was achieving well at school. This began to alter from the age of 17, and at 18 during the second year of his A Levels it was reported that John's performance began to deteriorate. John sat the second year of his A levels twice initially attending a 6th form college to sit his A levels and then re-sitting the second year of his A levels at another Welsh Campus.

Despite the apparent change in his mental health, John obtained a place to study at a University in England enrolling for the start of the 2018 academic year. His parents were aware of changes in his mental state during this period which became apparent during a long family weekend at the end of November 2018. During the break John stopped talking to his sister and his attitude towards her appeared to become hostile. The family didn't hear from him and he did not come home for Christmas despite repeated attempts to contact him. In February 2019 John's father received a call from John asking if he could come home and could he be picked up. When John's father arrived at the University John was being escorted by security which John said was due to acts of aggression. When John arrived home, he told his family he had been suspended for 2 weeks and was considering his options. John's family report that, in February 2019, John informed them that he was suspended from the University in England due to his behaviour. He stated he had damaged two student rooms he occupied at the University and was eventually housed in a block on his own which was under refurbishment. John had confirmed to his family that he was having counselling from student services. In line with policy and processes, the University in England did not share any of this information directly with John's family. The family were, however, in receipt of a bill for damages to University property.

Information received from the University in England provides additional information for this period of time. Learning from this is shared in the practice and organisational learning section.

John commenced his studies on 17th September 2018. Panel were informed that there is an expectation for students to self-identify in their application any health or mental health concerns which would trigger intervention, reasonable adjustments or support for the individual. John made no disclosures or concerns at admission. John included

on the application the details of his parents as emergency contact details. John also successfully applied for student accommodation for the academic year 2018 -2019 and was allocated a place in an 8-bedroom flat with shared bathroom facilities.

The University confirmed that between September and December 2018 no incidents were recorded. However, it transpired that John's attendance on his programme in the initial term was poor. The lecturers and tutor made contact with John. Records show that John did not respond. The system in place at that time to gauge engagement was via monitoring assessment submission.

In January 2019, following concerns reported by a fellow student about John's behaviour, it was established that before and after Christmas John had caused damage to his own room, property in the communal area, and the shared bathroom. Records verify that John remained in the University accommodation over Christmas. When spoken to by staff at the University he confirmed he had become angry and caused damage by throwing an item at the television which he agreed to pay for. John had said he wanted to make an appointment with the Well-being service, but he chose not to take up the offer from the Accommodation Manager to accompany him to the Well-being Service at the time.

John confirmed to his family that he was having counselling from student services.
John's peers had expressed concern about John's general appearance describing him as grey in colour, outlining the apparent anger and stating that he had become very distant. A referral was made by the Accommodation Team to well-being and John met and engaged with staff from that service on the 11th January 2019. During the meeting no specific risks were identified and the main issues were around isolation and lifestyle balance.

On 20th January 2019 following further reported concerns by fellow students, it was established that John had caused damage to his room. He agreed that it would be beneficial for both him and the other residents if he stayed in emergency accommodation for a few days to give them all some space. John made it clear that he did not want to return home and he did not want his parents contacted.

John settled in the emergency accommodation and requested to remain there for a longer period. He subsequently disclosed that he had anxiety issues which were triggered when he drank caffeine. It was later noted that John had caused damage to the walls in the emergency accommodation room for which he apologised in a meeting on the 5th February 2019. He said he was unable to control his anger. It was agreed that he would receive a final warning for the damage caused which was issued on the 11th February 2019. John agreed and confirmed he would not break any more rules in accordance with the Anti-Social Behaviour Discipline Procedure.

The Accommodation Manager was also concerned for John's well-being and mental health and requested for John to be considered under the Fitness to Study policy on the grounds of safety to self.

On the 14th February 2019 Accommodation Services confirmed ongoing concerns around John's well-being including concerns that he was not eating and was spending most of the time in his room and he disclosed he was treating himself by chanting mantra. On the 15th February 2019, as agreed with John, there was a discussion with the Mental Health Early Intervention for Psychosis Team. It was felt, at that point, that John's presentation did not warrant an NHS crisis team referral.

On the 22nd February 2019 there was a well-being triage consultation concerning John where concerns were explored. There was no consultation with John's parents to inform any decisions. It was agreed at this consultation to support a referral to the Mental Health Early Intervention Team.

On 23rd February 2019, a further incident occurred when John was shouting and kicked his bedroom door off. On 25th February 2019 John's presentation was discussed with the Mental Health Early Intervention in Psychosis Team and it was confirmed that he would be offered an assessment in 2 weeks. In a well-being appointment on 26th February concerning John's fitness to study, John confirmed that he would not be returning to his studies, and he was returning to live with his parents. It was agreed that because he was returning home voluntarily a formal suspension was not necessary. John confirmed he would be receptive to professional support, and it was agreed the University could make a referral to Mental Health Services.

On the 27th February 2019, John returned his accommodation key and said he was leaving the University and self-suspended for a period and was returning home. This was not John's parents' understanding of the situation. John had disclosed to them that he had been suspended due to his behaviour.

It was not until the 20th March that John confirmed that he would not be returning to the University and, as such, he was advised to submit the withdrawal form by the 6th April 2019 or he would become liable for fees.

It was recorded on the 22nd March 2019 that the Well-being Service had numerous failed attempts to contact John to explore how they might assist him to link with support in Wales or refer to Mental Health Early Intervention Team with John's consent or provide signposting information to John's GP.

There is a letter stored on file dated 8th April 2019 in readiness for disclosure to a medical professional should an enquiry be made in respect of John which confirms a referral to the local Early Intervention Psychosis Team in England, but John had left before any assessment was completed. John returned to University on the 27th April

2019 and the 2nd May 2019 to collect his belongings and on the 8th May John submitted a Notice to Quit University accommodation.

Following receipt of a third-party data sharing consent form to allow the University to liaise with John's parent about the accommodation costs, it was agreed to adjust his account to release liability to 25/04/19.

The family confirmed that whilst no information was shared with them concerning John's behaviour, they did receive a bill for the accommodation and damage at the University property. With the subsequent changes made to policy, family members who are disclosed as emergency contacts would be consulted in the welfare triage meetings and would therefore be made aware of such behavioural issues and concerns.

John returned to the family home and was reported by his family to continue to experience episodes of aggression – these were initially managed by primary care (who prescribed benzodiazepines). John's mother researched what support was available from the third sector and after many calls managed to fast track John into an anger management course by Mind. At this point, the timeline towards the index offence commences but for further contextual information, John enrolled for a foundation art course in September 2020 and upon completion of the course he enrolled in a graphic design course at a Welsh University in September/October 2021.

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Agency Timeline:

The timeline has been extended beyond the period of the event taking place as it was noted during discussions with family members and at the learning event that there were areas of learning for the partners during the period post-incident that require inclusion and these have been incorporated in the report under the heading of post-vention.

At the time of the index offence, John was 25-years-old. On leaving the University course in England and whilst living with his parents, John's mental health continued to deteriorate and he was described as becoming more withdrawn from his family and social network in addition to having episodes of aggression. This reached a crisis point on 26th March 2019 when John caused considerable damage to the family home and the police were called to attend and located John at a local petrol station. John was conveyed on a voluntary basis by the police to a mental health unit where he was assessed by a crisis nurse and admitted on an informal basis.

During John's admission there was care and treatment planning in line with good practice though this was not recorded on statutory Care and Treatment Plan (CTP) documentation as outlined in the Code of Practice for the Mental Health (Wales) Measure (2010). Early on in his treatment, it was identified that John was exhibiting signs and symptoms that were consistent with a psychotic episode. On 27th March 2019, blood tests tested negative for drugs which would have supported a working hypothesis of a form of psychosis that was not drug induced. At the ward round on 29th March 2019, it was noted that the family's reports detailed behaviour that was assessed by the medical team as being consistent with the negative symptoms of schizophrenia

(though they also note the presence of positive symptoms of schizophrenia including paranoid beliefs). Appropriately, antipsychotic medication was started. Records indicate that multi-disciplinary meetings were utilised to consider appropriate care pathways and there was reference and referral to a First Episode Psychosis (FEP) team. The SUSR panel understood that, in fact, this was something of an emerging or embryonic service and, at this point in time there was no agreed operational policy or process and the team consisted of a very small number of practitioners with special interest and expertise in the area. The referral to the FEP team was declined though there is no information regarding the clinical rationale for this decision. The onward plan was for Consultant Psychiatrist to discuss with FEP team. Subsequently, John was discharged to Crisis Response Home Treatment Team (CRHTT) with a plan for CRHTT to liaise with the Community Mental Health Team regarding the need for ongoing input.

During John's inpatient stay, there were meetings with the family which were documented as opportunities to obtain collateral information. This is good practice and allows clinical teams to broaden their awareness of the clinical picture, therefore supporting understanding of the presenting problem as well as associated clinical management. John's family have, however, expressed their concern about the limited access to education and information afforded to them about their son's difficulties. They are a family that are naïve to major mental health difficulties and they were not offered any additional support or intervention in their own right. The Mental Health (Wales) Measure (2010) advocates the involvement of family and carers. *"Where practicable and appropriate the views of any carers or significant others should also be sought and recorded" p12. "The care coordinator may also choose to keep in touch with family and carers where appropriate or necessary" p14 and "In preparing the care and treatment plan, the care coordinator is also required to take all practicable steps to consult certain other persons, including carers" and "maintain regular contact with the relevant patient and any significant others in the life of the relevant patient (parents, partners, carers, etc), so that changes in their health and social circumstances are known, and appropriate action is taken where required (p20).*

Furthermore, given that it was considered that John was experiencing first episode psychosis, reference could have been made to National Institute for Health and Care Excellence (NICE) guidelines for psychosis which indicate the degree of involvement that should be offered to carers and significant others. This includes information about schizophrenia or other forms of psychosis, early conversations about information sharing, the right to a carer's assessment and how to get help in a crisis.

During the admission and in conversations with family, ward staff learned that John had notebooks with nonsensical writing, in which he referred to his mother in a highly derogatory way. Clinical notes indicate that John was described by family members as "can be manipulative, strange ideas about women- feels better than them, struggles when challenged." Despite reported aggression in the home, there is no reference in clinical records of the above information being considered through a lens of domestic violence.

John was offered a period of leave from the ward environment which were supported by his parents. Records indicate that the ward team were responsive when the parents expressed concern on occasion about the planning of this, in particular that John had

been aggressive towards them and their home and that they did not feel they had been supported to understand this. However, the records indicate that following a period of weekend leave with family, John returned to the ward and was discharged to the home treatment team (an alternative to hospital admission often used to facilitate a safe and swifter discharge from hospital) on the 15th April 2019. John's parents have expressed that they were dissatisfied about the way in which this occurred. They told the reviewers that they were at work when John was discharged home and that the house was empty and that they were ill prepared for his return and unclear about how to support him with his condition when he was discharged including what signs to look out for which may be indicative of a deterioration in his mental state.

John was discharged to the crisis response home treatment team (CRHTT) following a three-week admission (this is recorded as 26th March 2021 to 15th April 2021). John was provided with appropriate medication for the period immediately following discharge and contact numbers should he need more immediate help. Clinical records indicate that following discharge John experienced feelings of anxiety and agitation and felt the need to walk several miles; he contacted the crisis team with his concerns and was advised to attend Accident & Emergency. John attended Accident and Emergency on the 17th April 2019 accompanied by his father. Staff at A&E attempted to contact the crisis team but were unable to do so. After a period of time John reported to staff that he was feeling better and had an appointment with mental health services in the morning and was discharged from A&E.

In conversation with reviewers, John and his parents reported that, generally speaking and whilst brief, involvement from the CRHTT was a helpful process and that they benefitted from the additional support and monitoring. In this time, there was support with the management of anxiety and side effects from medication.

Despite early recognition of symptoms of a serious mental illness, there followed significant delays in accessing an appropriate care pathway and allocation to the appropriate part of the Mental Health (Wales) Measure. There appeared to be a lack of cohesion and consistency between acute services (the inpatient ward and the CRHTT) and the community team and this resulted in unnecessary delays. John was referred to the FEP team (an aspect of the Community Mental Health Team) on 2nd April. This virtual team sat within the Community Mental Health Team (CMHT) and was accessed via the Single Point of Entry (SPE) system. Notification of discharge from inpatient services was provided to the CMHT on 15th April but John was still not offered an assessment. Records indicate that John was re-referred to the SPE on 24th May 2019 and his needs were discussed in the Single Point of Entry meeting on the 3rd June. This is not in line with the Health Board's CMHT operational guidelines.

John participated in an assessment by the Psychiatrist (ST6) and community psychiatric nurse on the 11th July 2019 where it was agreed that it would be appropriate for John to be supported by the First Episode Psychosis special interest team who would work with John to identify any indicators that he would need to look for that would suggest that his mental health was relapsing and how these would be dealt with and future monitoring would be via the psychiatrist based in the CMHT. This offer of care

is consistent with NICE guidelines for the treatment and management of first episode psychosis[1].

There is, however, no record of contact with the allocated Community Psychiatric Nurse (CPN) between 15th July 2019 (when the assessment was completed and entered on the clinical information system) and 26th September 2019 when a new CPN is allocated and proactively seeks contact with John. There are no significant incidents recorded in this time period. There is also no record of the care outlined above occurring. There was confusion about John's relevant patient status[2]. His care was clearly being provided by practitioners within a secondary care service and Care and Treatment Planning forms are completed. John was offered a period of intervention around relapse prevention, medication monitoring and access to regular reviews with a Consultant Psychiatrist. Despite this he was unaware of his relevant patient status, was not deemed to be being seen under Part 2 of the Mental Health Measure and does not appear to have been allocated a care coordinator. Arguably, the lack of an allocated care coordinator contributes towards the absence/interruption of care and monitoring that was proposed and offered at the outset and also the limited nature of the care offered. The NICE guidelines for the treatment and management of psychosis and schizophrenia in adults indicate a need for accessible services with a focus on engagement, the provision of biopsychosocial care (to include pharmacological, psychological, social, and occupational elements of care) and monitoring of medication, side effects and any withdrawal[3].

Between July 2019 and September 2019 there was an intention for support to be provided by two different CPNs. There is no evidence that the first CPN made any contact with John between July and September 2019. There are no significant incidents recorded in the timeline for this period. In September, the newly allocated CPN makes multiple attempts to make contact with John via telephone. As no contact is made a letter is sent that invites contact. The letter outlines that a lack of response would trigger discharge from the CPN's caseload (though will remain under the care of the psychiatrist). A typographical error on this letter also gave John only one day to make contact rather than four weeks. This may have caused confusion or alienation and could have inhibited engagement. The Health Board have a disengagement policy that details actions that should be taken in the event of a service user not making or responding to contact. This policy was not followed in this instance though contact was made with the treating Psychiatrist to inform of the situation.

John was seen by a consultant psychiatrist in an outpatient clinic appointment on the 9th January 2020 where he reported that he was enjoying his course at the local Further Education College and that his concentration was improved with no 'odd thoughts' however he was still experiencing some side effects from the medication he was taking. A reduction in medication was agreed with further follow-up in 2 months. In the absence

[1] Recommendations | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE
[2] Within the meaning of Part 2 of the Measure, an individual for whom a mental health service provider is responsible for providing a secondary mental health service; or one who is under guardianship of a local authority in Wales; or one for whom a mental health services provider has decided that they would provide secondary mental health services, if that individual cooperated with the provision of such services
[3] Recommendations | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

of the structured work regarding relapse prevention, John was encouraged to discuss his relapse indicators with his family. This is not an appropriate substitute.

The lockdowns and service restrictions associated with the COVID-19 pandemic commenced on 24th March 2020. John's appointment on the 22nd April 2020 was cancelled and the subsequent appointment on the 4th June was undertaken by telephone. Records indicate that during a telephone consultation in June 2020, John reported that he had no negative thoughts, that his mental health was stable and that he was looking forward to starting his University course in September. John was advised to continue with his current dose of medication which was Ariprazole for the next 6 months. Diagnosis at this appointment was recorded as unspecified non-organic psychosis.

John commenced his illustration course at a new University on the 15th September 2020. In line with policy and practice in Higher Education, John was invited to disclose his mental health condition and seek related University support at various points in the application, enrolment and induction process. Records show that John did not disclose his mental health condition, seek support from the University or give rise to any concern in his behaviour or academic performance throughout his first year of study.

In September 2020, the consultant psychiatrist who had oversight of the FEP team/clinic that supported John was seeking agreement from a colleague to oversee the service development aspect of the FEP work whilst they were on maternity leave. The email suggests that the clinical work would be subsumed into generic CMHT work. An email dated 16th October 2020 indicated that locum cover had been organized to cover the period of maternity leave in the main CMHT (the team providing care and treatment for John) and there is confirmation that this was in place. However, it is not clear whether the FEP clinic list was included in this. This is a considerable oversight. John's next two appointments were cancelled and there is no recorded contact or planned contact until his family proactively seek contact on the 23rd July 2021. It is reasonable to assume that in the absence of a care coordinator and substantive member of staff, John became lost to follow up in the period where there was locum cover. There was a pre-planned contact on 29th July 2021 which John did not attend.

Period three months prior to the index offence

On the 23rd July 2021 John's mother made contact with Mental Health services expressing concerns in respect of John's behavior since his return home from University (following completion of the first year of his course) indicating that he was not sleeping, pacing all night and had smashed his phone so any contact would need to be through his parents. It was agreed that he be seen at pre-existing appointment for 29th July 2021. At this point, plans were made in line with policy and communicated to the multi-disciplinary team in the event that there was further contact and requests for help prior to the planned appointment. Additionally, the Psychiatrist made efforts to contact the family. These efforts were not successful.

John did not attend his planned appointment with mental health services on the 29th July 2021 and health board records shared with panel indicate multiple attempts to contact him and his family by telephone were not successful. The family describe being vigilant of their phones at this time due to a family illness and report not being in receipt of any voicemails. The disengagement policy was followed in terms of communication with the multidisciplinary team and a plan put in place for proactive contact.

Discussions took place in the CMHT single point of entry meeting on the 2nd August 2021 where it was agreed that Practitioners would continue to attempt to make contact with John or his family and if contact had not been made in the next week, then a home visit would be made with the psychiatrist.

Contact was made with John's mother on the 3rd August 2021 where she reiterated her concerns around John's behavior and reported that, over the last 7 weeks since he had returned from University, John had been pacing all the time and not sleeping, he has also been talking and laughing to himself and writing. She reported that believed that John had not taken his medication in over a year and that he was also being aggressive towards the family.

A home visit was conducted by a Social Worker and a Consultant Psychiatrist on 4th August where John was seen and there was an opportunity to speak with his parents. The reports indicated that there were some successes (completion of the first year of the University Course but recent stress around finishing final assignment). There was also evidence of indicators of relapse in the context of recent psychosocial stress and planned discontinuation of medication (whilst the psychiatrist had planned a discontinuation it had not been prescribed or instructed; the information outlined above indicates that John had not been seen and had been lost to follow up between June 2020 and July 2021. He therefore discontinued without professional support and oversight). Practitioners did not feel John was in a crisis situation and provided a prescription for two weeks of antipsychotic medication and night sedation to aid sleep. A follow-up appointment was proposed within four weeks but this was, in fact, offered within three weeks. The family have reported that it would have been beneficial to have advice on next steps should John not take this medication.

John did not attend his scheduled appointment on 26th August. There was no response to attempts to contact multiple phone numbers. A letter was sent requesting updated contact details.

John enrolled on the second year of the University Course on the 15th September 2021. At this time, John had moved into shared student accommodation (private rental) outside of the treating Health Board's footprint. Due to lack of engagement with the course, University procedures were followed to proactively encourage re-engagement and multiple attempts were made to contact him. John did not respond and was, according to procedure, referred for withdrawal due to lack of engagement on 13th October 2021.

It would appear that John's mental state continued to deteriorate and by November the timelines between agencies begin to converge. John's father was sufficiently concerned in early November that he made further contact to seek advice from the

CMHT. Appropriate advice was given around seeking support in a crisis. The advice regarding pathways to care was, however, complicated somewhat by John residing in a neighbouring Health Board and by John's interrupted engagement with the CMHT as well as the absence of a care coordinator. As such, the onus for seeking help was placed on John's family. The family have shared that, at this point, they were desperate for help and felt that their concerns were not heard. On 11th November, a female housemate reported John to South Wales Police following an incident of verbal and physical aggression (where John threw water over female housemate). The housemate indicated to officers that John's father had told them that John suffered with his mental health. The housemate was appropriately safeguarded but no contact was made with the mental health triage service to share or seek information at this point.

By the 17th November 2021 concern for John was increasing and his mother contacted South Wales Police to report concerns for his welfare having not seen or heard from him directly since October. Police logs indicate that backgrounds checks and intelligence were used to grade the call and determine the response (G2 priority response within one hour) in line with standard operational processes. Due to commitments to other calls, officers were not allocated to the call until 23:46hrs (the original call being made at 17:12 hrs.). However, during this time additional information was sought from John's mother in relation to his mental health and there was communication with the mental health triage team in the police Public Service Centre to confirm the diagnosis and severity of difficulty that John experienced in order to obtain an objective level of concern.

On 18th November 2021, secondary to further contact from John's parents, mental health services logged a missing person's incident indicating that John was vulnerable by virtue of his mental health needs and that their opinion would be that John would require an assessment under the Mental Health Act if located. John's family were kept informed by the Mental health administrative team.

South Wales Police commenced initial inquiries and a preliminary search for John. When John was not found, Police forced access to John's living accommodation on the afternoon of 18th November 2021. John was not inside but it was noted that there were notes which appeared to be of 'ramblings' and lots of pictures of naked women tied up in ropes over the walls. Due to the enquiries not providing any information regarding the location of John, and his reported mental health issues John was categorised as a missing person at 19:06 on 18th November 2021 and assessed as medium risk. Officers were tasked to assist with obtaining information from his parents.

On the 19th November 2021, a PCSO received a text message on their community mobile phone from staff at USW Students Union, Treforest to make them aware of a male that was acting suspiciously at the SU the evening before (18th of November). The PCSO attended a short time later and spoke to staff about what had happened and viewed CCTV of the male. It was reported that, when confronted by staff on the evening, the male gave his name as John, stated he was a student at a different University in Wales and was a DJ and wanted to view the equipment on site. John produced a bank debit card when asked for ID. This information was subsequently

passed to the PCSO on the 19th November, who searched on police systems and identified John as a missing person. The PCSO advised staff of this and advised to call 999 if he returned. On the 20th of November, the PCSO was notified by University staff that further interrogation of the CCTV had identified that John had in fact been on campus from 1300 hours on the 18th of November.

On 20th November 2021, John's father informed officers that they had barely spoken to their son since 19th September 2021. His father provided potential leads for John's location though it should be noted that in retrospective interviews with John's family, they felt that they offered more guidance to the police and offered to accompany officers to a location they believed that John could be inhabiting on the mountainside. Police records indicate that this was heard and a 'what 3 words' location (provides a precise location) was taken and integrated into the missing person enquiries. The records available indicate that this location was searched in the early hours of the 23rd of November and therefore does not appear to have been prioritised by officers undertaking enquiries. The family gave information to suggest that John had been involved with homeless people in Cardiff and wanted to create an art centre to help and support them with their artwork. The family believed he could potentially be with them or frequenting those areas. The family highlighted concerns regarding John's mental state, describing that although they felt it was unlikely that John would harm himself, they were concerned about his deteriorating mental health and that this could result in him using violence. Police reports indicate that John's history of violence was explored with the family and assessed as being a risk of verbal aggression and aggression to property.

Checks were undertaken by Police with Llandough Hospital (18th November 2021), UHW (18th and 19th November 2021) and Huggard Centre (18th November 2021), all negative. Confirmation received from an acquaintance of John's that he had been active on Facebook that day (18th November 2021).

John was classified as a missing person and was considered to be medium risk. The rationale for this considered the information and intelligence known at that time. SWP policy in relation to Medium Risk Missing persons states, 'This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting' and this is evidenced in the entries on the Occurrence log. Police records confirm that the categorisation remained at medium consistently.

Although Police were able to ascertain John's mental health needs from existing information and the reporting person, they were not able to speak to John's care team directly despite an attempt to do so (clinicians were not available). There was some contact with the University to determine if John had been attending prior to him being sighted by Student Union staff but no evidence of a call back from the University to police. The family view was that more resources could have been given or a more concerted effort expedited. This would have required a different categorisation under the Missing Persons policy. This was explored at the Learning Event in terms of whether additional information such as more specific detail regarding John's mental health

needs, would have elevated this risk categorisation. It was concluded that there was no additional information that would have increased the grading of risk.

It is known that, at this time, John was still frequenting University premises. He had booked a well-being appointment on the 15th November for the 18th November but did not attend the virtual appointment; the co-ordinator attempted to make contact with John via his mobile phone with no success. John had also used services in the student union building.

Appropriate and sustained efforts to locate John continued. These included open-source checks on social media and foot patrols conducted at locations John may have been frequenting. A Facebook appeal was considered but records indicate that John's family were concerned that this could push John further away from them, so the offer was declined on 21st November 2021. South Wales police record systems indicate that on 21st November 2021, Detective Sergeant gave clear instruction for concerted effort under missing person's policy with repeat visits to frequently visited locations, the student residence, checks on belongings, homeless shelters and hospitals.

On the 21st of November, a Public Protection Notification (PPN) pertaining to the incident involving John and his housemate on the 11th November 21 was submitted by the attending officer as no contact had been made with John and they were aware of the further reports relating to him. The police staff member assessing the PPN noted the report made by mental health services on the 18th of November regarding concerns for John and recorded that there was no requirement to share the PPN, the rationale being that the Health Board were already aware of the concerns for him. Whilst Health Board colleagues were aware of John's history and some of the recent concerns, they were not aware of the pictures found in his room when entry was forced by police. Similarly, whilst Police were aware of some concerns, they were not aware, for example, of the information held by the Health Board that documented John having 'strange thoughts about women' or abuse directed towards his mother. This, along with other points in the timeline, were missed opportunities to bring these pieces of information together, to provide a holistic understanding of the nature of John's thoughts and actions towards women. Had information been shared, this may have changed the context within which agencies received and understood certain information about John.

These checks continued until John was arrested for the murder of June.

At 14:45 on 21st November 2021, June's daughter contacted 999 to report the discovery of her mother's body in the family home.

Following the incident, the Immediate Response Group Protocol was not invoked and this was discussed in the learning event.

The criteria for invoking the critical Incident Policy is outlined in the CTM Safeguarding Board policies as:

A critical incident (for the purposes of this protocol) can be defined as an event, or series of events;

1. That is sudden, unexpected and out of the realms of common human experience; **and**
2. it has resulted in (or could have caused) death, life threatening injury or sustained serious and permanent impairment of health or development; **and**
3. an immediate effective response requires multi-agency co-ordination to manage threat, risk, harm and the impact on a group of individuals and/or the wider community.

The nature of this incident would meet the criteria outlined above however on this occasion the protocol was not invoked and the rationale for this is not clear. The police were the agency who were first in receipt of the information about the murder and usual circumstances would have commenced conversations in a timely way with the safeguarding board regarding formation of an IRG. However, panel members have not been able to find any record of such conversations in any of the agencies partnered with the safeguarding board.

Practice and Organisational Learning:

Learning from Contextual Information (pre-timeline)

In terms of monitoring student well-being, engagement is one means of assessing this. The University in England have shared that the system for alerting to possible well-being or engagement needs has now changed, and student attendance and engagement are monitored through two parallel systems: My Engagement and My Attendance, where interventions are triggered if a student drops below the certain threshold.

Learning Theme One: Communication

The learning event identified that there was an overarching theme of communication. There were limits to the flow of information between all agencies including education, health, local authority and police, and between agencies and John and John's family. On occasion, the sharing of information was limited by practice and process at the time (for instance between HEIs). In other instances, problems with information sharing were based on myths and misunderstanding about when information can be shared, and assumptions about where information goes and how much information is held by partner agencies.

The learning event identified that 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 was noted in the review that there were differing accounts in respect of the perception of John's mental health recorded in different databases. This prevented professionals involved in John's care all being able to access the same information. The use of a single care record would provide everyone involved with all the information relevant to support and decision making.

Higher Education Institutions

Although not directly linked to this incident, there has been parallel learning from sector review that is pertinent to the issues identified in the current review. As such they are listed here for consideration:

- This is a recognised challenge in the Universities UK Minding our Future 2022[4] report, which stated 'that while the NHS is starting to consider students as "an atypical population" there remains significant difficulties in relation to co-ordinating care between providers and the NHS.

- The issue of information sharing between Higher Education and the NHS is considered in a published report in 2023, following the Children, Young People and Education (CYPE) Committee review of Mental Health Support in Higher Education[5]. A chapter of the report is dedicated to the issue of information sharing between agencies in the pursuit of effective support provision for students. In particular the report makes two specific recommendations identifying a need for the development of a shared understanding of the roles and responsibilities across healthcare and education for student mental well-being, and to establish effective data sharing protocols between higher education providers and the NHS in relation to mental well-being (recommendations 23[6]& 24[7]):

- Further, the 2023 CYPE committee report recognises as good practice the development of the pilot Mental Health University Liaison Service established in March 2023. The benefits of the data sharing arrangements between HEI and NHS, referral pathways and building relationships to reduce the risk of students falling between gaps in service is recognised in the recommendation to build on this learning and plan for full roll-out of the model across Wales (report recommendation no.25)[8].

[4] https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/minding-our-future-starting-conversation

[5] Mental Health Support in Higher Education (senedd.wales)

[6] CYPE Recommendation 23: "The Welsh Government starts scoping work with the NHS and higher education sector on the development of a shared understanding of the roles and responsibilities across healthcare and education for student mental well-being. This must encompass agreement on thresholds, language and definitions."

[7] CYPE Recommendation 24: "The Welsh Government in its first remit letter to the Commission asks the Commission to take the lead in establishing effective data sharing protocols between higher education providers and the NHS in relation to mental well-being."

[8] CYPE Recommendation 25 "The Welsh Government, HEFCW and the incoming Commission should build on the learning and evaluation from the Mental Health University Liaison Service in Cardiff and start planning for a

- A draft framework for information sharing between Welsh Universities and South Wales police exists based on the Wales Accord on the Sharing of Personal Information (WASPI). There are recognised weaknesses with its implementation, specifically identifying key contacts to request and provide information. The learning from this report about HEIs contact with family members of significant others, would support this shortfall being addressed.

- Universities should remain committed to contributing to the on-going work of the new commission for tertiary education and research, exploring how institutions can support students to disclose mental health conditions (recommendation no.14 of the CYPE report)[9]

- Specifically, under guidance from the new Commission for Tertiary Education and Research, contribute to the development of a shared understanding of the responsibilities across healthcare and education for student mental well-being, and the establishment of data sharing protocols. This will be informed by the continued investment and work of the Mental Health University Liaison Service for the Cardiff region.

Examples of limits to the flow of information between organisations/agencies

- The limited connectedness between different Higher Education Institutions (HEI) and between HEIs and agencies means that information about John's well-being and his mental health needs could not be shared.

- The extent of John's needs was not known by the University in Wales. The University that is within focus of this review was proactive in the range of activity to engage students to disclose mental health conditions and take up support prior to, during, and after enrolment. Nevertheless, it is recognised that there are multiple reasons why students choose not to disclose.

- The learning event highlighted differing thresholds across agencies in respect of the determination of risks to the public. The impact of the varying thresholds

full roll-out of this model across Wales. As part of this planning, long term funding should be committed to support full roll-out, development and maintenance of this model across Wales."

[9] CYPE Recommendation 14 In developing the supporting student welfare registration condition, the Welsh Government, the Commission, and Higher Education sector collaborate to explore how institutions can support students to disclose any mental health conditions. This may reflect examples of existing practice in providing multiple opportunities through the application, induction and welcome process for students to declare an existing mental health condition.

and agency specific decisions regarding information sharing means that no single agency had all of the relevant information that would have facilitated a comprehensive understanding of risk to self and others. It is clear that no one could have predicted the act of violence that occurred, but taken together, all of the information pointed to someone who was experiencing a significant and insidious deterioration in their mental state who had also expressed unusual beliefs about and acts of aggression towards women.

- Health Boards and Local Authorities should consider how information reaches the clinical team in a way that guarantees it is seen, acknowledged and acted upon. Practitioners in the learning event highlighted that PPN notifications are sent to the relevant locality team for screening and may, following screening, be filed in medical notes or elsewhere before they are seen by the treating team. Clinicians working at pace or away from clinical records would not have an opportunity to see this and this would prevent a timely review of clinical need.

- The learning event noted that, generally speaking, there can be variable quality and detail in PPNs and in the recording of information. Whilst there is a clear process for determining whether PPNs are shared with partner agencies, it transpired that this may be based on an assumption that information is already known. For instance, officers knew that mental health services were aware of John and that he was open to their care, so they did not share the PPN from the incident of aggression with the female housemates. However, the detail in this PPN may have alerted a system where someone was lost to follow-up, or living in a different location, and may also have alerted to potentially useful information regarding clinical profile and need. Health Board colleagues alerted the learning event to the problems in the use of multiple systems within the Health Board such that if someone is conveyed to A&E and therefore it is determined that a PPN is not required, A&E do not have a standard process that would support this being reported to colleagues in mental health. The police were not aware of this.

- Historically, there has been the use of mental health practitioners across agencies, for instance in control rooms. In this case (and others), this was used (where requested) to support a more accurate picture of John's mental health needs. This function is now provided by 111 press 2.

Limits to methods of communication to service users and their families

- John's family highlighted that being naïve to mental health difficulties it was very difficult to know what terminology to use, what to expect from services,

where services were located. There is no evidence that they were provided with this information. Their only point of contact was the police (in times of behavioural disturbance) or the CMHT duty desk. This would now be the 111, press 2 option.

- The timeline and learning event identified that, in this case, mental health services relied on traditional systems of contact that do not communicate openness or facilitate accessibility. This is typically via 'motivational letters.' Young people have expressed that they would prefer to text or email services. John expressed that other ways of making contact would have been helpful for him.

Communication with family

- In terms of learning from the events and experiences before the timeline commenced, there were issues in the communication of concern from the University to John's family. The University in England have advised that in 2021 the University revised their policy and should a similar situation now arise, the identified Emergency/Trusted Contacts would be contacted and notified. Furthermore, it is expected practice to invite those trusted persons to contribute to a coordinated support meeting. Any exception to that practice must be discussed with a duty manager and the rationale recorded.

- Whilst contact was made by the Health Board with John's family, this was often with the intention of acquiring collateral information. There was limited documented evidence that the family's needs were considered despite them describing the direct impact of their son's symptoms and difficulties (such as aggression towards their property and belongings, increased concern and worry, and derogatory references to his mum). In line with best practice guidelines, support for carers should be provided around diagnosis and how to identify and manage signs of relapse/illness. Clearly there are issues of consent. Health Boards should be clear that the patient must consent to sharing clinical information, but the Mental Health Measure makes clear reference to support for carers in their own right such that general information, advice and guidance about conditions can be provided to carers.

- The Health Board now have a formal service in place (with appropriate governance) delivering care to those experiencing a first episode of psychosis (FEP). The Standard Operating Procedure (version 2) for this service (dated 2023) outlines that support would be provided for families and carers including informal support and behavioural family therapy and systemic psychotherapy.

- It should also be noted that when a patient disengages and carers have not been offered an intervention or point of contact in their own right, there is no source of support to families/carers/significant others and also no flow of information from the family regarding the disengaged patient.

Learning Theme Two: The use of statutory processes to aid care

The review and the learning event identified that 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. This is an area for substantial improvement.

- Early on in the inpatient process, there was evidence of good practice in terms of early discharge planning and consideration of community care. However, the pathways between the respective services were not effective meaning that there were gaps in care and missed opportunities for consistent care.

- There was insufficient contact and partnership with the family in facilitating discharge for inpatient services. This is understandably a source of significant dissatisfaction for the family.

- The Community Mental Health Team processes did not allow for the timely or robust provision of care and treatment. There were a number of aspects to this:

    - The FEP team was, in fact, not a service at this time. Services should be minded that where special interests or pilot schemes exist, there should be stakeholder engagement and awareness and interim governance processes in place to ensure quality and patient safety.

    - As above, the Health Board now have a formal service in place (with appropriate governance) delivering care to those experiencing a first episode of psychosis (FEP). The Standard Operating Procedure (version 2) for this service (dated 2023) outlines inclusion and exclusion criteria, roles, responsibilities and function of the team. In specific regard to this incident this is therefore addressed but learning will still need to be taken in respect of any future pilot project.

    - No clear delineation between Part One and Part Two of the Mental Health (Wales) Measure 2010[10]. Information provided by the family coupled with John's presentation indicated the need for a period of specialist mental

[10] gen-ld8880-e-English.pdf (senedd.wales)

health care. Records indicate that despite the requirement for multidisciplinary involvement and that this care would be provided by Practitioners in a Secondary Care service, a Care and Treatment Plan was not offered. This meant there was a missed opportunity to use the relationship with a Care Coordinator to provide consistent monitoring of medication and its efficacy, to increase insight, to develop a relapse signature and crisis contingency plan, and to signpost to other elements of evidence-based intervention such as CBT and Behavioural Family Therapy.

- There was inconsistent use of the disengagement policy. There were periods where there was no contact with the service. Some of these were attributable to the service's lack of contact and some to John (though the reliance on written information and phone calls in the absence of a more contemporary system means that this is not always an effective means of contacting service users). Where Practitioners did follow the disengagement policy, it was more effective.

- Several clinics were cancelled. The Reviewers could assume that some of these cancellations were due to COVID. Others appeared to have been cancelled due to limited cover during the substantive Consultant's period of maternity leave. The cancellation of clinic policy would have guided service leads to have managed this. Cancellation of clinics should always benefit from clinical oversight and review. Records indicate that cover was provided for the Consultant while on maternity leave but it seems that the FEP was not picked up. The substantive Consultant is to be commended for the timeliness of their re-instatement of this clinic on their return. At the same time, the lack of contact from the service in the interim period could have affected John's trust in services and belief in the treatment models. Although the clinical plan would have included the reduction and cessation of medication following a first episode of psychosis, John did not benefit from monitoring and guidance during the period of withdrawal and subsequent relapse.

Learning Theme Three: The provision of evidence-based care including the involvement of significant others.

- In relation to the clinical management of a first episode of psychosis, NICE Guidelines indicate the need to offer family intervention as a frontline intervention alongside individual Cognitive Behavioural Therapy. Neither were offered in this case. All intervention focussed on psychotropic medication with no signposting to psychosocial interventions. Opportunities were missed to

apply the principles of Early Intervention – of establishing engagement, increasing hope, and facilitating awareness of risk of relapse. All of these could have helped John have faith in services and persist in his efforts to contact services during the subsequent relapse[11].

- The Health Board do now have a formal service for people experiencing first episode psychosis. The SOP for this service indicates that all of this would be available for people aged 14 - 35 that are able to access this service.

Learning Theme Four: Working across localities

The review and the learning event revealed that there is no identified mechanism for sharing information or delivering shared care when a person moves into another health board on a temporary basis such as, in this case, moving to University.

The responsibility for primary care support was transferred to an alternative GP however this did not include transfer of the mental health support to secondary care. The substantive consultant did make efforts to provide information about pathways to care in neighbouring health boards and made proactive contact with such services. A standardised process addressing this and facilitating shared care for those moving between health board areas on a temporary basis would be more robust. The learning indicates that this is broader than the treating health board and indeed, broader than those resident in Wales.

Learning Theme Five: Confidence in services

The learning event identified that for all 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.

John shared with the reviewers prior to the learning event that the inability to contact the service and the significant gaps in service provision undermined his trust in services and meant that he proceeded with changes to his clinical regimen with no advice, consultation or monitoring.

This case has highlighted that there is a reluctance on applicants for University to disclose any identified mental health issues. This was evident in the University in both England and Wales. Students need to be assured that disclosing such information will not have a negative impact on their application or be stigmatised but will be supported with the correct intervention or support to meet their needs.

Learning Theme Six: Managing post-vention

[11] Recommendations | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

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.

Both the learning event and conversations with family, friends and local councillors have informed this analysis. It is acknowledged that there is a very low base rate of such serious incidents and therefore any action associated with this learning needs to be proportionate.

- 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. Whilst it is acknowledged that, in the context of a murder investigation, the disclosure of information into an IRG must be considered very carefully, the majority of the difficulties and distress listed below could have been minimised or managed by the use of the IRG process.

- Those who were closest to this incident all reported negative experiences of the media including social media. Both families expressed the view that the fear of the media was considerable they were concerned that the media would be 'hounding them.' An IRG could have covered this.

- A good deal of attention comes towards local Councillors as a point of contact and yet such individuals told reviewers that they did not have media training or comms support. This could have been detrimental to the investigation.

- There is considerable impact on the ecosystem or community surrounding such rare and serious incidents. This incorporates direct family members, friends, neighbours, local community including schools. Members of the Learning Event highlighted the support that was afforded by South Wales Police and there were elements of this that members of the Learning Event felt were good practice. For instance, it is unusual for the perpetrator's family to be supported by police personnel but, in this case, a single point of contact was provided, and once requested by John's family there was proactive engagement to ensure that they were prepared for what would be presented in court. At the same time, there were limits to the support that meant that there were a number of affected individuals experiencing high levels of distress that were not able to access help in a timely way. Pam was the first person to discover June's body and had been at the property with her young son that day. Despite being exposed to a Type 1 Traumatic Life Event, she was not automatically entitled to formal and skilled psychological support in the same way that a first degree relative would be. Moreover, Pam was trying to manage

a child with ASD and special needs whilst managing her own emotional needs and the acute sequelae of being exposed to a traumatic life event. No support/respite was afforded to them to help this become more manageable. This could have been identified by an IRG had one been held and represents a missed opportunity.

- John's family have also experienced a loss and describe dealing with guilt and shame as well as the bewilderment of what has happened. Subsequent to some support from South Wales Police (in the form of a point of contact in SWP). John's family members attempted to seek help to support their own mental health and experienced multiple barriers including being told that Primary Care Mental Health Services "don't deal with this." Their needs remain unmet. Had an IRG been called, the Health Board could have proactively met their needs.

- The broader impact of such a serious incident in a small community has not been measured and, outside of South Wales Police (who undertook actions within the community in line with their Community Impact Assessment), organised interventions were not put in place to support the wider ecosystem. For instance, in their role as Governor of the local school the Local Councillor reported that they had been contacted by the Head Teacher with concerns about how they would advise staff and children immediately following the murder (before John was found and arrested) and how to support children who may be distressed by reports of the incident.

Improving Systems and Practice (National, Regional and Local):

To promote the learning from this case the review identified the following actions and anticipated improvement outcomes:

Learning Point One: Communication

1.1 Universities to provide South Wales Police with single point of contact details for enquiries relating to missing persons who are students.

1.2 Review the SWP/HEI data sharing agreement scope and audit impact of implementation effectiveness.

1.3 Contribute to the work led by the Commission for Tertiary Education and Research to explore how institutions can support students to disclose mental health conditions.

1.4 The need to cascade the recommendations outlined in the published report on sharing information between Higher Education and the NHS is considered

in a published report in 2023, following the Children, Young People and Education (CYPE) Committee review of Mental Health Support in Higher Education.

1.5 South Wales Police should ensure that messaging to officers continues; that when responding to incidents where concerns are raised regarding a person's mental health, action should be taken to identify whether the person is known to mental health services to better understand the associated context, concerns and/or risks. (At the present time, the mechanism for this would be the NHS 111 Option 2 Service).

1.6 South Wales Police should review the rationale not to share information based on an agency's existing involvement with a person / case in the decision making on whether to share information with other agencies.

1.7 'It is recommended that partners of CTMSB, including police, health and Local Authority review the current regional process for sharing Public Protection Notices (PPN) to ensure those with a mental health element are shared with the multi-disciplinary team MDT) for review of clinical implications and safeguarding. This should include a Health Board process for ensuring there is easy access to this information on a clinical system.'
These processes should be subject to audits to provide assurance that they are safe and effective.

1.8 With support from WG, the Health Board and Local Authorities should address problems associated with the use of multiple patient information systems (e.g. FACE and WCCIS) which affects effective information sharing and clinical decision making.

1.9 Clinical notes (FACE, WCCIS) should clearly document the rational of decisions making specifically in relation to the rational when declining a referral.

1.10 Communication with patients and families with FEP team should follow a more assertive outreach process around active engagement. This is now addressed by the fully established FEP service.

1.11 The Health Board should consider different and contemporary mediums of communication with all service users, but particularly young people, considering mediums such as text messages or email.

1.12 In line with best practice guidelines, support for carers should be provided around diagnosis and how to identify and manage signs of relapse/illness.

1.13 South Wales Police and Health Boards should work together to map the processes available that allows partner agencies to obtain clinically relevant

information in a timely way. This is to include escalation processes when this is not possible.

2. Learning Point Two: The use of statutory processes to aid care

2.1 Any special interest/pilot schemes or services should ensure interim governance processes are in place. These should cover inclusion and exclusion criteria and reporting arrangements as well as a forum in which to resolve professional disagreement (e.g. referral processes).

2.2 The Health Board should review & update 2018 MH36 policy "Mental Health Measures Parts 2 and 3 Care and Treatment Planning (CTP) and Re-access for Assessment Local Policy" and link to the Operational policies across the Health Board such as MH56 policy "Acute In-patient Admission Ward Operational Policy" and "CMHT Operational Policy" in order to ensure:

i. Clear delineation between part 1 and part 2 of the MH measure (when, who, what is completed).
ii. Clear pathway between acute services (inpatient ward & CRHTT) and the community teams.

2.3 The Health Board should review & update CMHT Operational policy to ensure:

i. The criteria for being accepted into a CMHT is reviewed so the community support needs of people with mental health problems are being appropriately met.
ii. There is clear guidance around the responsibilities and accountability of CMHT practitioners when allocated cases.

2.4 The Health Board should develop a standardised procedure (including escalation processes) to ensure that procedures are in place to fully cover Consultants' commitments (including special interests) when there are extended periods of leave (long term sickness absence, maternity leave, career breaks).

The Health Board have already reviewed and updated the Cancelled Clinic Policy and its implementation to ensure that there is oversight and risk assessment of people who have their outpatient's appointment cancelled.

3. Learning Point Three: The capacity to offer evidence-based care including the involvement of significant others.

3.1 NICE Guidelines indicate the need to offer family intervention as a frontline intervention alongside individual Cognitive Behavioural Therapy for people with psychosis. This did not happen in this situation. It is suggested 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.

The Health Board's SOP for the FEP service is noted (see learning theme three). It is therefore recommended that this is subjected to audit to provide assurance that this has improved. The Health Board should also provide information on how the needs of families sitting outside of the now established FEP service are met.

4. Learning Point Four: Working across localities

4.1 It is recommended that a protocol is developed between Health Boards and Local Authorities to facilitate the sharing of information and the continuation of care when a person moves to another Health Board on a temporary basis e.g. to attend University. This would need to accommodate both relevant patients and patients under part one of the Mental Health Measure.

5. Learning Point Five: Confidence in services

5.1 It is recommended that the Health Board consider their principles of co-production and/or learn from neighbouring Health Boards that are engaged in co-production exercises. 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.

5.2 Increasing access to evidence-based intervention should be a key priority and the Health Board should audit its current position in regard to this and form an improvement plan (see recommendation three).

5.3 Welsh Government /NHS England/Wales to consider including in any future mental health campaign the specific learning from this review concerning the need for prospective students who have either health or mental health issue to feel confident in disclosing the information within their application for University to ensure that they have the necessary support to allow them to reach their true potential.

6. Learning Point Six: Managing post-vention

After the incident, an IRG was not convened and therefore there was no multi-agency response to manage the situation and the associated risk and harm in relation to a group of individuals.

6.1 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 or not an IRG should be held. This should include identifying an escalation process when there is divergence of view and where there are sensitivities (e.g. a murder investigation).

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

6.3 As part of this process, the Health Board should work with multi-agency staff to ensure there is a procedure in place to ensure: -

i. Thorough and timely investigations are in place.
ii. Families of those affected by serious incidents are supported and regularly updated on the progress of investigations.

Final Learning Point

The Reviewers and Panel members involved in this SUSR are aware of a minimum of four reviews associated with mental health homicides being commissioned within this region between 2018 and 2021 and would recommend that Welsh Government conduct or commission a thematic review of the learning emerging from these incidents to identify common themes and associated actions.

Where panel are aware of learning and recommendations emerging from such reviews, these have been noted.

Dissemination

Date circulated to relevant policy leads:

Organisation	Yes	No	Reason

Single Unified Safeguarding Review process

The Safeguarding Board followed the process outlined in the draft statutory guidance for the Single Unified Safeguarding Review in inviting independent representatives from all agencies with prior involvement with the person/s subject to this mental health homicide to engage in the process. Representatives from the following agencies became panel members:

- South Wales Police
- Cwm Taf Morgannwg University Health Board
- Rhondda Cynon Taf Local Authority
- University of South Wales

The Reviewers were recruited from neighbouring local authorities and health boards and acted in a non-partisan role in reviewing the timeline, facilitating the learning event and hearing from families and significant others.

As noted above, practitioners with direct involvement with those individuals subject of this review between March 2019 and November 2021 were invited to and attend a Learning Event. The views of the families, significant others and the perpetrator were represented by the Reviewers at the Learning Event.

The Reviewers compiled the report identifying the learning and recommendations and an action plan has been produced.

Final confidence check

This Report has been checked to ensure that the Single Unified Safeguarding Review process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication ☐

For Welsh Government use only

Date information received:

Date acknowledgment letter sent to Board Chair:

Date circulated to relevant inspectorates/Policy Leads:

Agencies	Yes	No	Reason
CIW	☐☐	☐☐	

Estyn	☐☐	☐☐	
HIW	☐☐	☐☐	
HMI Constabulary	☐☐	☐☐	
HMI Probation	☐	☐	

Statements of Independence

Statement of Independence by Reviewer(s): Please read and sign the following statement. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES
Reviewer 1: Angela Edevane **Reviewer 2: Dr Liz Andrew**
Statement of independence from the case *Final check statement of qualification* I make the following statement that prior to my involvement with this learning review: • I have not been directly involved in the case or any management or oversight of the case. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer. • 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 recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies. • I have read and understood the 7 Nolan Principles and will apply accordingly. •
Signature:    **Name: Angela Edevane, Head of Adult Social Care, Merthyr Tydfil CBC** **Date: 24/07/24**      **Name: Dr Liz Andrew, Consultant Clinical Psychologist, ABUHB** **Date: 24/07/24**

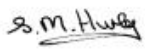
Statement of Independence by Chair of the Review Panel:
Please read the following statement and sign below. Consider the section on independence in the SUSR Statutory Guidance before completing. Single Unified Safeguarding Review (SUSR): draft statutory guidance | GOV.WALES

Final check statement of qualification

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- 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 recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.
-

Signature:



Name: Sue Hurley, Independent Chair
Date: 24/07/24

Appendix 1

Review Panel Members

Number of times the Panel met: **10**

NAME	TITLE	ORGANISATION	CONFIRM INDEPENDENCE
Sue Hurley	Independent Chair		X
Barbara Firth	Independent Advisor to the Panel		X
Liz Andrews	Independent Reviewer Consultant Clinical Psychologist	Aneurin Bevan Health Board	X
Angela Edevane	Independent Reviewer Head of Adult Social Care	Merthyr County Borough Council	X
Tracy Carlson	Consultant Clinical Psychologist	Cwm Taf Morgannwg University Health Board	X
Steven Hoare	Team Leader, Primary Care Mental Health Support Service	Cwm Taf Morgannwg University Health Board	X
Claire O'Keefe	Head Of Safeguarding	Cwm Taf Morgannwg University Health Board	X
Kate Riley	Services Manager, Adult Safeguarding	Rhondda Cynon Taf County Borough Council	X
Sharon Jones	Director of Student Services	University of South Wales	X

Beth Aynsley	Protecting Vulnerable Person Manager	South Wales Police	X

Appendix 2

Terms of Reference

Purpose of the Review

The draft statutory guidance for the Single Unified Safeguarding Review (SUSR) requires the Regional Safeguarding Board to undertake a SUSR when:

- A homicide is committed, and the alleged perpetrator has been in contact with primary, secondary, or tertiary Mental Health services within the last year.

In this criteria 'contact' may include an assessment or intervention. Specific consideration must also be given to the Mental Health (Wales) Measure 2010 which defines the provision of mental health services to patients in specific situations. NHS Wales responsible bodies are required to report certain incidents to Welsh Government through the NHS Wales National Reportable Incidents Framework (NRI). It should be noted that a Mental Health Homicide would require such a referral. The SUSR will be considered to be an appropriate investigation for the purposes of the National Patient Safety Incident Policy. On the conclusion of the review, the findings from the SUSR should be reported back to the NHS Wales Delivery Unit via a "Learning from Events" form available on the Delivery Unit's website.

Circumstances leading to the Review

John was the perpetrator of a homicide in November 2021. The victim was not known to John. At the time, he was under the care of secondary care services. John had a brief history of contact with secondary Mental Health Services dating back to March 2019, when he was admitted to Royal Glamorgan Hospital as a result of

experiencing psychotic symptoms which were described as negative symptoms of schizophrenia. Following a 3-week period of support as an inpatient and one week of intensive home treatment, John was followed up by the Taff Ely Community Mental Health Team (CMHT) through contact with a consultant psychiatrist.

Agencies Involved

The following agencies were involved with John and will be completing a timeline and analysis of their involvement:

- Secondary Mental Health Team
- Primary Mental Health Team
- South Wales Police
- Cwm Taf Morgannwg University Health Board
- Rhondda Cynon Taf, Adults Social Services
- University of South Wales
- University West of England
- Psychiatrist (Clinical Director) – possible co-opt as expert advisor as required.

Consideration in relation to if the Cwm Taf Morgannwg Safeguarding Immediate Response protocol should have been initiated in relation to this incident due to the children involved and managing the community impact.

Review and Panel Objectives

Specific process tasks of the Review Panel:

- Agree the time-frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s 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 reviewer/s contact arrangements with the family members prior to the event.
- Receive and consider the draft 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. Consideration needed in relation to the terminology used within the report in relation to the victims and perpetrators discussed within the same.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the CTMSB for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

The Core Tasks of this Review Panel are to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the Board.
- Examine inter-agency working and service provision for the individual, victim and family members where appropriate.
- Determine the extent to which decisions and actions were individually focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Determine if the coronavirus pandemic had any impact on the circumstances of this case.
- Consideration in relation to the impact on the Community (not non-statutory bodies).
- Cross-boundary arrangements – consider issues due to John living in a different local authority to the services where he was receiving support.

Additional questions to consider:

- What decisions could have been made and action taken by agencies to prevent or manage the potential risk of serious incidents?
- What consideration could have been given to past incidents that could have predicated this incident?
- How effective were agencies in identifying and responding to both need and risk?
- What appear to be the most important issues to address in identifying the learning from this specific homicide?
- Are there lessons to be learnt from this case relating to the way in which agencies work to safeguard victims (individuals) and promote their welfare, or the way risks posed by and to individuals are identified, assessed, and managed?
- Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?
- What might be the barriers for agencies in working more effectively with adults with mental health issues?

Any Parallel Reviews or Other Such Activity to be Noted

Early warning notification was submitted to Welsh Government.

This has been reported as a National Reportable Incident and there will be a Route Cause Analysis undertaken which should be completed in September 2023.

Inquest – pending.

Criminal proceedings have now concluded.

Timeframe for the Review and Rationale

The timeframe set for the Review is 26 March 2019 to 21 November 2021

Need to consider all admissions to hospital – first presentation to MH services in March 2019.

Learning Event

The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

It is anticipated that the Learning Event will be held 20th June 2023.

Completion Date

The completion date set for the Review was December 2023, however, due to unforeseen circumstances and a new chair being appointed a delay was incurred in the review process. The new date set for completion is August 2024.

Tasks of the Safeguarding Board

- Consider and agree any learning points to be incorporated into the final report and the action plan.
- Send the report, action plan and summary timeline to relevant agencies for final comment before sign-off and submission to Welsh Government.
- A communication strategy will be required to support publication, medial interest and manage public response.
- Confirm arrangements for the management of the multi-agency action plan.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.