1 A Serious Case Management Review

This review relates to the death on the Isle of Man. Mrs K was killed by her son 'Mark' who also seriously injured his father Mr K.

The review concluded that Mrs K's death 'could not have been predicted or prevented'. There was learning for professionals and several opportunities that were missed.

The full report and recommendations are available on the IOMSB website

www.Safeguardingboard.im

2 Professionals were aware that:

1. Mr & Mrs K had a longstanding alcohol issue.
2. Mr K had suffered a brain injury at work which ended his career and inevitably Mrs K and Mark were considered his carers.
3. There were several incidents of domestic abuse of Mrs K by her husband which resulted in her requiring medical treatment.
4. Mark was a young carer and therefore a 'child in need' according to Children Act 2001

3 This incident occurred during a COVID-19 lockdown period in January 2021

Mark was home from University with his freedom to leave the family home restricted due to COVID-19 lockdown and his elderly grandmother had come to stay placing an extra caring responsibility on the household

Mark was using cannabis and his mental health had deteriorated. Mark had been arrested for lockdown breaches

Mark's friend and his mother made calls to the Crisis team to raise concerns about his mental health. An alert letter was sent to Mark's GP sadly Mark had changed GP so the letter was returned to sender. The letter finally arrived but Mark was already in custody.

4 Mark frequently witnessed domestic abuse

Research tells us that Adverse Childhood Experiences can affect a child's brain development and life chances.

Mrs K could not be persuaded to leave the abusive relationship, a greater understanding of domestic abuse (DA) survivors could have better supported her.

Mr and Mrs K were in denial about their alcohol issues and their need for support.

The Domestic Abuse Act 2020 and the subsequent training, will lead to an improved understanding Domestic Abuse issues. The new legislation gives the Police powers to act to remove perpetrators giving victims a chance to escape coercion.

5 Professionals were not communicating well

A 'think family' approach was not adopted and Mark's needs as a child, appear to have been overlooked.

The Domestic Abuse risk assessment was only used by the police and no other agencies and only in relation to the couple.

A review of the IOM Multi-Agency Public Protection Arrangements in 2016 recommended the introduction of a MARAC and although this is not yet in place, work is actively ongoing to set up appropriate public protection arrangements.

The School and GP were not routinely informed of domestic abuse taking place within the home.

6 Recommendations from the Report

1) Specialist and dedicated support services to support survivors of domestic abuse; including Independent Domestic Abuse Advisors.
2) Adoption across agencies of a shared, evidence- based risk assessment tool e.g. Safe Lives DASH risk checklist, and agencies building chronologies of incidents to build a picture.
3) Establish structures for multi-agency risk management meetings.
4) GPs and schools need to be aware of known issues at home. They can therefore support and help to risk assess.
5) Develop an awareness of the needs of young carers

7 Progress in some areas

The Isle of Man Justice Reform Act 2021 gives professionals greater protection when sharing information where there is a safeguarding concern, information should have been shared

The 2020 Isle of Man Domestic Abuse Act 2020 was enacted January 2023

Increased funding was made available to psychological services to ensure timely provision of urgent support.

The Isle of Man Safeguarding Board developed an Information Sharing Protocol to strengthen the sharing of information as it relates to safeguarding along with a myth busting guide.

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