

the **national confidential inquiry** into **suicide**  
and **homicide** by **people** with **mental illness**

Independent investigations after homicide  
by people receiving mental health care (2010)



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## Report Summary

In 2006 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) began working with the National Patient Safety Agency (NPSA) to examine the process of independent investigations after homicides by people in contact with mental health services. Our first report was published in 2008. In this second report we have reviewed the independent investigation reports published between 2006 and 2009 with the aims of:

- 1) To analyse reports published in 2006 in order to examine the process of independent investigations and produce some good practice guidelines.
- 2) Establish Strategic Health Authority (SHA) procedures for implementing independent investigation report recommendations.
- 3) To collate key themes emerging from the recommendations from reports published between 2006 and 2009.

## Summary of recommendations

### I. Process

1. In uncomplicated cases, independent investigation reports should be available within six months of conviction. Extensions to this time in complex cases should be agreed with SHAs.
2. Investigation panels should have at least three members with relevant expertise.
3. SHAs should appoint a person responsible for communication with all relevant third parties (particularly families and carers) throughout the investigation.

4. SHAs who commission an inquiry should make their inquiry panel aware of actions that can be taken if perpetrator consent to disclose information is withheld.
5. Inquiry report recommendations should be focused and specific to be of direct use to services. SHAs should be responsible for challenging recommendations that are vague or difficult to implement or monitor.
6. SHAs should prepare an action point implementation plan with deadlines. Review of the plan should ideally include the investigation panel.

## II. Key clinical messages

1. Mental health trusts should ensure; (a) full implementation of the CPA by all clinical teams (b) robust risk management processes are in place for all service users (c) information about risk is shared between all individuals, professionals and agencies, based on a protocol approved by the trust board.
2. Mental health trusts should ensure that they have guidance documents in place to disseminate best practice advice about responding to the risk of violence to others. Specifically, this should include guidance regarding; (a) informing family members, carers and other potential victims of the risk of violence from a service user (b) appropriate intervention/ management strategies for working with service users with delusional ideas about specific individuals.
3. Whilst respecting service user confidentiality, mental health trusts should encourage and support family/ carer involvement in a service user's care management. Carers should also receive assessments of their own needs, which should be reviewed on a regular basis to ensure that identified needs and agreed actions have been addressed.

4. Mental health Trusts should review the referral criteria for Assertive Outreach and similar services on an annual basis and should regularly audit service users who have been rejected by teams in order to ensure that criteria are flexible and services are responsive to local need.
5. Mental health Trusts should review inpatient/ residential services and policies to ensure that they are working in line with guidance relating to service user safety, paying particular attention to issues regarding sexual relationships, bullying and violence/ abuse.
6. At transition points, such as from ward to community or forensic to general services, there should be a care plan review, including future risk management, involving representatives from the receiving services/ agencies.
7. Trainee psychiatrists should be provided with the necessary training, support and supervision to fulfil their responsibilities in terms of risk assessment and effective communication of information when service users are discharged from services.
8. Mental health trusts should ensure the provision of comprehensive community forensic mental health services for the management of service users who present a risk of violence in the community.

# 1. Introduction

## 1.1. Background

The late 1980s and early 1990s saw the publication of a number of Inquiry reports on homicides committed by people who had been in contact with mental health services. One of the most publicised was 'The Report of the Inquiry into the Care and Treatment of Christopher Clunis' (Richie et al, 1994). Increasing media attention and public concern surrounding such incidents resulted in two major policy developments. The first was the Secretary of State for Health's decision to establish the Confidential Inquiry into Homicides and Suicides by Mentally Ill People in 1992. The second was the introduction of mandatory independent homicide inquiries (Health Service Guidelines [94]27 & Local Authority Social Services Letter (LASSL) [94]4, Department of Health, 1994).

There have been numerous criticisms of independent inquiries since their introduction including:

- they involve a retrospective analysis of incidents which is susceptible to hindsight bias (Prins, 1998; Szmukler, 2000; McGrath & Oyebode, 2005; Maden, 2007).
- they are case studies lacking a common methodology, which makes it difficult to compare reports (Petch & Bradley, 1997; Buchanan, 1999; McGrath & Oyebode, 2005).
- they are expensive and time consuming (Crichton & Sheppard, 1996; Eastman, 1996; Prins, 1998; McGrath & Oyebode, 2005; Maden, 2007).
- they often neglect the larger systems involved and focus on individual responsibilities which can be damaging to staff morale and lead to defensiveness (Maden, 2007).
- the quality of reports varies as does the way they are published (Crichton & Sheppard, 1996; Petch & Bradley, 1997; Prins, 1998; McGrath & Oyebode, 2005; Maden, 2007).

- the number of reports published does not match the number of homicides committed by people in contact with mental health services (Reiss, 2001; McGrath & Oyebode, 2005).
- the recommendations and lessons to be learned have become repetitive leading some to question their value (Eastman, 1996; Prins, 1998; Walsh & Higgins, 2002; Munro, 2004; Maden, 2007).

In two major reports ‘An Organisation with a Memory’ (Department of Health, 2000a) and ‘Building a Safer NHS for Patients’ (Department of Health, 2001a) there was acknowledgment of many of the criticisms of the independent inquiry process, describing the system as, “...adversarial, does not lend itself to a learning environment and does not meet the needs of the victims’ families for support and information” (Department of Health, 2001a). These reports provided details of proposed changes to the process of dealing with adverse incidents within the NHS including the introduction of a new national system for reporting and learning from such events and the establishment of a National Patient Safety Agency to oversee the system. They also signalled a move away from the adversarial approach focusing more on learning lessons in an open, blame free (when possible) environment and using standardised root cause analysis techniques to look at whole systems rather than concentrating on individual human error.

In June 2005 the Department of Health published new guidelines removing the necessity for an independent inquiry after all cases of homicide, with new criteria specifying that independent investigations should be conducted:

- “when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.”
- “when it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a

sufficient element of public scrutiny and involve the next of kin to an appropriate extent.”

- “where the SHA determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.” (Department of Health, 2005).

These guidelines again recommended the use of root cause analysis in order to facilitate an open environment for learning lessons and stressed the importance of appropriate communication, sharing of information and providing support and advice for the families and carers of both victims and perpetrators. Detailed advice supporting these guidelines was published by the National Patient Safety Agency (NPSA) in February 2008 (NPSA, 2008).

Since September 2006 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) has been working with the NPSA examining the independent homicide investigation process. In 2008 the NCI published its first report (NCI, 2008).

The report outlined that during the study period 2053 convicted homicide perpetrators were notified to the NCI (for offences committed 1 January 2002 – 31 December 2005). Ten percent of perpetrators were known to have been in contact with secondary mental health services in the 12 months prior to the homicide. Of these, 50 were cared for under the provisions of enhanced CPA and in six month contact before the offence. In 16, (32%) of these cases no independent investigation was commissioned. There were no significant socio-demographic or clinical differences observed between those who did and did not receive an independent investigation.

The NCI obtained copies of 39 independent investigation reports relating to 40 homicides incidents within the study period and analysed the recommendations made. There were over 500 recommendations across all 39 reports. The recommendations were collated and organised into the following six broad themes:

- clinical practice
- clinical procedures
- service management & support
- staff training
- working with external agencies
- serious untoward incident management

## **1.2. Current report**

The aims of the current study are as follows:

1. to analyse reports published in 2006 in order to examine the process of independent investigations and produce some good practice guidelines.
2. establish Strategic Health Authority (SHA) procedures for implementing independent investigation report recommendations.
3. to collate key themes emerging from the recommendations from reports published between 2006 and 2009.

## 2. Method

### 2.1. Sources of data

#### 2.1.1. The National Confidential Inquiry

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) is a UK-wide case series of all people who have been convicted of homicide and had lifetime contact with secondary mental health services. Whilst reporting data on those with lifetime contact, the NCI focuses particularly on those people who were in contact with secondary mental health services in the 12 months prior to the homicide offence.

The method used by the NCI is described fully elsewhere (Appleby et al., 2006). In brief, there are 4 stages to data collection:

1. Data on all perpetrators are provided by the Home Office Homicide Index
2. Information on perpetrators is sent to administrative contacts within each Trust nationally, to identify those perpetrators who had been in contact with services
3. Detailed socio-demographic and clinical data are collected via questionnaires sent to the clinical teams
4. Information on previous offences is collected from police national computer searches provided by Greater Manchester Police.

The response rate for questionnaire completion is over 95%.

#### 2.1.2. Independent investigation reports

The Strategic Health Authorities (SHAs) were contacted with requests for information about any reports published between 2006 and 2009. The majority of reports were obtained by downloading copies from the websites of the Strategic Health Authorities, NHS Trusts and local government/ councils (for serious case review reports).

### 2.1.3. Strategic Health Authority monitoring data

The SHAs were contacted by telephone and asked to provide brief information about the policies/ procedures employed to monitor the implementation of recommendations. Copies of all relevant policy documents were also obtained where possible.

## **2.2. Procedure**

### 2.2.1. Analysis of reports published in 2006

A detailed analysis of all independent investigation reports published in 2006 was undertaken in order to examine the clinical characteristics of the service users/ perpetrators and the process of conducting such investigations. Core NCI data were used as a source of information for the clinical characteristics of the service users/ perpetrators including:

- primary mental health diagnosis
- in-patient at time of homicide
- homicide within three months of discharge
- under enhanced CPA at time of homicide
- missed last appointment
- non-adherent with medication in the month before homicide
- previous detention under mental health legislation
- previous detention under forensic sections of mental health legislation
- time between last health service contact and homicide.

The following information was extracted from the independent investigation reports:

- date of the offence, conviction and publication of the investigation report.
- length of report
- investigation panel composition
- involvement of families/ carers.

### 2.2.2. SHA monitoring data

Contacts at each of the ten SHAs were telephoned and asked to participate in a short interview where they were asked about their monitoring procedures.

Questions included:

- “does the SHA have policies/ procedures relating to the implementation and monitoring of homicide investigation report recommendations?”
- “how and who monitors progress?”
- “are action plans used?”
- “are deadlines set for achieving actions on the recommendations?”

Detailed notes were taken during the telephone interviews with the Strategic Health Authorities. These were then reviewed along with all obtained policy documents in order to extract and summarise details of the procedures in place for monitoring progress.

### 2.2.3. Analysis of recommendations from reports published between 2006 and 2009

A thematic analysis was carried out on all report recommendations for the independent investigations published between 2006 and 2009. The recommendations were extracted from the investigation reports, collated and organised into 6 broad themes; additional sub-themes were identified where appropriate. The categories into which these themes were grouped were developed and refined through a series of consensus meetings with senior NCI clinical staff.

## 3. Results

### 3.1. Process of investigations: reports published in 2006

A total of 28 independent investigation reports and 1 serious case review published in 2006 were identified. In 1 case the independent investigation report presented details of 2 separate homicide cases.

#### 3.1.1. Social and clinical characteristics

The majority of homicide perpetrators were male (n=26, 87%). The mean age of perpetrators at the time of the offence was 32 years (range 15-60, median=31). Two of the perpetrators had previous convictions for homicide.

There were a total of 32 victims. Twenty eight (93%) perpetrators killed one victim, 2 (7%) killed two victims and in one of these cases the perpetrator was also convicted of attempted murder. The mean age of victims was 40 years (range 6-84, median=37).

In nearly a quarter of cases the victim and perpetrator were strangers (n=7, 23%). In 8 cases (27%) the victim and perpetrator were spouses/ partners, a further two (7%) were ex-spouses or partners and for three (10%) cases the victim was the parent/ step parent. In two (7%) cases the relationship between the victim and perpetrator was prostitute to client. In one (3%) case the victim was a health care worker known to the perpetrator. In the seven (23%) remaining cases the victims and perpetrators were known to each other, for example they were friends, co-habitees, neighbours etc.

Table 1 presents a summary of clinical characteristics of the homicide perpetrators. The commonest diagnoses were schizophrenia (n=9, 36%) and personality disorder (n=9, 36%).

Table 1: Clinical characteristics of homicide perpetrators<sup>1</sup>

	n	%	95% CI
Primary diagnosis (n=25)			
• Schizophrenia / other delusional disorders	9	36	17-55
• Bipolar affective disorder	1	4	0-12
• Depressive illness	3	12	0-25
• Anxiety/ phobia/ panic disorder/ OCD	1	4	0-12
• Personality disorder	9	36	17-55
• Adjustment disorder	1	4	0-12
• Other (e.g. dementia, organic disorders)	1	4	0-12
In-patient at time of homicide (n=25)			
• Yes	3	12	0-25
• No	22	88	75-100
Homicide within 3 months of discharge (n=22)			
• Yes	4	18	2-34
• No	18	82	66-98
Subject to enhanced CPA (n=25)			
• Yes	11	44	25-63
• No	14	56	37-75
Missed last appointment (n=22)			
• Yes	9	41	20-61
• No	13	59	39-80
Non-adherent with medication in month before homicide (n=23)			
• Yes	7	30	12-49
• No	16	70	51-88
Previously detained under mental health legislation (n=25)			
• Yes	12	48	28-68
• No	13	52	32-72
Previously detained under forensic part of mental health legislation (n=25)			
• Yes	5	20	4-36
• No	20	80	64-96
Time between last contact and homicide (n=25)			
• < 7 days	13	52	32-72
• 1 – 4 weeks	4	16	2-30
• 5 – 13 weeks	3	12	0-25
• 14 weeks – 6 months	2	8	0-19
• 7 months – 12 months	3	12	0-25

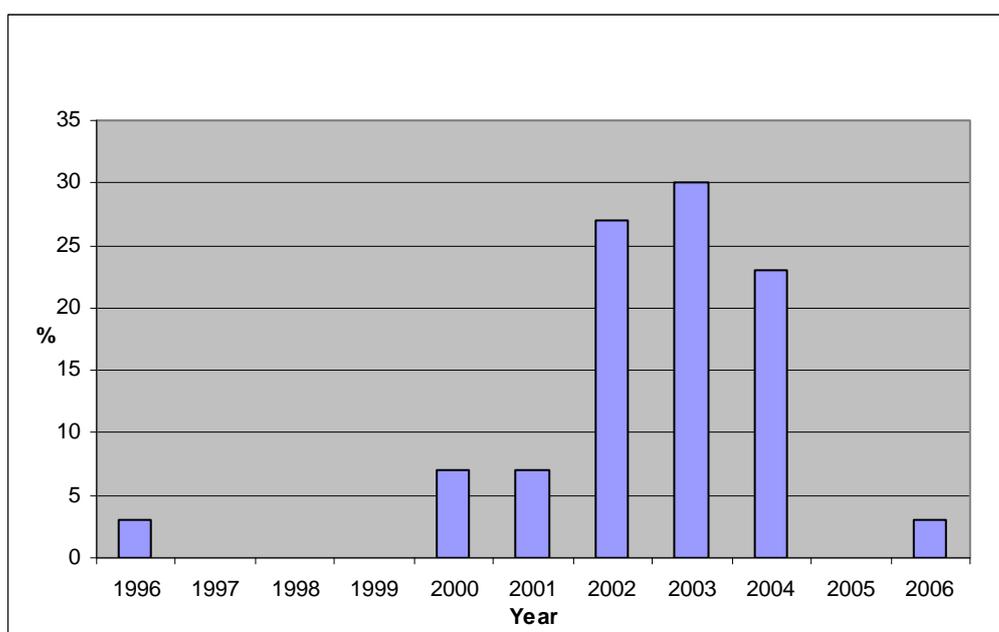
In terms of disposal a little over half of the perpetrators were given a hospital order (n=16, 53%), the remaining perpetrators were given prison sentences (n=14, 47%).

<sup>1</sup> Investigation report cases were linked to core Inquiry data where possible. However, the Inquiry had not received data on all cases and in some items information was not known or missing, therefore the denominator varies between items.

### 3.1.2. Year of offence

The independent investigation reports published in 2006 covered homicides committed between July 1996 and April 2006. Figure 1 illustrates the year of offence for all thirty homicide incidents.

Figure 1: Year of homicide (n=30)



### 3.1.3. Length of time between offence and report

The median length of time between the homicide and conviction was 10 months (range 3-26). The median length of time between the homicide and the publication of the independent investigation report was 38 months (range 7-119) and between conviction and report publication 28 months (range 3-93).

The longest time from homicide incident to the publication of the independent investigation report was 119 months in the well publicised case of Michael Stone. In this case the report was actually completed in November 2000, however, there were significant delays in the publication of the report. The two main reasons for this were:

- the commissioning agencies were concerned that naming staff in the published report would potentially put them at risk. Therefore they consulted with the police and sought legal advice before deciding to partially anonymise the report

- Michael Stone mounted a legal challenge to prevent the publication of the full report as it contained his personal medical information. He instead requested that an edited version be published and that the personal information he provided to the inquiry should be shared only with those who needed to know in order to learn lessons. However, in 2006 the High Court ruled that it was in the public interest to publish the report in full.

Cited reasons for delays to the investigation process in other reports included:

- unspecified legal concerns with publishing
- problems experienced by the investigation panel in obtaining medical records.

Most reports did not discuss reasons for delays.

#### 3.1.4. Length of investigation reports

The length of investigation reports ranged between 21 pages to 424 pages, with a mean of 109 pages (median = 87).

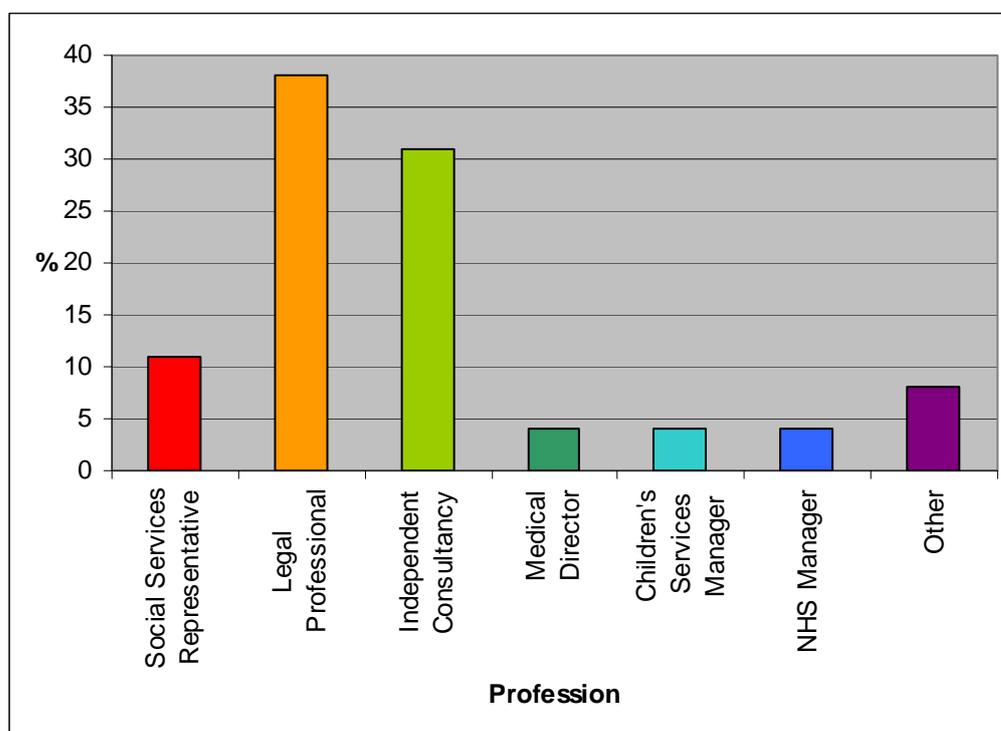
#### 3.1.5. Panel composition

Information about the investigation panel was included in 26 (90%) of the 29 reports. The majority of panels comprised between 1 and 5 members (n=25, 96%) with a range of professional expertise. One panel listed 15 members. In two cases the investigations had been conducted by one individual, in one case this was a former medical director and in the other it was a person described as an independent investigator with no further information about his/her professional experience. A further two were investigated by a panel of two. Both of those involved independent consultancy firms. The mean number of panel members per investigation was 3.58 (median = 3, range 1-15). Presented in table 2 are details of occupational group representation on the investigation panels and figure 2 illustrates the occupation of the panel chairperson.

Table 2: Occupational representation on investigation panels (n=26)

	n	%	95%CI
Consultant psychiatrist	21	81	66-96
Medical director	2	8	0-18
Nurse	9	35	16-53
Psychologist	2	8	0-18
NHS Manager	5	19	4-34
Children's services manager	1	4	0-11
Social services representative	8	31	13-49
Police/ Probation/ Prison staff	2	8	0-18
Legal professional [Barrister/ Solicitor/ Law academic/ Magistrate etc]	10	38	20-57
Independent consultancy [Verita/ Consequences etc]	9	35	16-53
Other [Trust (Non)Executive directors/ Healthcare Commission associate etc]	10	38	20-57

Figure 2: Occupation of investigation panel chairs (n=26)



### 3.1.6. Involving families and carers

In 17 cases the families/ carers of the service user/ perpetrator participated in the independent investigation in some way. In a further 5 cases the investigation reported that attempts had been made to contact family members/ carers but that this had been unsuccessful or they had declined to take part and in the remaining 8 cases there was no evidence of contact in the

reports. Sixteen family members/ carers for the victims participated in the independent investigation. In 6 cases contact was unsuccessful or was declined and in 8 cases there was no evidence of contact. A number of concerns were raised about the quality of information and support provided to families/ carers, particularly in the early stages of investigating the homicides.

“Whilst the police supported the families there was no contact made from the senior staff in the Trust or from the Health Authority to inform them that an external Inquiry would be implemented.” (X report)

“The Trust had contacted both the families of Mr D and Mr E and asked them to participate in the internal review. However, although Mr D’s family had seen a copy of the internal review report, this had not been fully explained to them. They considered that without the initiatives that they had taken to keep themselves informed of the situation. Information would not have been forthcoming.” (E report)

“When the inquiry panel met with Mr D’s family it became clear that they needed formal support and this was arranged via the Trust. Likewise Mr E’s mother was in need of formal support and this was also arranged via the Trust. Mr E’s mother had not seen the internal review report and no contact had been made with her after she had given evidence.” (E report)

“We were disappointed to note that despite being discussed at the Trust Board meeting in October 2002 no contact with KM’s family was made until some time later. KM’s mother was interviewed as part on the internal investigation in 2004 but even this did not prompt further contact with her to inform her of the outcome of the internal investigation.” (KM report)

“Neither Mr. H nor Mr. M were ever contacted by either organisation. When we interviewed Mr. H he felt that there was no point in conducting an external inquiry because nothing would be achieved.” (KM report)

## **3.2. Monitoring progress**

### **3.2.1. Procedures**

All of the Strategic Health Authorities contacted by telephone (September/ October 2008) reported having policies for the management of serious untoward incidents which included homicides by mentally ill persons. Four also stated that their policies were currently being reviewed and amended in light of the NPSA’s independent investigation good practice guidance published in February 2008.

The procedures for monitoring progress made with implementing recommendations were similar across the SHAs, with all making use of action plans containing the report recommendations, proposed actions to be taken and milestones/ dates for completion. In some cases the timescales for completion of actions were set by the independent investigation panel, but more often they were agreed between Trusts, PCTs and SHAs.

NHS East Midland's 'Policy for managing and investigating the most serious events in mental health services' (2008) provided details of the minimum standards they expected not only for the investigation reports but also the action plans. With regard to action plans this included:

- root causes/ contributory factors
- actions to be taken by the Trusts to deal with the root causes
- the level of the recommendation (i.e. individual, team, directorate, organisation)
- person responsible for ensuring actions are completed
- proposed dates for completing actions
- resources required
- evidence demonstrating actions have been completed
- date when action has been satisfactorily completed.

Usually, the SHAs work with the relevant Trusts and increasingly the commissioning Primary Care Trusts (PCTs) to develop the action plans. Regular progress reports were then filtered back up to the Boards of the SHAs through the relevant management/ governance structures. The closer involvement of PCTs reflected changes in performance management more generally within the NHS, with the SHAs taking the role of performance managers for PCTs who in turn performance manage their provider organisations.

In some cases the independent investigation panels became involved in the monitoring process. For example, in response to recommendations made in two separate investigation reports, one SHA invited the investigation panel back to review the progress made after 6 and 12 month intervals. The

subsequent reports produced by the panel were then published. However, this was not routine practice. Another SHA reported that they involved the lay chairperson from the investigation panel when reviewing action plans and recommendations as they felt that it was important to include someone who was involved in the writing of the recommendations.

### 3.2.2. Foundation trusts

One issue raised in conversation with the SHAs was the reporting/ monitoring arrangements between themselves and Foundation Trusts (FT). NHS London's 'Serious untoward incident (SUI) reporting guidance' (2007) states; "It is not compulsory for FTs to report to their SHA as there is no direct line of accountability". Several SHA policy documents have stated that Foundation Trusts have to report to their commissioning PCTs but are also encouraged to report incidents directly to themselves, for example; "Whilst Foundation Trusts are not obliged to report SUIs to the SHA we will seek voluntary agreement that they should do so. In any case, there is an expectation that all SUIs must be robustly investigated and associated action plans implemented. The SHA does expect that SUIs will be reported to their commissioning PCT, and PCTs contracts with providers, including Foundation Trusts and independent providers of NHS care should be set to reflect this." (NHS East of England, 2007)

However, the policy documents for NHS East Midlands state; "As agreed by the Department of Health homicides will continue to be managed by the SHA, even if the mental health trust involved is a foundation trust because SHAs are independent from both the provision and commissioning of services." (NHS East Midlands, 2007)

They also outline the SHA's responsibilities to monitor the implementation of action plans resulting from independent investigations commissioned by themselves and other authorities to ensure that all appropriate actions are taken in order to learn lessons and improve services.

### **3.3. Recommendation themes: reports published between 2006 and 2009**

The NCI identified:

- 28 reports (with one covering two separate homicide cases) and 1 serious case review published in 2006
- 7 independent investigation reports and 1 serious case review published in 2007
- 15 independent investigation reports (with one covering two separate homicide cases) and 1 serious case review published in 2008
- 14 independent investigation reports published in 2009 (one of which was also subject to a serious case review).

All of the recommendations made in the reports were analysed and categorised into the following 6 broad themes:

- clinical practice: Emerging sub-themes within this category included the Care Programme Approach (CPA), assertive outreach and crisis services, risk assessment and management, treatment issues, dual diagnosis and personality disorder
- clinical procedure: Within this category the following sub-themes were identified; communication, information sharing and record keeping, staff work practice and policy, failure to attend appointments, assessments and reviews, referrals and discharges
- service management & support: This theme included recommendations in the areas of professional support and supervision, service provision, management and leadership, staffing levels/ workloads and equality/ diversity
- staff training: Key issues within this theme included training in relation to the CPA, risk assessment and management, communication, dual diagnosis and substance misuse, carers and safeguarding children. Recommendations referring to training with external agencies such as police and probation were included in the next category
- external agencies: This theme included recommendations about working with external agencies mostly in relation to the criminal justice system. Key issues included domestic violence and safeguarding children,

MAPPA, information sharing, liaison and transfer of care and multi-agency training

- serious untoward incident management: Included within this theme were recommendations on the process of investigations, progress made with report recommendations, supporting families and media interest.

### **3.4. Appraisal of the content of recommendations: reports published between 2006 and 2009**

In this section we want to highlight three issues. Firstly, how certain recommendations are bland, general and not useful for Trust implementation purposes. Secondly, how issues related to basic clinical practice continue to recur year on year. Finally, we will highlight the most important themes from the reports published in this time period.

#### 3.4.1. Style of recommendations

There was wide variation in the style and level of detail in recommendations made across the reports. In many cases recommendations were considered to be somewhat bland and unfocused. For example:

“The Trust should continue its work developing and implementing its business-planning process.” (JC report)

“Recording practice in the Access team should be checked.” (MC\* report)

“Support all medical practitioners, at a grade lower than Consultant, to provide optimum quality patient care.” (PW report)

#### 3.4.2. Repetition of recommendations

Several themes within the recommendations were identified as recurring not only across the reports analysed in this study, but also in earlier inquiry/ investigation reports. The main areas which appeared to be repeated year on year were as follows.

- The Care Programme Approach (CPA)

Introduced in the United Kingdom in 1990 in response to recommendations made in the Sharon Campbell public inquiry published in 1998 (Spokes et al.,

1988), the CPA continues to be the subject of many independent investigation report recommendations. Examples of such recommendations are provided below.

“The Trust should ensure that the Care Programme Approach is fully implemented in line with national guidance, that its implementation is fully audited using available audit tools, and that staff are fully trained to ensure that both the spirit and the letter of the CPA are embraced and adopted.” (Mishcon et al., 1995)

“Care Programme Approach  
The Team manager should have responsibility for ensuring that the Care Programme Approach is fully implemented in respect of every patient, including those treated only as outpatients. The Trust should ensure that this function is performed effectively through appropriate supervision and audit.” (MM report, 2006)

“The Trust should ensure that its Care Programme Approach policy and procedures are fully implemented and are supported with appropriate resources and training. the Trust should undertake frequent audits to ensure compliance with this recommendation.” (JD report, 2008)

Concern about the continued repetition of such recommendations is illustrated by the following quote.

“The Care Programme Approach (CPA) should provide the care planning framework for all mental health care in this country. That we are criticising its use and effectiveness in this Inquiry Report is of concern because it has been operational nationally since 1990. That these criticisms follow criticisms made in two previous independent homicide inquiries locally is of even greater concern.” (MN report)

In another report failure to properly implement CPA procedures at the point of discharge was considered by the investigation panel to be the root cause of the incident.

“MC was admitted under Section 2 of the Mental Health Act (1983) on the 18th August and discharged on the 11th September 2002. MC’s Consultant Psychiatrist, who was responsible for his care whilst an inpatient, did not implement or activate the CPA/ECC process, according to existing Trust policy, or as required by nationally recognised guidance at the time of his discharge from hospital into the community on 11 September 2002. This was considered by the RCA team to be the root cause of this incident.” (MC report)

The investigation panel commented that failure to implement the CPA on discharge led directly to; A&E staff lacking relevant information and having to

rely on self reported information from the patient; no social worker involvement after discharge and no formal on going follow-up after discharge. They therefore recommended the implementation of a system of random audits of care planning and co-ordination of policies and practice.

▫ Risk assessment & management

The examples cited below illustrate some of the repetition in recommendations relating to risk assessment and management.

“That risk assessment must be carried out on a multidisciplinary basis to ensure that all professionals have the fullest possible level of input.” (Brown et al., 1999)

“All mental health professionals should participate in multi-agency training on exchanging information about clinical risk and other aspects of risk management. This should be based on joint training strategy.” (Mishcon et al., 2000)

“The assessment and management of risk takes account of a multi-agency and multi-disciplinary information and informs the CPA process” (KM report, 2006)

“The following areas need to be considered with regard to risk assessment of forensic patients:

- There is a need for a single evidence-based risk assessment format, with associated training and multidisciplinary input
- Risk assessments should be completed by members of at least two professions within the team and shared with the remainder in draft form before completion
- There should be a formulation of the individual's risk which should be tied in with the known historical risks with a clear indication as to what, if anything, has changed
- The risk assessment should form an integral part of the CPA process and documentation
- The risk assessment document should be regularly reviewed and updated and the patient and any carers should be involved in the process of its formation and review
- The risk assessment document should be easily identifiable within the clinical record for ease of access.” (PB report, 2009)

▫ Communication, information sharing & record keeping

The similarity between report recommendations in this area across time can be seen in the following quotes.

“The [Trust Name] should introduce a system to ensure the adequate involvement of general practitioners on discharge from inpatient care. In particular, it is essential to ensure that information is conveyed where possible to the general practitioner immediately, followed by a formal discharge summary within ten days.” (Richardson et al., 1997)

“That the [Trust Name] and the [Area Probation Service] should review liaison arrangements between the two services, taking account of developments since the arrest of DN, and establish protocols for joint working to ensure effective communication and information sharing; and should review existing liaison between adult psychiatry and the police and probation services, and firm up these arrangements where need be, building on the stronger links with these services already developed by forensic psychiatry.” (Crisell et al., 2004)

“Clear guidelines need to be developed to guide written communications with a service user’s GP by medical staff in particular. In discussing such guidelines consideration might be given to the following; clarity of diagnosis, instructions regarding monitoring medication, criteria for re-referral if a patient is being discharged/ having outpatient appointments reduced, reasons for discharge and any expectations of primary care services.” (W report, 2006)

“The Trust needs to ensure that its’ staff have clear guidance on confidentiality, with illustrative examples. In any event better interagency liaison – we specifically recommend close liaison with the local police – absolutely requires clear thinking about the permissible extent and limits of mutual disclosure.” (PH report, 2006)

“That the Trust also be asked to confirm that all professional staff are aware of the need to keep General Practitioners fully informed of all matters affecting, or likely to affect, the care and treatment of their respective patients, particularly where any such matter has repercussions for the care and treatment which the General Practitioner himself may be called upon to provide.” (DF report, 2008)

In one particular report published in 2006 the CPA, risk assessment/ management, communication/ information sharing and record keeping were all identified as:

“Key areas of weakness that need constant monitoring”. (SSW, report)

▫ Working with families/ carers & assessing their needs

References to families and carers regularly occurred within independent investigation report recommendations. Often cited was the importance of ensuring that families/ carers receive assessments of their own needs as carers. Other frequently repeated themes included the need for effective communication with families/ carers and their involvement in CPA and risk assessment processes.

“We recommend that the Trust should carry out a review of current practice for aftercare planning, to take account of patients’ carers and patients as carers with a view to giving more weight to their needs in those contexts. The review could form part of the planning for the implementation of the Carers (Recognition and Services) Act 1995 and would then involve Social Services.” (Barlow et al., 1995)

“Local policy and guidance on CPA. Steps should be taken to incorporate current guidance into local practice and procedure including the following:

- carers should be involved in planning care;

- care plans should be agreed with carers as far as possible;
- carers may need their own needs assessed.” (Harbour et al., 1996)

“The clinicians have a clear responsibility to seek the views of the immediate family in a situation where the medical opinion is that the patient should be in hospital and the patient refuses informal admission. The family should be involved if possible in the taking of any history and in the assessment of the patient’s current condition especially when the patient is being cared for in the community and is refusing or unable to attend outpatient appointments. A proper risk assessment should always include the views of the family where possible” (Mischon et al., 1996)

“We recommend that the Trust makes arrangements so far as is practicable for carers to be involved in the after-care process on an equal footing with professionals. We also recommend that the Trust ensures that information shared by professionals must also be shared with the carer, subject to the user’s consent.” (Crawford et al., 1997)

“Risk assessment and Management. We recommend that the Trust should introduce a policy of involving families and carers in violence risk management, and their views should form part of the CPA documentation.” (PH report, 2006)

“Relatives, friends and carers should be supported in their role and if they meet the criteria for a carers assessment, this should be done. At any rate, they should be given appropriate information and support. This should be done whether or not they are in contact with the service user.” (GB report, 2009)

### 3.4.3. Key themes from the recommendations

#### 1. Forensic community services

Issues regarding the variable provision of forensic community services were raised in several reports. Problems were identified in the co-ordination of care between general and forensic services. For example:

“PH was assessed by forensic services on several occasions, although most of his treatment was within general services. The situation may have been different if the Tribunal that rejected PH’s application for discharge from the [Hospital Name] in early 1997 had not recommended his transfer back to a general ward. In our view this recommendation was not based on a rational analysis of the patient’s care needs. It was an unhelpful recommendation and served to cut short an attempt to administer long term depot medication that could have made a crucial difference to the outcome in this case.” (PH report)

In this case they therefore recommended:

“Co-operation and co-ordination between general and forensic services. We recommend that the PCT should commission a comprehensive forensic outreach service.

We recommend that the forensic outreach service should offer a full range of services from advice to general psychiatry teams, to full care in the community of patients who present a sufficient risk of serious violence.” (PH report)

In one case the community teams treating the service user considered making a referral to the local forensic service but none was made. In the investigation report the panel commented that:

“The evidence of the CMHT and EIS staff suggested that they consider that the forensic services are of limited value and relevance to their work. As the case of SP demonstrates, we think that this perception can lead to the neglect of a potentially beneficial approach to the care and management of a patient.” (SP report)

They made the following recommendation:

“The Trust should ensure as part of its current review of forensic services that those services can offer the community teams the support and advice they need. Arrangements should be put in place for effective liaison between the forensic and community services.” (SP report)

In another case the Forensic Liaison Service were commended by the investigation panel.

“The Forensic Liaison Service (FLS) provided [W’s] care co-ordinator with regular support in exploring [W’s] risk factors and in making recommendations regarding his ongoing management. The forensic CPN for [CMHT Name] was noted to be particularly supportive.” (W report)

However, in the same report they were critical that a planned follow-up by the service did not happen. They also raised concerns that the service was lacking a policy with which it could audit its operation/ performance, there was a lack of clarity in the role/ remit of the service and the high case loads of the forensic CPNs. It was recommended that:

“Prior to the finalisation of the Forensic Liaison Service’s Revised Operational Policy (2005) [PCT Name] facilitates an objective assessment of how the current model for the provision of the Forensic Liaison Service is working and its terms of reference. Such an assessment should include an assessment of the capacity of the FLS against the demands currently placed upon it.” (W report)

Concern over the provision of forensic CPNs was raised in another report. In this case it was recommended that:

“Those responsible for commissioning forensic psychiatric services should review with Health Authorities in their catchment area their provisions for funding of forensic Community Psychiatric Nurses.” (MS report)

Forensic community services have been developed in an ad-hoc manner, with great variation in the amount of integration with generic services. These cases highlight the need for a review of practice and the relationship between forensic and generic mental health teams.

## 2. Restrictive criteria for accessing assertive outreach services

The inflexibility of assertive outreach services in accepting patients at risk was highlighted in one case where, five months before the homicide, the patient was referred by his CPN to the assertive outreach team (AOT) as he had been disengaging from services since discharge from hospital, was not adhering to medication and using illicit substances. The AOT responded that as the patient had not disengaged for a period of six months or more he did not meet their eligibility criteria. The independent investigation panel commented;

“... that this response showed a lack of flexibility and disregarded the main issue, that [E] was not engaging with his CMHT workers and was not concordant with his prescribed anti-psychotic medication.” (E report)

They also made the following recommendation;

“It is recommended that the eligibility criteria for access to the Assertive Outreach Team is reviewed and that if the six month guidance remains then professionals seeking support for their patients/clients who are not accepted should be able to have an opportunity to discuss the case with the team and mechanism for dealing with unresolved referrals between the teams should be developed.” (E report)

This case raises important issues with respect to the organisation and criteria of referral between the various teams established in modern mental health services. It is clearly important to have robust eligibility criteria to maintain case load size (smaller in the case of AOTs) and to ensure that staff with specialist skills treat appropriate patient groups. However, there is a real need to keep these criteria under constant review and consider for example whether time limits (as in this case) should be adhered to or whether in certain circumstances with certain patient characteristics and presentations, that clinical criteria should over-rule the time criteria. Regular review of services and patient referral patterns should also prevent people ‘falling between the

cracks' and enable services to adjust their eligibility criteria for teams according to the needs of the population served.

### 3. Risk assessment at transition point

A number of investigation reports raised concerns and made recommendations about the assessment of risk at transitional points.

- Transition from prison to community

"It was clear to the Panel that although all Prison establishments had in place Child Protection Procedures during TB's various imprisonments, which would have identified him as a Schedule 1 offender and monitored that, information about his receipt into, transfer between, and release from some of those Prisons was not always sent to the Probation Service and Social Services. The Panel has been unable to ascertain what, if any, planning took place within the Prison from which TB was finally released in October 2000, when he was discharged without statutory oversight." (TB report)

"It is imperative that the Police, Probation and Prison Services, and where relevant, Healthcare professionals, liaise closely regarding risk assessment and planning for the management of offenders, especially prior to the release from Prison of offenders who have mental health problems and who potentially pose a risk to females and children." (TB report)

"The Panel are concerned to note that it was left to chance whether or not a man with a long prison history of mental ill health problems, deemed sufficient to require ongoing psychotropic medication, contacted a general practitioner within a short time after his release and, having done so, whether he gave the prison discharge letter to the doctor." (MS report)

"There should be a review of current systems by the prison health care service to ensure that the medical and psychiatric care of prisoners with medical and psychiatric needs is transferred to appropriate practitioners in the community." (MS report)

- Discharge from inpatient care

"It is disappointing that at key points in the care of GL, for example at the time of his conditional discharge and at the time of the decision to discharge him from S.117 aftercare, a more rigorous reassessment of risk was not made." (GL report)

"In relation to risk assessment and risk management, there should be mechanisms in place to ensure that risk factors are explicitly identified, with rigorous reviews of risk at appropriate stages in the care of a patient, particularly where steps such as conditional discharge or discharge of S.117 arrangements are being planned. Where patients have committed serious offences, risk assessment should take account of the risk of re-offending as well as the risk of deterioration in mental state." (GL report)

“The recommendation of the clinical team (including the team from [High Secure Hospital Name]) to the MHRT therefore appeared to be that they required more time in order that they could properly assess the risk that [PB] might pose following discharge from the medium secure unit and then construct clear and structured treatment programmes. Further assessments were carried out in the following few months but we did not find any evidence of ‘clear and structured treatment programmes’ having been devised, let alone provided. No formal risk assessment was carried out other than the proforma assessment completed by Nurse 5 on [PB’s] admission.” (PB report)

“A formal risk assessment (such as an HCR-20) should be carried out as part of the discharge plan from a secure unit, which should then be handed over to the community team.” (PB report)

“His GP indicated at interview that the risk assessment in the discharge letter was misleading and the GPs would have dealt with MC differently if they had known the true risk.” (MC report)

“The effectiveness of training in risk assessment for all clinical staff should be reviewed. This should include the need to adequately document risk in the clinical notes and communicate such to all those staff involved with the ongoing care of the service user (e.g. General Practice clinical staff).” (MC report)

The cases of PB and MC quoted above highlight another important issue in relation to risk assessment generally, but particularly at the point of discharge concerning the quality of training and supervision provided to junior/ trainee psychiatrists. In the case of MC, a senior house officer with limited psychiatric experience wrote the discharge letter which was later criticised for being misleading. The investigation panel commented that the failure of the supervising consultant to check the accuracy of both the discharge letter and the risk assessment were contributory factors in the case. In their recommendations they stated;

“The effectiveness of induction training for newly appointed SHO’s in psychiatry should be reviewed. Induction training should include an emphasis on risk assessment processes and when to access and seek advice from senior clinical staff in particular during circumstances where service users are known to be at risk of harm to themselves and others during non-compliance with medication.” (MC report)

“A supervision policy for newly appointed SHO’s in psychiatry by senior staff should be developed/ reviewed. This should include supervision in outpatients and supervision of written communication, in particular during the management of patients with a severe and enduring mental illness.” (MC report)

Similarly, in the case of PB the investigation panel raised concerns about an addendum report prepared by a specialist registrar for a Mental Health

Review Tribunal hearing and signed by the consultant psychiatrist as it failed to sufficiently address the issue of risk.

“There is no discussion in the report about risk and there is no emphasis on the fact that [PB] had not yet had any unescorted leave into the community (although it does mention that permission for such leave had been requested from the Home Office).” (PB report)

The investigation panel also commented about the support and supervision provided.

“The Panel considers that there should have been at least one hour of individual supervision per week for someone of JHC, Psychiatrist 3’s relative inexperience.” (PB report)

The specialist registrar found herself in the position of being the only medical representative from the clinical team at an important Mental Health Review Tribunal hearing where a decision was going to be made about whether or not to release PB, a Section 37/41 patient.

“The Panel consider that JHC Psychiatrist 3’s lack of experience at that time (this was her first post as a Specialist Registrar) meant that she should not have been put in the position of being the sole medical representative at the MHRT considering the discharge of any Section 37/41 patient. She told us that this was one of her first MHRTs and she was not really given any instructions as to how to conduct such a tribunal.” (PB report)

The panel recommended;

“Trainee specialist registrars (now STR 4-6) should be supervised by the consultant at all MHRTs until their supervisors consider them to be competent to represent the clinicians on their own at any such Tribunal.” (PB report)

Risk often increases at points of transition in a patient’s care and comprehensive assessment and management of this risk by suitably trained and experienced staff is crucial at these times.

#### 4. Risk to victims

There were a number of related points made in various reports regarding issues of risk to victims.

- Recognising previous patterns of violence

In three cases the service user/ perpetrator had previously been convicted of homicide. In one case, the service user/ perpetrator had previously killed his spouse. The investigation panel was critical that there had been insufficient consideration given to the risk of forming new relationships. In another case the victim in the index offence was a partner who was also in receipt of mental health care. Limited attempts were made to work with them as a couple and the service user/ perpetrator eventually acted as the main carer for the victim. In this case the panel stated:

“Drawing back to look at the larger picture, what emerges is that [DF\*] and PC were two severely mentally ill people at this point in time. If, as we have suggested, joint inter-agency assessments had been conducted periodically, we think it is likely that this clearly risk-laden situation would have come to the attention of those professionally responsible for one or other of them. The National Service Framework in 1999 had identified the need for the assessment of carers needs, and [DF\*] would have fallen within that requirement in relation to PC.” (DF\* report)

“[Mental Health Trust Names], should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.” (DF\* report)

▫ Domestic violence and safeguarding children

In two further cases where the service user/ perpetrator and victim were partners and were in contact with mental health services, issues were again raised about the response to each as individuals and as a couple/ family particularly with regard to risk:

“The Inquiry Panel recommends that where there is more than one patient in a relationship this needs addressing through the application of the CPA process. The focus is to promote an appreciation of the needs of each person as an individual, and also as an individual in a relationship with another person who has needs of their own.” (M report)

“It is our view that if he had been prosecuted, the likelihood is that he would have been placed under a hospital order, and probably a restriction order. Thereafter he would probably have been treated far more assertively. Many previous homicide inquiries have similarly regretted that the police failed to prosecute the individual into whose care and treatment they were inquiring before the fateful index offence.” (PH report)

“We recommend that the Trust follow the approach pioneered by the [Trust Name] with the [Area Police]. This process should amongst other things aim at agreement on a charging policy, as in [Area Name], but it would have far wider objectives falling outside the scope of our report.” (PH report)

In the case of PH the victim was killed by her partner nine days after the birth of their child, raising further concerns about the way in which mental health services

work with families as a whole and also their response to issues around domestic violence and safeguarding children. Additionally, in a report published in 2008 the investigation team identified problems with the quality of information recorded about risk behaviours.

“The inadequacy particularly relates to the records of the social worker (SW1) who initially assessed the MHSU in A & E on 9<sup>th</sup> March. On return to the CRHT office it appears that SW1 was advised by a non-qualified team member that she had previous knowledge of the MHSU and his family and believed there to have been a problem of domestic violence during his time. The record made of this exchange merely states ‘violence and aggression’ on the risk assessment form.” (MHSU 2006/1787 report)

Leading them to recommend:

“The Trust must introduce a section on safeguarding children and adults, to include domestic violence (emotional, verbal and physical) as part of the standardised screening and full risk assessment paperwork.” (MHSU 2006/1787 report)

- Delusional ideas concerning named people

Several cases were identified where the service user/ perpetrator had expressed delusional thoughts about the eventual victim. For example, in one report the investigation referred to a ward round where it was noted that the service user/ perpetrator had contacted the police telling them that the eventual victim (a spouse) wanted to kill her. Some time later the victim contacted the emergency doctor stating that the service user/ perpetrator was threatening to kill him. At the trial it was accepted that:

“... participation in the killing of her husband was influenced by her delusions concerning him and that her responsibility was impaired by her mental illness.” (MM report)

The investigation panel raised several concerns about the care received in this case, particularly with regard to decisions to discharge the service user, the lack of discussion about discharge with the victim and in the planning of care, again leading to recommendations to improve the implementation of the CPA.

There were also two serious case reviews identified where service users (both mothers) experienced delusional thoughts about their children and went on to kill them. In one, the report stated that there had been concerns that the

service user/ perpetrator had not been feeding her children and had said that her children did not belong to her. Later the same year she began to express other delusional thought, for example that her babies had been still born and had at birth been swapped for two others. There was a period of compulsory inpatient treatment where the service user/ perpetrator quickly showed signs of improvement and started to acknowledge her children. After discharge supervised contact with her children was started, the first overnight contact was two weeks before their deaths. The serious case review concluded that:

“No single judgement or action within any agency triggered or failed to prevent the killing of child A or child B” (Child A & B report)

The report made a number of recommendations aimed directly at mental health Trusts, including:

“The Trust should ensure via briefings and procedures and reinforce through training programmes that relevant staff are made aware of the need to undertake explicit risk assessments for patients suffering with / who have suffered from delusional beliefs involving child/ren and such assessments should:

- Specifically cover the risk to the children
- Be undertaken in liaison with professionals from relevant other agencies
- Involve family members, in particular other parents / other carers of those child/ren.” (Child A & B report)

“The Trust should, via briefings and procedures ensure that all staff are informed:

- Of the need to base assessments on accurate and objective information of the patient’s history
- That if a patient was looked after at any stage in her/his childhood, information should be sought from [Area Name] Children & Young People’s Service and that this should be taken into account in the consideration of the level of involvement of the family in care planning arrangements
- That support should not be provided for a patient to resume care of her/his child unless there is a process in place to ensure that future arrangements would be in the interests of the children.” (Child A & B report)

“The Trust should introduce a procedural expectation that adult mental health services consider risks to, and impact of parental mental illness on, non-resident children of patients and seek advice and involvement from ‘parental mental health workers’ and the ‘safeguarding children team’, who should continue to be informed about key events until a joint decision is made that safeguarding children or parental mental health issues are being managed appropriately without their support.” (Child A & B report)

“The Trust should review its ‘Safeguarding & Promoting the Welfare of Children’ policy to ensure it covers lessons learned from this serious case review with respect to physical risks to children arising from parental delusions.” (Child A & B report)

## 5. Homicides on inpatient wards

Three homicides occurred on inpatient wards. The investigation reports raised various concerns regarding the provision of services in these cases. Key points highlighted included:

- Sexual relationships between inpatients

In one case a service user with a significant history of violence towards women, particularly those with whom he formed intimate relationships, was transferred to a mixed sex unit despite having been previously turned down by the unit because of the risk he presented to women. He then went on to form a relationship with a female service user and later killed her. This incident was subject to both a serious case review (vulnerable adult) and an independent investigation. The independent investigation concluded that;

- “... there were seven occasions during RR’s time at [Unit Name] when steps should have been taken which could have averted this tragedy.
- In July 2004, when the relationship between RR and AT was first noticed, steps should have been taken to ensure it did not develop.
  - On 12 October 2004 AT reported that RR had threatened her and the notes said the two of them were spending time together, unobserved, in each other’s bedrooms. This should have been perceived as a wholly unacceptable state of affairs, given RR’s history of violence towards women with whom he was having a relationship.
  - On 29 October 2004 RR threatened to kill AT because of what he considered to be her infidelity. Given RR’s history, it is difficult to envisage a clearer warning flag. However, CONS4’s involvement at this stage seems to have been nonexistent.
  - At [Hospital Name] in the first few days of November 2004 RR again said he wanted to kill AT, and he asked to see his social worker so he could be moved from [Unit Name]. This information was not communicated to [Unit Name]. The notes from [Hospital Name] record that a psychiatric assessment was to be arranged, but there is no record of this happening.
  - On 11 November 2004 CONS4 reviewed RR’s case, probably on the basis of the nursing notes and without meeting him. He did not perceive recent events as requiring any action other than a review of the risk assessment (a task to be carried out by a nurse) and a review of RR’s condition in six weeks time.
  - On 18 November 2004 W2 reviewed RR’s risk assessment. He categorised RR’s risk of violence to others as high, or very high, but no further action was taken.
  - On the morning of 12 December 2004 and before the homicide, RR told W2, that he was hearing voices. The only action taken was to administer RR’s cardiac medication.” (RR&AT independent investigation report)

Both the serious case review and the independent investigation recommended that service providers develop policies regarding sexual relationships between inpatients:

“Service providers should develop policy and procedures in respect of patient relationships. This must include consideration of the need to risk assess personal relationships at a multi-agency level, including respective Care Managers. Additionally, environmental safety should also be included with appropriate observation points and discrete single sex areas available. The practice of patients entering each other’s bedrooms must be explicitly addressed within the policy. Placing authorities should ensure that providers have such policy and procedures in place and that all such risks are discussed at the placement panel with full instructions on how they should be managed, taking into account the necessary safeguards.” (RR&AT serious case review report)

“We recommend to Trusts that all units providing residential care to the mentally ill should have a formal policy relating to sexual relationships involving in-patients; and that whenever a placement is being considered “out-of-area”, or in the independent sector, steps are taken to ascertain the policy adopted in this regard by the establishment(s) under consideration.” (RR&AT independent investigation report)

▫ Observation & seclusion

In the two other reports relating to homicide on inpatient wards, issues were raised about observation and seclusion practices. In one case the service user/ perpetrator was admitted to a psychiatric intensive care unit under Section 136 of the Mental Health Act. He was assessed and detained under Section 2 later the same day. When he was informed of his detention he assaulted a member of staff and was placed in seclusion. After being moved from seclusion he spent two periods of time being observed in a locked lobby corridor. During the second period of observation he killed a health care assistant. The independent investigation report highlighted failures to follow seclusion policies, to undertake required observations/ checks and the misuse of the lobby area.

In the second case the service user/ perpetrator had committed a homicide in the past and had received a hospital disposal with or without restriction. Eventually, he was released back into the community, killed again was admitted to a high secure hospital where he then went on to kill a fellow inpatient within ten days of this admission. In this report the investigation team

were critical of the level of observation of both the perpetrator and the victim.

For example, it was noted that the victim:

“... was on a regime of constant observation for his first week on [Ward Name]. Despite this he was attacked on several occasions without staff noticing. He had water and ash thrown over him. He was also subjected to spitting and verbal abuse. Observations were not carried out to an appropriate standard and nor were adequate records of observations maintained.” (PB&RL report)

“... made the task of protecting him more difficult by deliberately ignoring advice given to him by staff for his own safety. Staff knew that he would not comply with advice, in particular advice to avoid putting himself in danger. This only increased the need to keep him under greater observation but his observation levels were not increased.” (PB&RL report)

When the perpetrator was admitted to the ward he was placed in seclusion and when he came out he was placed immediately onto general (15 minute) observation. The independent investigation panel commented that:

“The understandable desire to allow the least restrictive regime compatible with safety was allowed to outweigh the risks involved in caring for highly dangerous patients who were properly regarded as unpredictable. In our view a high level of observation was required for any patient about whom so little was known as in the case” (PB&RL report)

The report also cited examples of breaches to the Trust’s policies regarding the observation of inpatients and commented on the inappropriateness of inpatients being allowed to be ‘in association’ whilst out of sight of staff members.

“Had there been a requirement for patients to be kept in sight of staff whilst in association it is unlikely that any assault on [RL] by [PB] would have been prolonged and it is less likely that he would have received fatal injuries.” (PB&RL report)

Amongst the many recommendations in this case, the investigation panel advised:

“All wards should have a local engagement and observation protocol which sets out minimum requirements for the observation of patients on that ward to ensure environmental safety and security.” (PB&RL report)

“All wards should review how their local engagement and observation practice is carried out to ensure it complies with the hospital’s policy. Each ward must have a system in place which allows staff to know the location of all patients at all times. A named member of the nursing staff should have the responsibility on

each shift for monitoring compliance with engagement and observation policy.”  
(PB&RL report)

“On assessment wards patients should be kept in sight of staff at all times during association unless there are express reasons for a different regime in respect of individual patients. These should be agreed by the clinical team and documented.” (PB&RL report)

“The engagement and observation policy should be revised to take account of the need for engagement and observation when a patient is at risk from others.”  
(PB&RL report)

▫ Inpatient incidents – abuse/ bullying

The case of PB and RL cited above also illustrated the problem of ward based abuse and bullying. In this case the victim had been subjected to physical and verbal abuse and bullying from other inpatients throughout his admission. The independent investigation report stated that the victim had been seen by a Mental Health Act Commissioner three days prior to his death and had reported incidents of physical abuse. The report also referred to a link between the bullying and the homicide.

“If the bullying had been taken sufficiently seriously it is unlikely that [PB] would have had the opportunity to mount a sustained attack on [RL] in the dining room without being observed by staff.” (PB&RL report)

They therefore made a number of recommendations including:

“All incidents believed by staff, or perceived by the victim, of serious or persistent harassment and victimisation should be the subject of an incident report and review by senior management.” (PB&RL report)

“Any allegation of verbal or physical abuse of a patient should be treated as having substance unless there is persuasive evidence to the contrary, and the RMO agrees that the allegation may safely be rejected.” (PB&RL report)

“When an incident of abuse by one patient on another occurs, the perpetrator must be managed on the basis of the threat posed to other patients on the ward.”  
(PB&RL report)

“Any incident of abuse between patients must be reviewed by the team and a joint management plan in relation to both the victim and the perpetrator agreed and implemented.” (PB&RL report)

“When a patient is the victim of more than one incident of verbal or physical bullying the second and any subsequent incidents must be reported to security and logged as a serious incident regardless of whether any injury is sustained.”  
(PB&RL report)

“Patients must be given information in an accessible form about the anti-bullying policy and their rights to complain about harassment, victimisation and bullying and to have their complaint recorded.” (PB&RL report)

## 4. Conclusions

### 4.1. Timing of investigations

There are advantages in conducting independent investigations without delay. It is beneficial to families and carers and aids recall of information for staff. However, in cases of homicide there will always be a need to take into consideration legal issues relating to any criminal investigation and prosecution in order to ensure that these processes are not impeded in any way. The 'Memorandum of Understanding' between the Police, Health and Safety Executive and the NHS and related guidance (Department of Health, 2006a,b) advises on effective liaison and communication between all three agencies when investigating patient safety incidents and is referred to in several of the Strategic Health Authority's serious untoward incident policies.

It is not possible to commence the investigation prior to conviction because the accused may be acquitted (found not guilty) and because of the risk of undermining the legal process. However, it should be possible to select the panel, assemble relevant case records etc. during this period so that the investigation can begin immediately after conviction. The SHAs should give a deadline for completion of the report (length of time being proportional to the complexity of the case). This should reduce delays in report production to a minimum.

#### **Recommendation**

In uncomplicated cases, independent investigation reports should be available within six months of conviction. Extensions to this time in complex cases should be agreed with SHAs.

#### 4.1.1. Investigation panels

The most recent guidance (Department of Health, 2005; NPSA, 2008) suggests that independent investigation panels should include persons with:

- relevant clinical, social care and managerial experience

- other expertise relevant to the investigation, for example probation or housing officers
- investigation skills, for example expertise in root cause analysis
- excellent report writing, interviewing and communication skills
- no involvement in the clinical care of the patient/ perpetrator or victim
- not employed by the organisation involved in the case.

The investigation reports analysed in this study revealed that the majority had representation from a consultant psychiatrist and that there was a variety of other professional clinical expertise. However, it was also noted that in four of the reports published in 2006 the panel comprised only one or two members. Whilst the guidance does not specify an exact number required for an independent investigation panel, it indicates that a suitable range of expertise is available. This is not possible, in our opinion, with a panel of less than three.

### **Recommendation**

Investigation panels should have at least three members with relevant expertise.

#### 4.1.2. Supporting families/ carers

It is of particular concern that in some cases even when contact has been made with the families/ carers of victims and service users/ perpetrators that services are failing to keep them sufficiently informed throughout proceedings and more importantly failing to recognise their need for formal support. The NPSA good practice guidance (NPSA, 2008) emphasises the importance of supporting families/ carers and provides checklists to help formulate appropriate correspondence, which may assist in improving the responses of health services to the families and carers of victims and service users/ perpetrators. It is vital that services recognise the need to initiate contact at an early stage and maintain this throughout the entire investigation process, including both internal and independent investigations.

## **Recommendation**

SHAs should appoint a person responsible for communication with all relevant third parties (particularly families and carers) throughout the investigation.

### **4.1.3. Confidentiality and consent to publish**

There were significant delays to the publication of one report in this time period due to legal proceedings resulting from the service user/ perpetrator's refusal to provide consent and whilst "The facts in [MS] may never rise again; he appears to be the first homicide inquiry subject to object this strenuously to publication" (Munro, 2007), consideration should be given to the panel's recommendation that service user consent should be sought but if it is not given:

"... the commissioning agencies should consider whether it is in the public interest for such disclosure to be made in spite of the absence of consent. Any decision to disclose information without consent on public interest grounds should be communicated to the patient together with reasons for the decision.

Where such consent is not forthcoming, or it is anticipated that significant evidence can only be obtained by compulsion, commissioning agencies should invite the Secretary of State to consider constituting the inquiry under Section 84 of the National Health Service Act (1977)" (MS report)

The confidentiality of medical information is of course extremely important. However, as issues surrounding communication and sharing of information repeatedly appear in report recommendations, all those involved with service users need to be aware of the circumstances in which it is permissible to share information with full consideration of the confidential nature of such data.

## **Recommendation**

SHAs who commission an inquiry should make their inquiry panel aware of actions that can be taken if perpetrator consent to disclose information is withheld.

### **4.1.4. Monitoring progress**

This report has summarised on the improvements being made to the procedures for monitoring progress with the implementation of recommendations and this should continue to be developed. All Strategic Health Authorities (SHAs) should ensure that they have robust systems in place to cover all mental health services including Foundation Trusts and independent services. The minimum standards expected for action plans detailed in NHS East Midlands serious untoward incident policy (NHS East Midlands, 2008) referred to earlier in this report provides a constructive basis for this.

Recommendations to involve the independent investigation panels in the monitoring process have been made in earlier investigation reports (for example see Mishcon et al., 2000). This approach is not used routinely. Future research should examine the dissemination of reports and information about progress made with implementing changes. This could be done by asking clinicians and stakeholders about their knowledge of the outcome and important learning points of homicide investigations conducted both in their own services and more generally in the UK.

### **Recommendation**

SHAs should prepare an action point implementation plan with deadlines. Review of the plan should ideally include the investigation panel.

In conjunction with the NPSA, the authors of this report produced the investigation checklist attached in appendix A to be utilised to streamline the process of independent homicide investigations.

## **4.2. New messages from 2006-2009**

### **4.2.1. Care programme approach, risk and information exchange**

There have been a number of attempts by researchers to collate and review the recommendations made in independent investigation reports in the past (for example Sheppard, 1996; Petch and Bradley, 1997; Parker and McCulloch, 1999; McGarth and Oyebode, 2002). Many themes identified in those reviews are the same as those highlighted in this report.

Several areas of recommendations were identified as particularly concerning as they related to basic aspects of clinical care/ management and yet they continue to arise:

- the Care Programme Approach
- risk assessment
- communication, information sharing and record keeping
- involving families/ carers and assessing their needs.

In some cases failings in these areas have been highlighted as root causes or significant contributory factors to the homicide.

Unfortunately, these investigations show that individuals with severe and enduring mental illness and identifiable risk are still not receiving care under the CPA. Furthermore, even those who are identified as being at risk by services and placed on the CPA may not receive care appropriate to their needs. It is clear that services need to ensure that not only are all high risk patients cared for under the provisions of the CPA, but that when under the CPA they receive the care and treatment required, with respect to risk and needs. The new guidelines (Department of Health, 2008b) provide a comprehensive framework which should help services to provide appropriate management of, and support to, more complex patients with high levels of risk and needs. It is of fundamental importance that services adhere to these guidelines and that deficits with implementation are identified and addressed.

The quality of record keeping and communication/ sharing of information between clinical teams both within and between health services needs to be

maintained at a high standard so that all relevant professionals are easily able to access the patient information they require.

### **Recommendation**

Mental health trusts should ensure:

- (a) full implementation of the CPA by all clinical teams
- (b) robust risk management processes are in place for all service users
- (c) information about risk is shared between all individuals, professionals and agencies, based on a protocol approved by the trust board.

#### 4.2.2. Risk of violence to others

Mental health professionals' duty of care extends not only to service users/perpetrators, but also to the wider community and this is particularly important when assessing and managing risk to others. The investigation reports in this study provided several examples where the consideration of risk to victims could have been improved. It is essential that risk assessment/ management and care planning regularly considers both static and dynamic factors associated with risk of violence and considers potential victims by assessing a service user's previous history of violence, particularly the characteristics of any previous victims and the context and circumstances surrounding any previous violent incidents.

The Department of Health's 2007 guidance regarding risk assessment highlighted the importance of working collaboratively with carers. It recommended that carers be offered assessments of their own needs and be given an opportunity to speak individually to practitioners, "... so that the risks can be explored and actions can be agreed." (Department of Health, 2007).

Mental health professionals should also consider recent changes to the Mental Health Act 1983 and the Domestic Violence and Victims Act 2004 (Department of Health, 2008a) regarding the rights of victims of some sexual and violent offences to be given certain information and to make representations about conditions of release. In the past such consideration was only available to the prisoners' victims, however in 2005 this was

extended to the victims of patients/ perpetrators who received restriction orders. This has since been further amended and from November 2008 applies to victims of patients/ perpetrators detained on all hospital orders with or without restrictions.

### **Recommendation**

Mental health trusts should ensure that they have guidance documents in place to disseminate best practice advice about responding to the risk of violence to others. Specifically, this should include guidance regarding:

- (a) informing family members, carers and other potential victims of the risk of violence from a service user
- (b) appropriate intervention/ management strategies for working with service users with delusional ideas about specific individuals.

#### 4.2.3. Needs of carers

The responsibility of being a carer often lies with family members or spouses. According to NCI data homicides by people who have been in contact with mental health services in the 12 months prior to the offence involve a family member or current/ former spouse as the victim in 111 (45%) cases (Appleby et al., 2006). Furthermore, it has been reported that the caring role can adversely affect carers' health and well being (Keeley & Clarke, 2002; Pinfold & Corry, 2003). The carer's assessment was first introduced in 1995 with the Carers (Recognition and Services) Act and the need to involve families/carers and assess their needs has continued to be acknowledged by further Acts (Carers and Disabled Children Act, 2000; Carer (Equal Opportunities) Act, 2004) and government documents including the Department of Health's recent report on best practice in risk assessment and its CPA guidelines (Department of Health, 2002; 2007; 2008a). It is therefore essential that services work to improve their response to families and carers.

## **Recommendation**

Whilst respecting service user confidentiality, mental health trusts should encourage and support family/ carer involvement in a service user's care management. Carers should also receive assessments of their own needs, which should be reviewed on a regular basis to ensure that identified needs and agreed actions have been addressed.

### 4.2.4. Focus of recommendations

Repetition of certain themes within the recommendations may be unavoidable if these areas continue to be identified as important factors in the care and treatment of service users who become the subject of homicide investigations. However, care planning, risk assessment/ management, communication, information sharing and working with families/ carers including assessing their needs are all basic procedures which should form the bedrock of a well functioning mental health service and they should no longer be appearing in the recommendations of reports with such frequency.

In the review of the reports we also found that there were still several bland recommendations included. In our opinion reports should in general terms include only focused, specific recommendations which are directly useful to services.

## **Recommendation**

Inquiry report recommendations should be focused and specific so as to be of direct use to services. SHAs should be responsible for challenging recommendations that are vague or difficult to implement or monitor.

### 4.2.5. Assertive outreach

Between 1999 and 2001 the Department of Health announced changes to the provision of mental health care (Department of Health, 1999, 2000b, 2001b) signalling their intention to modernise services and to provide treatment for those with severe and enduring mental health problems in services "that are more responsive to their needs" (Department of Health 2000b), including assertive outreach and crisis resolution/ home treatment services.

Analysis of the independent investigation reports highlighted a need for these services to review and clarify their working procedures. Of particular concern was the rigidity with which eligibility criteria were applied in some cases. Such services should develop a more flexible approach to assessing the appropriateness of accepting service users, as inflexibility can lead to people 'falling through the net'. With complex services with multiple teams, some with specialist expertise, it is important to have criteria for referral. However, it is also important to keep this under review so that if the needs of the population change, the services are responsive to this and change accordingly. Similarly, it is important to regularly review the needs/ presentation of service users on the margins of these services who are referred from one team but not accepted by another, to establish whether the eligibility criteria need to be modified.

### **Recommendation**

Mental health trusts should review the referral criteria for Assertive Outreach and similar services on an annual basis and should regularly audit the characteristics of service users who have been rejected by teams in order to ensure that criteria are flexible and services are reacting to changing local need.

#### **4.2.6. Homicides on inpatient wards**

Homicides committed on inpatient wards are extremely rare. Findings from the NCI data identified only seven such homicides between 1997 and 2006 (Appleby et al. 2006). The independent investigation reports for three of these cases have been included within the sample of reports analysed for this study.

It has long been recognised that sexual activity occurs on inpatient psychiatric wards raising issues of consent and capacity to consent (Warner et al., 2004; Lawn & McDonald, 2009). The Department of Health published guidance in 2000 about mixed sex accommodation in mental health services requiring the provision of separate single-sex sleeping and bathroom accommodation and female only lounge/ activity areas (Department of Health, 2000c). However, in 2004 a report by MIND showed that whilst the government reported that 99

per cent of trusts had met targets for single sex accommodation, 23 per cent of inpatient respondents in their survey said they had been accommodated on mixed sex wards (MIND, 2004). The NPSA raised the issue of sexual safety in their 2006 patient safety observatory report in which they suggested that there needed to be a "... greater awareness of the risks of sexual vulnerability of mental health inpatients and greater protection for patients". They also recommended that, "Risk of inappropriate sexual behaviour, or vulnerability to sexual harassment, should be considered as part of each patient's initial assessment and be re-assessed on a regular basis, including histories of rape and childhood sexual abuse, and of sexual offences. This assessment should take into account that men, as well as women, are at risk" and reiterated the Department of Health's requirements regarding accommodation (NPSA, 2006).

The MIND and NPSA reports also discussed the problem of violence in inpatient psychiatric wards. According to the NPSA report incidents involving disruptive or aggressive behaviour were the second most frequently reported type of patient safety incident (NPSA, 2006). MIND reported that 51 per cent of respondents in their survey reported being physically or verbally threatened, with 20 per cent stating that they had been physically assaulted (MIND, 2004). A recent study of service users experiences on acute inpatient psychiatric wards found that most respondents reported feeling safe on wards, but there were some who reported being concerned for their own safety and some who reported experiences of being bullied by other service users (Jones et al., 2010). Both the National Institute for Health and Clinical Excellence and National Institute for Mental Health in England have produced guidance for the management of violence on inpatient wards (NICE, 2005; NIHME, 2004).

Of particular concern in the independent investigation reports discussed in relation to these issues was that in the case of RR and AT, staff were aware of the sexual vulnerability of the victim, of the sexual offending and risk of the service user/ perpetrator and of the sexual relationship that developed between them; in the case of PB and RL the staff were aware that the victim

was unpopular with his peers and had been subject to assaults and bullying. However, there appears to have been a failure to fully appreciate, assess and manage the risks involved in these cases.

### **Recommendation**

Mental health Trusts should review inpatient/ residential services and policies to ensure that they are working in line with guidance relating to service user safety, paying particular attention to issues regarding sexual relationships, bullying and violence/ abuse.

#### **4.2.7. Risk at transition phases**

Transitional times in a service user's care can be times of increased risk. For example when a service user is discharged from inpatient hospital treatment to the community there will be a decrease in the protective factors associated with being in hospital and an increase in the potential risk factors associated with a move into less supervised accommodation within the community. The reports analysed in this study raised concerns not only about the transition between hospital and discharge to the community, but also in the transfer from prison to the community.

It is vital that not only risk assessment/ management but also care planning are considered as fluid, dynamic processes and that procedures are in place to ensure that they are reviewed at regular intervals and at key transitional stages, whilst maintaining the flexibility to conduct reviews if circumstances change.

### **Recommendation**

At transition points, such as from ward to community or forensic to general services, there should be a care plan review including future risk management involving representatives from the receiving services/ agencies.

The Royal College of Psychiatrists recommends that trainee doctors receive one hour per week of personal supervision, stating that this "... has been, and continues to be, invaluable, enabling the development and assessment of

clinical and personal skills under direct one-to-one supervision by an expert.” (Royal College of Psychiatrists, 2010). It is essential that junior/ trainee psychiatrists who are often closely involved in the day to day care of service users be provided with the necessary training, support and supervision to fulfil their responsibilities in terms of risk assessment/ management and in preparing for the discharge or transfer of service users.

### **Recommendation**

Trainee psychiatrists should be provided with the necessary training, support and supervision to fulfil their responsibilities in terms of risk assessment and effective communication of information when service users are discharged from services.

#### **4.2.8. Forensic community services**

The independent investigation reports in this study identified variations in the provision of forensic community services and in the co-ordination of care between general and forensic services. In the UK two main models of service provision for community forensic services have been developed, integrated and parallel, both have advantages and disadvantages (Malik et al, 2007).

To date research into the efficacy of these models of service provision has been limited. A recent study comparing the outcomes of patients discharged to specialist forensic services or to general adult services reported no significant differences between either service in terms of re-offending and readmission to hospital (Coid et al, 2007). However, it is clear from the reports we have examined that in the care of certain individuals, general adult services alone cannot provide the necessary forensic mental health experience.

### **Recommendation**

Mental health trusts should ensure the provision of comprehensive community forensic mental health services for the management of service users who present a risk of violence in the community.

### **4.3. Further developments**

In 2008 when the NCI became aware of the serious case reviews regarding mothers who had experienced delusions about their children and had killed them, the NCI reviewed the reports, examined the NCI's own homicide data and alerted the National Patient Safety Agency to the issue. This led them to develop the rapid response report 'Preventing harm to children from parents with mental health needs' and supporting information published in May 2009 (NPSA 2009a,b).

A previous draft of this report was presented to the National Patient Safety Agency in February 2009. This earlier version of the report had referred to the issues of restrictive access to assertive outreach and similar services, risk at transitional stages of care and to victims. Since then the NPSA has developed a 'Safer Mental Health Checklist', due to be published in 2010.

The NCI proposes to continue analysing the independent investigation reports as they are published, monitoring themes and implementation of recommendations.

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## Appendix A: checklist for independent investigation procedural issues

Independent investigation checklist	Yes
<p>Investigation completed within 6 months of patient/ perpetrator's conviction</p> <p><i>If no, reasons:</i></p> <ul style="list-style-type: none"> <li>• Complexity of the case</li> <li>• Delays to the investigation</li> </ul> <p><i>Details:</i></p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p style="text-align: center;">○</p> <p style="text-align: center;">○</p> <p style="text-align: center;">○</p>
<p>Investigation panel with 3 or more members</p> <p>Panel composition:</p> <ul style="list-style-type: none"> <li>• Consultant psychiatrist</li> <li>• Medical director</li> <li>• Nurse</li> <li>• Psychologist</li> <li>• NHS manager</li> <li>• Social services representative</li> <li>• Legal professional</li> <li>• Independent consultancy professional</li> <li>• Other professional (please specify)</li> </ul> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p style="text-align: center;">○</p>
<p>Media / communications strategy implemented</p>	<p style="text-align: center;">○</p>
<p>Family support/ communications strategy implemented</p>	<p style="text-align: center;">○</p>
<p>Staff support/ communications strategy implemented</p>	<p style="text-align: center;">○</p>
<p>Patient/ perpetrator consent to access medical records obtained</p> <p>Patient/ perpetrator consent to publish final report obtained</p> <p><i>If no, actions taken:</i></p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p style="text-align: center;">○</p> <p style="text-align: center;">○</p>
<p>Specific, focused recommendations agreed by all relevant parties</p>	<p style="text-align: center;">○</p>
<p>Recommendation action point implementation plan agreed by all parties</p>	<p style="text-align: center;">○</p>
<p>Schedule of progress monitoring agreed by all relevant parties</p>	<p style="text-align: center;">○</p>