the centre for
suicide prevention

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The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Report of the pilot study examining independent homicide investigations

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Report summary

In the autumn of 2006, the National Patient Safety Agency (NPSA) commissioned the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) to estimate the number of independent investigations that had been commissioned by Strategic Health Authorities (SHAs) following serious untoward incidents that resulted in a conviction for homicide for patients in recent contact with mental health services.

The period January 2002 to December 2004 was selected being the most recent and complete years of NCI data on patient homicide and to ensure sufficient time had elapsed for an independent investigation to have been commissioned and completed. One hundred and fifty four cases were identified in the period of which 108 cases were sampled and followed up with Strategic Health Authorities (SHAs). Seventy-seven (71%) of these cases had been in contact with services within 6 months of the homicide and 29 individuals in this group were identified as subject to enhanced Care Programme Approach (CPA) at the time of the homicide.

Having determined the expected number of cases, the remit of the research was to determine how many independent investigations had been carried out, to obtain a sample of reports, establish the timeline from date of homicide to the commissioning and publication of the independent investigation and to determine where delays in the process occurred.

Other factors the NCI examined included the membership and individual expertise of the panel members, the investigation process(es) employed, the range of witnesses called, the documentary evidence considered and the panel's recommendations.

The NCI obtained a response from 9 of the 10 SHAs and received data about the cases sampled, and/or reports from 8 authorities. It was not possible therefore to confirm that an investigation had been carried out on all the cases

for which an investigation is mandatory according to current Department of Health guidelines.

The findings indicated that there was wide variation in the time taken to conduct an independent investigation and not all the reports were subsequently published. Publication occurred between 2 and 11 months following completion of the investigation. Delays in the process were identified in only 2 cases and related to difficulties in appointing the panel and the unavoidable absence of panel members.

Recurring themes in the findings of the reports received included:

- Improved staff training and development; with risk assessment of patients and closer contact with families highlighted as specific issues of importance
- Service development; particularly the use of CPA and improved communication between agencies involved in the care of the patient in general
- Recommendations for how independent investigations should be conducted following an incident
- Recommendations for the regular review of protocols and procedures for the management and care of patients with assessment of the quality of the services delivered

The report concludes that a mechanism for the notification of all homicides by mental health patients, and the development of a central registry for all independent investigation reports, is crucial for monitoring that investigations are commissioned for patients that meet the Department of Health criteria for an investigation. The NCI, as a national independent research centre, would be an appropriate base for this registry.

Once a central point for independent investigations into homicide is established further research would be possible into patient and service characteristics to extract common learning points and good practice for wider dissemination across the health service.

1. Introduction

In the autumn of 2006, the National Patient Safety Agency (NPSA) commissioned the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) to estimate the number of independent investigations that had been commissioned by Strategic Health Authorities (SHAs) following serious untoward incidents that resulted in a conviction for homicide for patients in recent contact with mental health services.

The importance of a rigorous investigation following any serious untoward incident for patients was made clear in two major Department of Health reports: 'An Organization with a Memory' (2000) and 'Building a Safer NHS' (2001). Both reports emphasized that a modern health service must have processes in place to monitor, investigate and learn lessons from adverse patient events in order to reduce the risk of similar events occurring in the future. National reporting systems have since been implemented through the NPSA for both health professionals and the public to report patient safety incidents. The purpose of this research was to examine the reporting, investigation and dissemination of lessons learned following homicide by a patient in the care of mental health services.

The criteria for independent investigations of adverse events in mental health services are set out in Department of Health circular HSG (94) 27 and LASSL(94)4 (Department of Health, 1994. Although following the period of time that the cases in this research fell within, the guidance was further amended in 2005 to state clearly that an independent investigation should be undertaken:

- When a homicide has been committed by a patient under the care of specialist mental health services, subject to standard or enhanced levels of the Care Programme Approach (CPA), in the 6 months before the homicide
- When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights

- Where the SHA determines that an adverse event warrants independent investigation

Previous research has been critical of homicide investigations. Peay (1996) questioned whether investigations provide the best platform for learning lessons, as they are essentially case reports. Although investigation reports all make recommendations for service development, this information is poorly disseminated and there are few opportunities for wider learning. Investigations have also been labelled inefficient, costly, misleading and potentially unjust (Eastman, 1996) and by not adopting a common methodology this has limited their usefulness (Petch & Bradley, 1997).

Using the NCI database of patients convicted of homicide whilst in the care of mental health services it was possible to extract cases for a given period of time, examine their clinical history, establish how many met the criteria for the commissioning of an independent investigation and follow these cases up with the relevant SHA. A sample of the reports could then be requested for further examination of a range of variables relating to the commissioning of the investigation and whether any delays were encountered, how it was carried out, its findings and recommendations and wider dissemination of key learning points.

2. Aims

The aims of the NCI research were to:

- Estimate the number of independent investigations undertaken into the circumstances of homicide carried out by patients convicted between 2002-2004
- Collect and examine a sample of reports
- Compare the characteristics of cases against the NCI database
- Provide an overview of the reports content
- Determine the time course of the independent inquiries including any delays in the process

3. Methodology

The cases selected were perpetrators convicted of homicide between the years 2002-2004 who had been in contact with mental health services in England within 12 months of the offence. This period was chosen because it allowed sufficient time from the date of conviction for an independent investigation by the trust to have been carried out and also enough time for the case to have been processed by the NCI.

One hundred and fifty-four cases were eligible for inclusion. Each case was assigned a regional code relating to the district where the offender had been treated by mental health services. The number of cases per SHA ranged between 6 and 32. Where regions had fewer than 13 cases in their locality, all of these cases were included. If the region had more than 13 cases, a random selection was made. This method of selection enabled us to ask each SHA for information on a similar number of cases. The final sample contained 108 cases.

Contacts at each SHA were asked to complete a short questionnaire on all the perpetrators listed, whether they had been the subject of an independent investigation or not. If an investigation had been commissioned, a copy of report was requested. A copy of the internal investigation report was also requested however, this document presents the findings of the examination of the independent investigation reports received only.

4. Results

At the end of March 2007, the NCI had received a response from 9 of the 10 SHAs and data from 8. The NCI did not receive a complete data return from all SHAs therefore the findings are based only upon the data received at time of writing this report – in the next phase further follow up of data sheets would be required. Of the sample of cases selected, the NCI was informed that 26 independent inquiries had been undertaken, of which 15 reports were received. A breakdown of the returns is given in Appendix 1.

A number of difficulties in providing reports were encountered by SHA contacts and included:

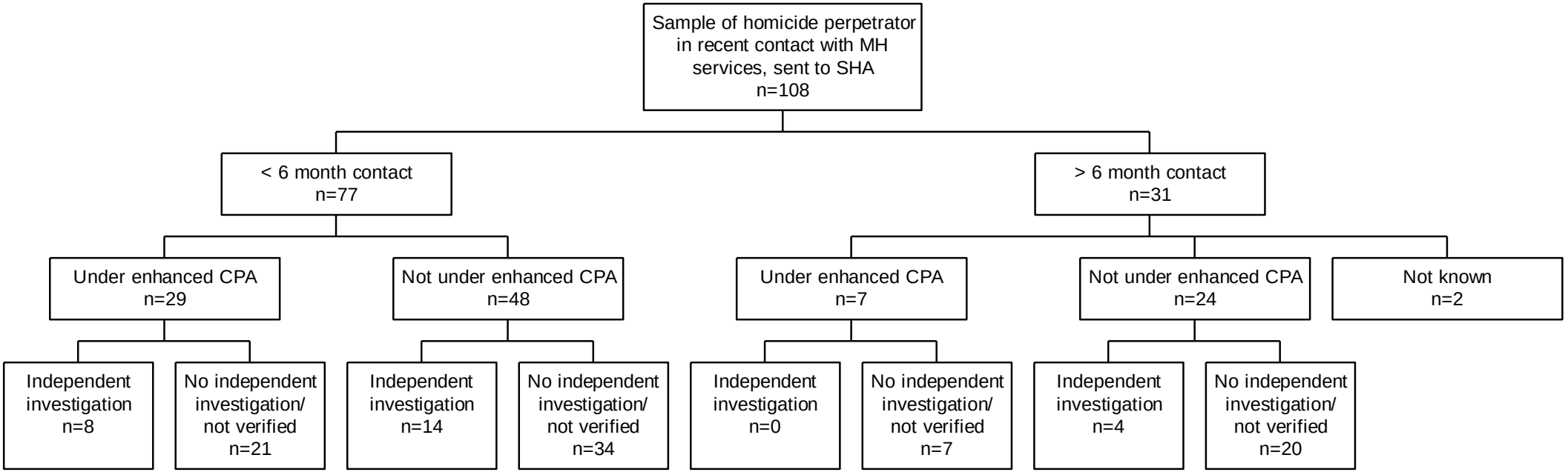
- Reports being anonymised (as stated in NPSA guidelines). SHA contacts had difficulty matching reports to the NCI list of names. Whilst acknowledging the need for confidentiality and the patient's right to privacy, anonymity will create difficulties in linking some reports to the NCI database.
- Uncertainty on the part of one SHA contact as to whether they could share the report from an independent investigation which, for legal reasons (unspecified), had not been published. The NCI only received 58% of the reports known to have been written.
- Difficulty in accessing case files and identifying appropriate personnel due to the recent re-organisation and merger of SHAs
- Staff shortages and current workload at the time of receiving the NCI list
- The investigation into the incident still on-going and therefore the report not yet completed

The 108 cases selected had been treated by mental health services 12 months before committing a homicide. Figure 1 details cases in relation to enhanced CPA status and the time of last contact with mental health services. Seventy-seven (71%) of case were in contact with mental health services within 6 months of the offence. Of these, 29, a quarter of the total sample, had been subject to the higher levels of CPA. As far as we could ascertain

independent inquiries were commissioned on 8 of these. Of the 48 patients in recent contact who were not under enhanced CPA (but possibly standard CPA), an independent investigation was undertaken in 14 cases. In addition, 4 investigations were undertaken which would have satisfied other criteria under HSG (94) 27.

The following analysis is based on the reports received during this period.

Figure 1: Independent inquiries by contact with mental health services and by enhanced CPA status



* Because a complete return of information from all SHAs was not obtained it was not possible to verify that an independent investigation had been commissioned for all cases in the care of services in the six months prior to the offence.

4.1 Social and clinical characteristics

Ninety-three percent of the suspects were male, just over half killed a female. The median age for perpetrators was 34 (range 15-63) and median age for victims was 37 (range 13-80). Thirty-three percent had a primary diagnosis of affective disorder, a quarter had schizophrenia. Over half killed using a sharp instrument, a quarter used strangulation. Most victims were current or ex spouse/partners or family members.

There were few statistically significant differences between perpetrators who had an independent investigation compared to those that did not (see appendix 2). As expected, perpetrators under the CPA were more likely to have been subject to an investigation. Likewise perpetrators receiving a hospital disposal more often had inquiries. An investigation was less likely if the perpetrator received a prison disposal.

4.2 Content and structure of independent investigation reports

Most of the reports contained the following information:

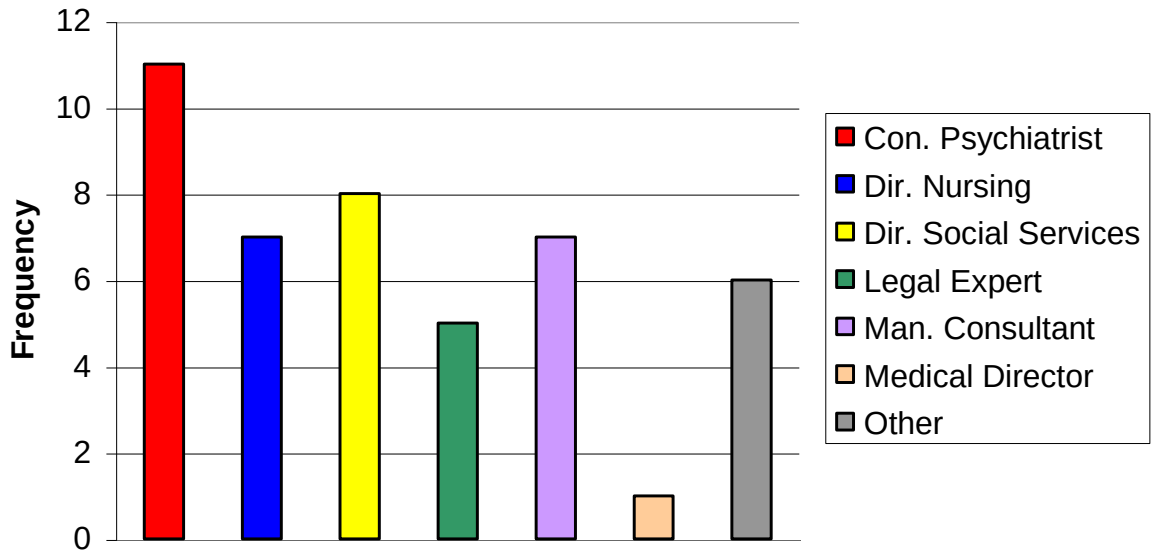
- Introduction
- Panel membership
- Documents considered and witnesses called
- Terms of reference
- Chronology of treatment and care
- Conclusions and findings
- Recommendations

There was a difference in the style, structure and content of the reports. The length of the documents ranged from 26 to 245 pages.

4.3 The panel members

The panel normally consisted of 3 or 4 members with a range of expertise. Figure 2 shows how often these professionals were commissioned (this information was unavailable for 2 cases). The management consultants appointed to the panel specialised in the investigation of serious untoward incidents. The term 'legal expert' includes law academics / directors of legal institutes and solicitor/barristers. Thirty-six percent of panels included a legal expert. A consultant psychiatrist was appointed in 73%. In 47% a director or former director of nursing was present and 53% of panels commissioned a director or former director of social services. From the reports we analysed, no panel contained all of the following; a legal expert, consultant psychiatrist, nursing specialist and social care representative. However, in 31% of cases a representative from psychiatry, nursing and social care was appointed to a sit on the panel. The reports did not provide any information on how the number of panel members was arrived at, how they were selected and if they had previous experience of the process. Therefore it is unclear how the most relevant expertise was determined.

Figure 2: Composition of the independent investigation panel



4.4 The investigation process

The time taken to complete an investigation ranged from 4 months to 33 months with a median average of 14 months. Not all of the reports were published or the date of publication known. However, for those where this data were available, publication followed between 2 and 11 months after the report had been completed. A delay was specified in 2 cases only. The reasons given were:

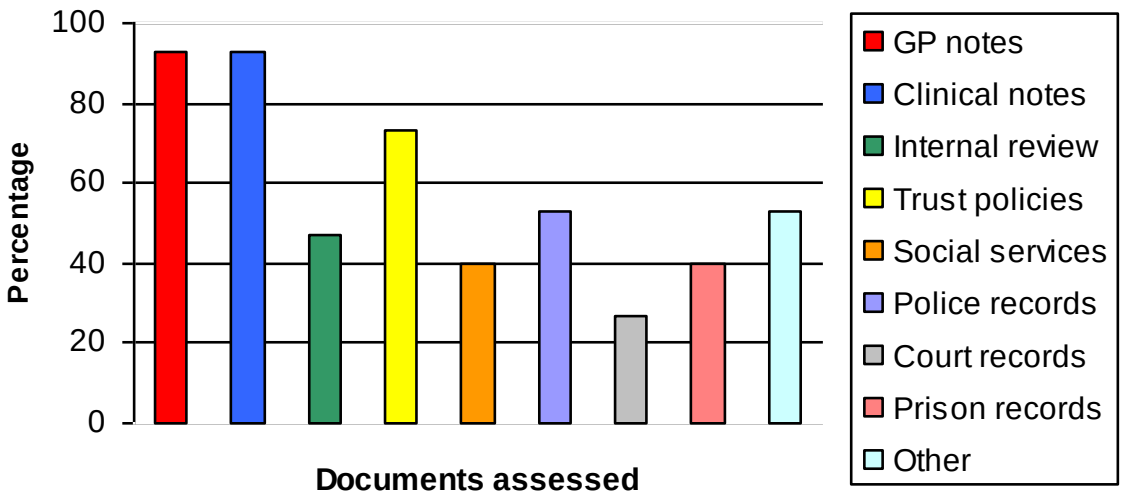
- time taken to commission the investigation after the trial and encountering long delays with panel selection
- unavoidable absence by panel members.

The methodology used to evaluate the evidence obtained was not clearly detailed in most reports. Although witnesses were interviewed and documents reviewed, in only a few instances the report specified that a methodology such as Root Cause Analysis was applied.

4.5 Data sources

During the course of an investigation the panel members reviewed a wide range of documents pertaining to the treatment and care of the patient prior to the homicide. These documents were requested from departments and organisations both internal and external to the NHS Trust where the patient was treated. Figure 3 details the type of material reviewed (where this information was specified).

Figure 3: Documents reviewed during the investigation



In addition to reviewing the above documents the panel also interviewed personnel involved in the treatment provided to the patient. From the reports obtained, we established the external bodies providing evidence to the investigation included:

- The offender's family
- Social Services
- The Probation Service
- The Police
- Local Authority Housing Department
- The Court Service
- Voluntary Agencies

On average 22 witnesses were interviewed per investigation. The number ranged from 10 to 47 interviewees. There was little information provided about the interview process. It was not clear how the interviewees were selected, if they had legal representation, how often individuals were interviewed, whether the interview was semi-structured or conducted using a standardised method. The method used to analyse the resulting data is also unreported.

5. Key recommendations in reports

5.1 Summary of main themes

All reports proposed recommendations for service improvement and development. The key themes that emerged are outlined below:

- Staff training and development
  - Training in risk assessment and management of high risk patients
  - Improvement of staff supervision, management and leadership within teams
  - Staff retention rather than reliance on agency staff unfamiliar with patients
  - Caseload size
  - Protected time for Community Mental Health Team discussion, reflection and education
  - Closer contact with families to inform them of care and the support available

- Service development
  - Improved implementation and management of CPA
  - Communication and information sharing within other services involved in the patient's care (General Practice, A&E & liaison psychiatry, and social services)
  - Clearer documentation in case-notes of the decisions taken
  - Protocols for liaison/information sharing with substance misuse services and development of dual diagnosis services
  - Two reports indicated the need for protocols for working with 'external agencies and practitioners' (unspecified) to assist in supporting and protecting ex-partners and where domestic violence within a relationship is known or suspected

- Review and audit services
  - Assessment of quality standards and the regular review of protocols and procedures
  - Clinical governance reports
  - Evaluate if services are meeting clients needs

- Undertaking independent inquiries
  - Internal investigations following an incident should be conducted by experienced and impartial personnel
  - External inquiries should begin shortly after the event to avoid recall bias and ensure prompt access to key staff and documents
  - Panels can be appointed and documents requested earlier to avoid delays after the trial

5.2 Action plans

Action plans were provided with 40% of the reports. We were unable to determine from the reports alone how this information was disseminated to services and whether recommendations were implementation.

6. Conclusions

In the short period of time for this initial phase of the research it was possible to get a complete picture of the number of independent investigations that took place following homicide; similarly - the number of cases that fulfilled the criteria (in contact within 6 months and under enhanced CPA) but that were not subject to an investigation.

Key to the success of any evaluation of independent inquiries that the NCI might undertake is that inquiries are being carried out on all cases that were in contact within 6 months of the incident and under enhanced CPA (as the guidelines set out) and that the NCI receives all reports undertaken by trusts. For the success of the research in 2007-2008 it is crucial that the NCI develops strong working relationships with SHA and trust contacts.

7. Next steps

A meeting between the NPSA and the NCI took place in April 2007 to discuss how the research will move forward in 2007-2008. Topics discussed included:

- An evaluation of the Root Cause Analysis method for conducting inquiries, possibly in partnership with one SHA, following the process right through to the implementation of recommendations.
- Thematic analysis of specific issues, e.g. social and clinical characteristics of homicides by patients with mental illness linked with NCI data.
- Whether qualitative research methods might be employed to obtain more in-depth information about the homicide investigation process and its impact
- A more detailed examination of delays in the investigation process.

Longer term this research may become part of the NCI's core work. Regular liaison between the NCI and the NPSA throughout 2007-2008 will ensure that the appropriate systems and resources are in place for this to happen.

7.1 Project activity 2008/09

Appendix 3 sets out the proposed timetable and outputs for the study between April 2007 and March 2008 and a provisional indication of how the research might be extended into 2008-2009.

8. References

Department of Health. (1994) Guidance on the discharge of mentally disordered people and their continuing care in the community. NHS Executive HSG(94)27 and LASSL(94)4. London

Department of Health. (2000) An Organisation With a Memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. London

Department of Health. (2001) Building a Safer NHS for Patients. London

Eastman, N. (1996) Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *British Medical Journal*;313:1069-71.

Petch, E. & Bradley, C. (1997) Learning the lessons from homicide inquiries: adding insult to injury. *The Journal of Forensic Psychiatry*;8;161-184.

Peay, J. (1996) Inquiries after Homicide. London: Duckworth.

Appendix 1: Information received by SHA

SHA	Total NCI cases per SHA (contact <12 months)	Information requested on NCI cases	Received notification that independent investigation had been undertaken (or on-going)	No. of independent investigation reports received
NHS North East	6	6	3	0
NHS North West	29	12	3	3
NHS Yorkshire & Humber	13	13	No data	No data
NHS East Midlands	10	10	4	2
NHS West Midlands	21	12	No data	No data
NHS East of England	12	12	2	0
NHS London	32	12	2	2
NHS South East Coast	13	13	8	6
NHS South Central	10	10	3	1
NHS South West	8	8	1	1
Total	**154**	**108**	**26**	**15**

Appendix 2: Characteristics of mentally ill perpetrators with and without independent investigations

	With an investigation N=26	%	Without an investigation N=24	%	p-value
Demographic features					
Age of perpetrator: median (range)	34	15-63	29	15-52	0.63
Male suspect	23	88%	21	88%	0.92
Ethnic minority	0	0%	1	6%	0.47
Not currently married	12	60%	12	60%	1.00
Unemployed	12	57%	9	45%	0.44
Living alone	6	27%	2	13%	0.43
Behavioural features					
History of alcohol misuse	16	73%	13	68%	0.76
History of drug misuse	14	64%	14	70%	0.66
Previous convictions for violence	13	54%	9	39%	0.30
Primary diagnosis:					
Schizophrenia & other delusional	10	40%	4	17%	0.11
Affective disorder (bipolar & dep.)	5	20%	2	8%	0.42
Personality disorder	5	20%	4	17%	1.00
Alcohol dependence	1	4%	1	4%	1.00
Drug dependence	0	0%	3	13%	0.11
Priority groups					
Under enhanced CPA	14	54%	4	17%	0.01
Missed last contact	9	41%	8	33%	0.60
Non-compliant	8	33%	3	16%	0.29
Mental state					
Mentally ill at time of offence	15	68%	9	45%	0.13
Psychotic at offence	10	48%	6	30%	0.25
Delusions	8	40%	3	15%	0.16
Hallucinations	5	28%	4	20%	0.71
Offence variables					
Age of victim: median (range)	37	13-80	39	16-83	0.70
Male victim	12	46%	16	67%	0.14
Victim was a stranger	3	15%	3	15%	1.00
Sharp instrument used	12	46%	14	58%	0.39

Appendix 2 (cont): Characteristics of mentally ill perpetrators with and without independent inquiries

	With an investigation N=26	%	Without an investigation N=24	%	p-value
Final outcome					
Murder	10	38%	12	50%	0.41
Manslaughter (diminished responsibility)	4	15%	1	4%	0.35
Manslaughter (other including provocation, self defence)	10	38%	11	46%	0.60
Disposal					
Prison	15	58%	21	88%	0.02
Hospital order (with or without restriction)	11	42%	3	13%	0.03
Other					

Appendix 3: Plan of activity for 2007-2008

Proposed timetable of activity/outputs for the coming financial year. To be reviewed at mid-year meeting with NPSA. Development in 2008-2009 to be agreed as part of annual recontracting process with NPSA:

Time period	Activity
Apr – Jun 07	▪ Develop database of investigations published since Jan 2005 (likely to be incidents occurring in 2003). Provisional population of database from Inquiry cases in 2003 where contact within 6 months of homicide & enhanced CPA[1]. From April 2007, information on the reporting of an incident, timeline for the internal investigation, and the commissioning of the external investigation to be gathered prospectively as cases arise. Database will be both an electronic file and paper document library. ▪ Identify sources of published reports, e.g. SHA/trust websites, private organizations who carry out investigations, DH, NPSA's collection of reports from scoping exercise (if appropriate). ▪ Confirmation of key contacts within SHAs. ▪ Update on progress of launch/publication of new guidance for SHAs from NPSA. ▪ Begin read through of reports obtained to extract 'quantitative' data and to begin the identification of recurring themes. Special focus on: o Personnel/ methodology employed to carry out investigation o Delays incurred o Recommendations arrived at (were these trust specific/ of national relevance?),

[1] All of these cases under the new NPSA guidance should have had an independent investigation

	○ Evidence in the report supporting that recommendations, ○ Plan for dissemination (were these trust specific/ of national relevance?) and ○ Follow up of recommendations (how/ by whom?). ▪ End of ¼ update on progress as part of the Inquiry's NPSA return.
Jul – Sep 07	▪ Receipt of copies of published reports received by the NPSA as part of the new guidance/process. ▪ End of quarter update from NPSA on notification of homicide incidents since Apr 07 to be added to database for tracking. ▪ Mid-year report (brief) summarizing some of the key quantitative characteristics of the reports and emerging 'themes'. ▪ End of ¼ update on progress as part of the Inquiry's NPSA return (see point above).
Oct – Dec 07	▪ Receipt of copies of published reports received by the NPSA as part of the new guidance/process. ▪ End of quarter update from NPSA on notification of homicide incidents since Apr 07 to be added to database for tracking. ▪ End of ¼ update on progress as part of the Inquiry's NPSA return. ▪ Meeting to be arranged with NPSA (end Sep/ beginning Oct). Items of discussion to include, but not exclusively: ○ Findings to date – recurring themes (readily actionable of national relevance?) ○ Dissemination strategy – the role of the Inquiry in the dissemination of national learning points the research identifies. Resource/cost implications. ○ Agreement of timetable for dissemination – e.g. safety newsletter/ website announcements are quick, awareness raising seminars require longer lead in

	time. Resource/cost implications. o Identification of an SHA/trust(s) to approach with a view to working in partnership in order to develop the research into a more qualitative phase in 2008/09– i.e. to attempt to 'drill down' on implementation of recommendations on the ground and other areas of specific interest. o Preliminary costings for the project in 2008/09 based on current research activity. ▪ Begin discussion with SHA/ trust(s) identified at joint meeting to work more closely. Challenges: o Time for this level of access to be negotiated/ obtained o Clarity as to why we are asking for the trust's help – letter of support from/ possible joint meeting with NPSA o Response to request for paper evidence of implementation – e.g. changes to policy as a result of an investigation/ evidence of implementation in the training new and existing staff receive?
Jan – Mar 08	▪ Receipt of copies of published reports received by the NPSA as part of the new guidance/process. ▪ Report on first year's activity; forward plan for 2008-2009 o Publication of report on NCISH/ NPSA websites? ▪ End of ¼ update on progress as part of the Inquiry's NPSA return ▪ End of quarter update from NPSA on notification of homicide incidents since April 07 to be added to database for tracking. ▪ Further discussion/negotiation as appropriate with partner SHA/trust(s) to put in place the access we need to begin the qualitative phase of the research examining the impact of recommendations in regard to conducting investigations.

Future development: April 2008 through March 2009

In 2008/09 the Inquiry would aim to continue its:

- Quarterly monitoring/tracking of reported incidents via the database
- Examination of published investigations to further describe the similarities and differences between incidents with regard to how the investigation was commissioned carried out and reported
- Examination of published investigations to further develop an understanding of the recurring themes in report recommendations with a view to establishing national learning points.

Through 2008-2009 the research could be developed into a qualitative phase in which in-depth interviews with key members of SHA/trust staff (as appropriate) would be undertaken to establish the implementation and impact of recent investigation recommendations with regard to policy and practice.

In 2008-2009 the research will continue to play an important role in informing the development of a national strategy for disseminating ‘lessons to be learned’ from serious patient incidents resulting in homicide.