East of England

Strategic leadership for your local NHS

# A review of 14 mental health homicides committed between April 2002 and June 2006

**A report for**
**NHS East of England**

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Authors:

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Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

Capsticks is a leading health sector law firm.

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# 1. Introduction

All homicides[1] committed by individuals in the care of mental health services in England should be investigated. The Department of Health set out what organisations should do following a mental health homicide in its guidance on *The discharge of mentally disordered people and their continuing care in the community* (HSG (94)27) and the amendment published in 2005. The guidance says that mental health trusts should:

- carry out an initial management review (usually within 72 hours) to identify any immediate concerns; and
- commission an internal investigation to establish a chronology of events and determine possible shortcomings in the care provided.

The guidance also states that strategic health authorities (SHAs) should:

- commission an independent investigation.

These investigations are separate from any criminal investigation by the police.

NHS East of England (the SHA) has commissioned Verita and Capsticks to undertake a systematic review of 14 homicide cases (including one alleged homicide) committed between April 2002 and June 2006 by patients under the care of mental health services. These cases were believed not to have been subject to independent investigation as required under the terms of the HSG (94)27.

The aim of the review was to provide NHS East of England with recommendations about further action it needs to take to comply with the HSG (94)27. Furthermore it is to identify common themes and issues to enable the SHA to learn from these cases. NHS East of England will use this information to improve internal investigations and to help ensure consistent improvements to mental health services across the SHA.

The term "we" refers throughout this report to the joint view of Verita and Capsticks.

[1] "Homicide" refers to the act of one person killing another.

## 2. Executive summary

NHS East of England was created in 2006 following the merger of the three SHAs which previously covered the area. In 2007 NHS East of England carried out a review of the reports of internal investigations into mental health homicide cases it inherited from the three former SHAs.

NHS East of England's review found 14 cases of homicide (including one alleged homicide) committed between April 2002 and June 2006 by patients under the care of mental health services that may not been subject to independent investigation as required under the terms of the HSG (94)27.

We were asked to examine the internal investigation reports and other available material for each case in order to recommend whether any further work is necessary and, if so, what action is appropriate bearing in mind the seriousness and complexity of individual cases. We were also asked to identify any common themes arising from the internal investigation reports.

A team from Verita and Capsticks assessed each case. The members of the team have management, mental health and legal experience.

The assessors used an assessment framework (or toolkit) designed to ensure a consistent approach to all 14 cases. NHS East of England approved the assessment framework before the review started.

Each assessment was subjected to peer review and to a legal assessment. In addition to this, regular meetings between assessors and reviewers were held where, for example, definitions and an interpretation of the HSG (94)27 were agreed. This ensured a consistent approach.

Based on our analysis of the internal investigation reports, which we generally found to be of a good standard, we recommend that 11 of the 14 cases should be investigated further. For two of the cases, we recommend that no further action needs to be taken by the SHA. In one case we are unable to recommend further action

because the criminal proceedings are incomplete, but we have reviewed the case and made comments on the internal investigation report.

Other than the need for an investigation to be independent, the HSG (94)27 does not stipulate what type of investigation is necessary in order to ensure that lessons from cases of mental health homicide are learned and then applied. We therefore identified three broad types of independent investigation that could be used to satisfy the HSG (94)27. Each has values that make it best suited to examining certain cases and no one type of investigation is more important than another. The three broad types are:

- Type A – a wide-ranging investigation carried out by a team examining a single case
- Type B – a narrowly focused investigation by a team examining a single case or a group of themed cases
- Type C – a single investigator (with peer reviewer) examining a single case or a group of themed cases.

Our recommendations for a specific type of investigation are based on an analysis of the documentation received. In this review, we do not recommend any cases for a type A investigation, but we recommend five cases for a type B investigation and six for a type C investigation.

For four of the cases where we recommend a type B investigation, we suggest a themed review. The four cases are from North Essex Partnership NHS Foundation Trust and we recommend that it would be useful to have a joint themed review focusing on the implementation of the Care Programme Approach (CPA) and risk management.

We recommend a flexible approach to all types of investigations. We recommend early appointment of the investigation lead and the terms of reference agreed before the remainder of the team is identified. This would allow for the approach to be easily changed if it becomes apparent that a different type of investigation is more appropriate.

## 3. The brief

The purpose of the review is to assess each case and:

- confirm whether each of the cases meet the HSG (94)27 criteria
- establish whether there are other factors, apart from the criteria expressed in the HSG (94)27, that NHS East of England needs to take into account to decide whether further action is necessary
- recommend whether any further work is required on each case
- in those cases that require further work ensure that any previous work undertaken is not duplicated and that recommendations for future work are proportionate to the scale, nature and complexity of the incident
- in those cases where further work is required, to advise on the nature of the action needed and the reasons for it in order to improve services and maintain public confidence
- establish any common themes emerging from the internal investigations of the cases
- produce a report that recommends action for NHS East of England in relation to the 14 cases.

We are aware that all work must take into account satisfying a public interest in ensuring that services are as safe as possible, and where they are not, finding out why not and what can be done to improve them.

# 4. Methodology

## Our approach to the task

It was essential to ensure that all the cases were reviewed in a consistent manner. We therefore developed an assessment framework (which we refer to as an "assessment toolkit") for use by the team in reviewing each homicide case (see appendix A for a blank example of the document). The same assessment toolkit was completed for each case. This meant that all cases went through the same evaluation and ensured a thorough process and consistent approach to making recommendations for further work. The recommendations are based on a review of documents made available to us.

We developed the assessment toolkit using our knowledge of the application of the HSG (94)27 and our previous experience of advising SHAs about the appropriate and proportionate investigation of mental health homicides. The assessment toolkit included sections for the initial assessment, the peer review, the discussion between the assessor and peer reviewer, the legal assessment and the group assessment (see appendix B for a full description of methodology).

We selected an experienced team of assessors and lawyers to carry out this review. The team have extensive experience of mental health services including management, clinical practice and the commissioning of independent investigations by SHAs. Full biographical details are found in appendix C.

# 5. General observations

Overall we found that the internal investigation reports were of a good standard. This chapter outlines some of our observations following our review of the information included in the internal investigation reports.

## Information on context

In conducting the review we considered the information contained in the internal investigation reports in relation to available national data.

The latest data about homicides by people with mental illness were published in December 2006 by The National Confidential Inquiry at the University of Manchester. *Avoidable deaths: five year report by the national confidential inquiry into suicide and homicide by people with mental illness* says:

> *The Inquiry investigated 249 cases of homicide by current or recent patients, occurring between April 1999 and December 2003, 9% of all homicides occurring in England and Wales during this period. This figure translates into 52 patient homicides per year. Our data show no clear evidence for either a rise or a fall in the number of homicides by people with mental illness.*

We noted that the national data were based on homicides between 1999 and 2003. The 14 cases included in this review happened between 2002 and 2006 and so no meaningful comparison could be drawn between the two sets of information. The National Confidential Inquiry did not collect data by region so information exclusively concerning NHS East of England was not available for comparison.

## Summary data

General information about the 14 cases appears below. This information includes the case where criminal proceedings are still incomplete.

**Table 1: Number of cases by trust and year**

| | 2003 | 2004 | 2005 | 2006 | Total number of cases |
|---|---|---|---|---|---|
| Bedfordshire and Luton Mental Health Partnership and Social Care NHS Trust | 0 | 1 | 1 | 0 | 2 |
| Cambridge and Peterborough NHS Foundation Trust | 0 | 0 | 0 | 1 | 1 |
| Hertfordshire Partnership NHS Foundation Trust | 0 | 2 | 2 | 0 | 4 |
| North Essex Partnership NHS Foundation Trust | 2 | 0 | 3 | 2 | 7 |
| Total | 2 | 3 | 6 | 3 | 14 |

## Themes

Our brief required us to identify any themes arising from the review. To help us do so, we included a series of prompts in the assessment toolkit for each assessor to consider during his or her review of each case. The themes used for the prompts were derived from our experience of mental health homicide investigations.

The summary of the theme section of the toolkit is in the table that follows. The table includes themes identified in the internal investigation report and those identified by us. Many of the themes were jointly identified but four additional themes were identified by the assessors.

**Table 2: Themes identified**

| Theme | Identified in internal investigation report | Identified by assessor |
|---|---|---|
| Inadequate risk assessment and management | 8/14 | 8/14 |
| Poor communication between professionals within the trust | 4/14 | 4/14 |
| Poor communication between agencies | 4/14 | 4/14 |
| Inadequate application of care programme approach | 2/14 | 3/14 |
| Lack of implementation of child safeguarding procedures | 1/14 | 2/14 |
| Lack of or inappropriate use of mental health act | 1/14 | 1/14 |
| Failing to listen to carers | 0/14 | 1/14 |
| Insufficient response to the patient's non-engagement | 1/14 | 1/14 |
| Misdiagnosis and medical mismanagement | 0/14 | 1/14 |
| Non-compliance with medication | 0/14 | 0/14 |

## Other information

### Relationship between victim and perpetrator

In one case we were unable to identify whether the victim was known to the perpetrator. In 10 of the remaining 13 cases, the perpetrator (or the alleged perpetrator in one case) and the victim knew each other, for example they were partners or acquaintances. In the three remaining cases, the internal investigation report indicated that the victim and perpetrator were unknown to each other.

# 6. Assessment criteria

The principle consideration in making recommendations about the type of independent investigation needed was whether the case met the HSG (94)27 criteria. The assessment toolkit was therefore designed so that each assessor considered the criteria as part of the review of each case. The assessment toolkit then directed the assessor towards other key information that would inform the recommendation about further action.

## The HSG (94)27 criteria

The guidance sets out the three criteria that determine whether an independent investigation is needed. It states that an independent investigation is needed in the following circumstances.

- *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 [CPA], 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 or life threatening injury, there is an obligation on the State to carry out an effective investigation.*
- *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.*

## Interpretation of the HSG (94)27 criteria

It was necessary in applying these criteria for us to make a judgement about the meaning or intention of some of the phrases contained in the HSG (94)27.

We therefore agreed on common interpretations which we applied to each case.

1. An individual who was "under the care of specialist mental health services" is defined in the guidance solely as someone who was "subject to a regular or enhanced care programme approach". In some cases it was apparent that a perpetrator had contact with mental health services, but was not subject to CPA[2].

   Our interpretation of this point is that "under the care of specialist mental health services" is not intended to mean *only* somebody who is subject to CPA, but rather that the person has been referred, assessed and accepted for treatment or care by the mental health services. In a case where a perpetrator was *not* under CPA, but for example *should* have been, our assessment is that an independent investigation still needs to be undertaken.

2. The guidance does not specify whether substance misuse services can be defined as "specialist mental health services" for the purposes of commissioning an independent investigation under the HSG (94)27.

   Our interpretation of this point is that an independent investigation under the HSG (94)27 should take place where perpetrators are in the care of substance misuse services only when the internal investigation report highlights systemic service issues in the care provided.

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[2] *Effective care co-ordination in mental health services: modernising the care programme approach: a policy booklet* published in 1999 by the Department of Health sets out the current policy on CPA. It states that the four main elements of CPA are:

- *systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;*
- *the formation of a care plan which identifies the health and social care required from a variety of providers;*
- *the appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care; and*
- *regular review and, where necessary, agreed changes to the care-plan.*

## Other criteria

In making recommendations in addition to the HSG (94)27 criteria and the interpretations outlined above, we have considered other relevant factors including:

- nature of the incident
- information about the perpetrator and victim
- details of the court case where it was available
- scope and quality of the internal investigation
- views of the Department of Health and/or other government departments
- any apparent similarities between cases from the same trust.

# 7. Recommendations

Our recommendations for each case are set out below. Full details of each case are included in the individual assessment toolkits, along with the rationale for our recommendations.

Each case has a reference number only. This is because NHS East of England and the mental health trusts agreed that the internal investigation reports and additional documents would be made anonymous before they were given to the review team.

## Recommending no further work

In two cases we recommend that no further action needs to be taken. These are outlined below.

| Trust case number | Trust | Year |
|---|---|---|
| 33A and 33B | Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust | 2004 |
| I11228 | Hertfordshire Partnership NHS Foundation Trust | 2004 |

**Case 33A/33B**: We recommend no further action in this case because the perpetrator was not a patient of mental health services in the six months before the incident. This case does not satisfy the first of the HSG (94)27 criteria, nor is it an "adverse event warrant[ing] independent investigation" (HSG (94)27).

**Case I11228:** The previous SHA commissioned an independent review of the perpetrator's care and treatment, meaning that the responsibility for commissioning an independent investigation under the HSG 94(27) has been discharged.

## No recommendation due to ongoing criminal proceedings

| Trust case number | Trust | Year |
|---|---|---|
| 0277/06 | North Essex Partnership NHS Foundation Trust | 2006 |

**Case 0277/06:** We cannot recommend what further action needs to be taken because criminal proceedings are incomplete at the time of writing.

## Recommending further work

Our review makes clear that the same scale of investigation is not appropriate in every case. The HSG (94)27 criteria do not specify the type of investigation needed (other than that it needs to be independent).

The objective of our review is to establish key facts to enable lessons to be learnt and action to be taken. This can be achieved through a variety of approaches to the conduct of investigation, depending on the individual circumstances of each case. For example, this might involve up to three investigators, with more or fewer witnesses. This applies both where an investigation is particular to a single incident and where it is grouped with others presenting similar themes.

We recommend a variety of different approaches to the conduct of further investigations. They are based on our experience of mental health homicide investigations. The recommendations for further action fit into one of the types outlined below with no one type of investigation more important than another.

**Table 3: Types of further investigation recommended**

| | |
|---|---|
| A | Wide-ranging investigation by a team examining a single case |
| B1 | Narrowly focused investigation by a team examining a single case |
| B2 | Narrowly focused investigation by a team examining a group of themed cases |
| C1 | Single investigator (with peer reviewer) examining a single case |
| C2 | Single investigator (with peer reviewer) examining a group of themed cases |

These recommendations are not of rigidly defined types and we suggest a flexible approach in all cases. The lead for the investigation should be appointed and the terms of reference agreed *before* the composition and required skills of the remainder of the team are specified. This allows the nature of an investigation to be changed if further information is obtained that suggests a different approach would be more beneficial.

The brief required us to identify themes. We feel that SHA-wide themed investigations would be unlikely to produce tangible benefits on improving services and confidence because the organisational characteristics of each trust are so different. We believe a themed trust-wide investigation is more beneficial and it may well be that once the themed investigation is complete the learning can be applied throughout the SHA. We recommend that four of the North Essex Partnership NHS Foundation Trust cases be investigated together around a common theme.

Table 4: Summary of recommendations for further investigation for all 14 cases

| Proposed further action | Trust case number | Trust | Year |
|---|---|---|---|
| B1 | I15731 | Hertfordshire Partnership NHS Foundation Trust | 2005 |
| B2 | 0076 | North Essex Partnership NHS Foundation Trust | 2003 |
| B2 | 0184/05 | North Essex Partnership NHS Foundation Trust | 2005 |
| B2 | 0211/05 | North Essex Partnership NHS Foundation Trust | 2005 |
| B2 | 0233/06 | North Essex Partnership NHS Foundation Trust | 2006 |
| C1 | 91 | Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust | 2005 |
| C1 | 075/2006 | Cambridge and Peterborough NHS Foundation Trust | 2006 |
| C1 | I11954 | Hertfordshire Partnership NHS Foundation Trust | 2004 |
| C1 | I11955 | Hertfordshire Partnership NHS Foundation Trust | 2005 |
| C1 | 0108/04 | North Essex Partnership NHS Foundation Trust | 2003 |
| C1 | 179/05 | North Essex Partnership NHS Foundation Trust | 2005 |
| No further action | 33A and 33B | Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust | 2004 |
| No further action | I11228 | Hertfordshire Partnership NHS Foundation Trust | 2004 |
| No recommendation due to ongoing criminal proceedings | 0277/06 | North Essex Partnership NHS Foundation Trust | 2006 |

Key

| | |
|---|---|
| A | Wide-ranging investigation by a team examining a single case |
| B1 | Narrowly focused investigation by a team examining a single case |
| B2 | Narrowly focused investigation by a team examining a group of themed cases |
| C1 | Single investigator (with peer reviewer) examining a single case |
| C2 | Single investigator (with peer reviewer) examining a group of themed cases |

## Detailed recommendations

**Type A - Wide-ranging investigation by a team examining a single case**

We feel it is necessary to recommend a panel investigation only where the apparent scale of the failures is organisation-wide, multi-agency and involves many systems and processes. We would expect this type of investigation to be used only where the case is clearly complex. This type of investigation would have broad terms of reference and involve more witnesses than any of the other types of investigations.

None of the cases for NHS East of England meet these criteria and we therefore do not recommend this type of investigation for any cases.

**Type B - Narrowly focused investigation by a team**

An investigation of an individual case by a team of two people (with the ability to call on expert advice if needed) is suitable in cases that are less complex than those where we recommend a type A investigation (a wide-ranging investigation by a team examining a single case). A type B investigation would include a review of the key issues and focus on learning lessons. We would expect this type of investigation to include fewer interviews than a type A investigation.

We recommend two different forms of this type of investigation. First, an individual investigation of a particular case. Second, cases that can be grouped together around a common theme.

***Type B1- Narrowly focused investigation by a team examining a single case***

We recommend one case for a type B1 investigation and we recommend that the investigation could be jointly commissioned by the SHA and the local authority.

| Trust case number | Trust | Year |
|---|---|---|
| I15731 | Hertfordshire Partnership NHS Foundation Trust | 2005 |

*Type B2 - Narrowly focused investigation by a team examining a group of themed cases*

We recommend the following four cases from North Essex Partnership NHS Foundation Trust are investigated together. This themed investigation would include not just an investigation of the care and treatment of the four perpetrators but would also focus specifically on the themes of CPA and risk assessment and management. A themed approach will ensure a proportionate response and that the investigation is undertaken effectively and without duplication. In addition, a themed approach will also recognise that there are likely to have been developments made in the trust since the incidents in its application of CPA and risk assessment and management.

| Trust case number | Trust | Year |
|---|---|---|
| 0076 | North Essex Partnership NHS Foundation Trust | 2003 |
| 0184/05 | North Essex Partnership NHS Foundation Trust | 2005 |
| 0211/05 | North Essex Partnership NHS Foundation Trust | 2005 |
| 0233/06 | North Essex Partnership NHS Foundation Trust | 2006 |

### Type C – Single investigator (with peer reviewer)

This type of investigation would be conducted by a single investigator supported by a peer reviewer, with access to expert advice as necessary. The investigation would involve a smaller number of interviews alongside a review of documents, including medical records. The interviews would focus on managers rather than on front-line staff.

Cases suitable for this type of investigation would be those where the facts of the case could easily be attained through the internal investigation report. This type of investigation is appropriate where the issues are not overly complex.

We recommend this type of approach for the following cases.

*Type C1 – Single investigator (with peer reviewer) examining a single case*

| Trust case number | Trust | Year |
|---|---|---|
| 91 | Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust | 2005 |
| 075/2006 | Cambridge and Peterborough NHS Foundation Trust | 2006 |
| I11954 | Hertfordshire Partnership NHS Foundation Trust | 2004 |
| I11955 | Hertfordshire Partnership NHS Foundation Trust | 2005 |
| 0108/04 | North Essex Partnership NHS Foundation Trust | 2003 |
| 179/05 | North Essex Partnership NHS Foundation Trust | 2005 |

*Type C2 – Single investigator (with peer reviewer) examining a group of themed cases*

We have not recommended this approach for any cases.

# Appendices

## Appendix A – Blank assessment toolkit

INVESTIGATIONS – REVIEWS – INQUIRIES

**Assessment toolkit**

**Name of NHS trust**:

**Initials of the perpetrator**:

**Verita reference number**:

**Assessor**: **Peer reviewer**: **Lawyer**:

**List of documents seen when reviewing**:

The assessment toolkit provides the criteria for:

1. Assessing the quality of individual internal investigation reports and associated reports and paper work
2. Identifying the themes from each investigation report and highlighting new themes that may need more investigation
3. Identifying cases that need more investigation.

**Executive case summary (to be completed at the end of the review):**

| Incident |
| --- |
| History of care and treatment |
| Quality of internal investigation report |
| Service failures identified in the internal investigation report |
| Proposed further action |

| STAGE ONE |
| --- |
| **Part 1. Overview** |
| **1.1.1 Details about the incident:**<br>Name of perpetrator(s)<br>Name of victim(s)<br>What happened<br>When it happened<br>Where it happened<br>Additional information provided about the incident |
| **1.1.2 Information about the perpetrator:**<br>Age<br>Sex<br>Ethnic background<br>Contact with mental health services, e.g inpatient, community patient, absconded, discharged from services, out of contact |

| Date last seen by mental health services | | |
|---|---|---|
| Next planned contact with mental health services<br><br>Was there non-engagement by the perpetrator? (If yes, please specify last appointment attended, date of appointment and also if there was appropriate follow-up)<br><br>Was the perpetrator under the care of specialist mental health services, i.e. referred, assessed and accepted for treatment or care within the six months prior to the homicide? | | |
| Please tick all applicable: | | Comments: |
| Enhanced CPA | ☐ | |
| Standard CPA | ☐ | |
| Subject to mental health act, e.g. section 2, 3, 25, 117 | ☐ | |
| CAMHS | ☐ | |
| Contact with drug and alcohol services | ☐ | |
| Primary care only | ☐ | |
| Probation services | ☐ | |
| MAPPA | ☐ | |
| Sex offenders register | ☐ | |
| POVA | ☐ | |
| Was the perpetrator given a diagnosis? | ☐ Y | ☐ N |

| If yes, what was it? | Comments (including possible secondary diagnosis): |
|---|---|
| What medication was the perpetrator prescribed? And by whom? | |
| Compliance with medication | |
| Was there a history of violence? | |
| Type of accommodation (own property, hostel etc) | |
| **1.1.3 Information about the victim**<br><br>Is any available?<br><br>If any is available:<br><br>Age<br><br>Sex<br><br>Ethnic background | <br><br>☐ Y ☐ N |
| What was the victim's relationship to the perpetrator:<br><br>Acquaintance<br><br>Stranger<br><br>Family member<br><br>Partner/Spouse | <br><br>☐<br><br>☐<br><br>☐<br><br>☐ |

| Known to services (e.g. mental health, probation, prison, social services)? | ☐ Y ☐ N ☐ Unknown |
|---|---|
| If no, please continue to Part 2. | |
| If yes:<br>Contact with mental health services, e.g inpatient, community patient, absconded, discharged from services, out of contact<br>Date last seen by mental health services<br>Next planned contact with mental health services<br>Was there non-engagement by the victim? (If yes, please specify if there was appropriate follow-up)<br>Was the victim under the care of specialist mental health services, i.e. referred, assessed and accepted for treatment or care within the six months prior to the homicide?<br>Out of contact with services/non-engagement? (If yes, please specify if this was by patient choice or due to services not following up) | |

| Please tick all applicable: | | Comments: |
|---|---|---|
| Enhanced CPA | ☐ | |
| Standard CPA | ☐ | |
| Subject to mental health act, e.g. section 2, 3, 25, 117 | ☐ | |
| CAMHS | ☐ | |
| Drug and alcohol services | ☐ | |
| Primary care only | ☐ | |
| Probation services | ☐ | |

| | | |
|---|---|---|
| | MAPPA | ☐ |
| | Sex offenders register | ☐ |
| | POVA | ☐ |
| | Was the victim given a diagnosis? | ☐ Y ☐ N |
| | If yes, what was it? | Comments (including possible secondary diagnosis): |
| | What medication was the victim prescribed? And by whom? | |
| | Compliance with medication | |
| | Type of accommodation (own property, hostel etc) | |
| **Part 2. Criminal proceedings and additional information** | | |
| **1.2.1** What was the perpetrator charged with? | | |
| **1.2.2** If the case has come to court, what did the perpetrator plea, e.g. diminished responsibility? | | |
| **1.2.3** If the criminal proceedings are complete, what was the verdict? | | |
| **1.2.4** What was the outcome of the coroner's hearing on the victim? For example, was there a narrative decision? | | |

| **Part 3. Internal investigation** | Yes | No | Comments |
|---|---|---|---|
| **1.3.1** Has the trust carried out an internal investigation?<br><br>If no: please go straight to Part 4. | ☐ | ☐ | |
| **1.3.2** Were there terms of reference?<br><br>If no: please go to 1.3.3<br><br>If yes:<br>Were they appropriate? | ☐<br><br><br><br>☐ | ☐<br><br><br><br>☐ | |
| **1.3.3** The internal investigation team:<br><br>**a)** Name the team members and their titles:<br><br>**b)** Comment on the independence of team members (i.e. were team members independent of the service where the incident took place and to what degree) | | | |
| **1.3.4** What time elapsed between the incident and the completion of the investigation report? | | | |

| | Yes | No | Comments |
|---|---|---|---|
| **1.3.5** Did the internal report indicate that: | | | |
| a) Staff were involved in the investigation? | ☐ | ☐ | |
| b) Staff were supported as necessary? | ☐ | ☐ | |
| c) Victim's families were involved in the investigation? | ☐ | ☐ | |
| d) Victim's families were supported as necessary? | ☐ | ☐ | |
| e) Perpetrators or their families were involved in the investigation? | ☐ | ☐ | |
| f) Perpetrators or their families were supported as necessary? | ☐ | ☐ | |
| **1.3.6** Did the internal investigation report: | | | |
| a) Cover the correct period? | ☐ | ☐ | |
| b) Provide a list of evidence (including a list of witnesses)? | ☐ | ☐ | |
| c) Neglect to interview any witnesses that you think should have been seen? If yes, please specify: | ☐ | ☐ | |
| d) Provide a chronology of events leading up to the incident? | ☐ | ☐ | |
| e) Provide findings based on evidence? | ☐ | ☐ | |
| f) Include recommendations that were… | | | |
| i. relevant to the findings | ☐ | ☐ | |
| ii. clear | ☐ | ☐ | |
| iii. actionable | ☐ | ☐ | |
| iv. comprehensive/sufficient | ☐ | ☐ | |

| | | | | |
|---|---|---|---|---|
| **1.3.7** Is there an action plan outlining the recommendations?<br><br>If no: please go straight to 1.3.8 | ☐ | ☐ | ☐ Don't know | |
| If yes: Are there people identified to take forward the recommendations?<br>Does it have a clearly identified timescale for implementation?<br>If so, is the timescale proportional?<br>Has the senior management reviewed the implementation of the action plan? | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | | |
| **1.3.8** Has the trust board accepted the investigation report? | ☐ | ☐ | ☐ Don't know | |
| **1.3.9** Does the internal investigation report demonstrate significant/systemic service failure?<br><br>If no: please go straight to 1.3.10<br><br>If yes, do any of the documents supplied indicate that action is being taken to address these? | ☐<br><br><br><br>☐ | ☐<br><br><br><br>☐ | | |
| **1.3.10** Do you think that the internal investigation was robust? | ☐ | ☐ | | |
| **1.3.11** Do you think that the report is of a good standard? | ☐ | ☐ | | |

**1.3.12** Do you think there are any significant systemic service failures, which were not identified in the internal investigation report?

| **Part 4. Any other relevant information to take into consideration** | Yes | No | Comments |
|---|---|---|---|
| **1.4.1** Is there any evidence that an independent investigation or review was commissioned by anybody OTHER than the SHA (for example HCC, CSCI, chapter 8 review, probation or local authority)? If yes, please specify: | ☐ | ☐ | |
| **1.4.2** Is there any indication in the documentation made available to you (the assessor) that the family of the victim think the trust or other agencies have failed?<br><br>If no: please go straight to 1.4.3 | ☐ | ☐ | |
| If yes:<br><br>**a)** What do the family think the failure is?<br><br>**b)** How do you (the assessor) know this? | | | |
| **1.4.3** Is there any indication in the documentation made available to you (the assessor) that the perpetrators or their family feel that the trust or other agencies have failed?<br><br>If no: please go straight to 1.4.4 | ☐ | ☐ | |

| If yes:<br><br>a) What do the family think the failure is?<br><br>b) How do you (the assessor) know this? | | | | |
|---|---|---|---|---|
| **1.4.4** Are the families requesting an independent investigation? | ☐ | ☐ | ☐ Don't know | |
| **1.4.5** How much media coverage has there been? | | | | |
| **1.4.6** Have the Department of Health, any other NHS body or other government departments expressed a view or offered advice about the case? | ☐ | ☐ | ☐ Don't know | |

| Part 5. **Main themes, findings and recommendations outlined in the internal report** | | | |
|---|---|---|---|
| **1.5.1** Narrative comment on main themes, findings and recommendations in internal report | | | |
| **1.5.2** Were any of the following themes identified… | in the report | by you | Comments |
| **A** Inadequate risk assessment and management | ☐ | ☐ | |
| **B** Poor communication between professionals within the trust | ☐ | ☐ | |
| **C** Poor communication between agencies | ☐ | ☐ | |
| **D** Inadequate application of CPA | ☐ | ☐ | |
| **E** Lack of or inappropriate use of MHA | ☐ | ☐ | |
| **F** Failing to listen to carers | ☐ | ☐ | |
| **G** Insufficient response to the patient's non-engagement | ☐ | ☐ | |
| **H** Non-compliance with medication | ☐ | ☐ | |
| **I** Lack of implementation of child safeguarding procedures | ☐ | ☐ | |
| **J** Misdiagnosis and medical mismanagement | ☐ | ☐ | |

| **Part 6. Independent investigation** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| **1.6.1** Are any of the criteria from HSG (94)27 outlined below met in this case? | | | |
| **a)** 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 | ☐ | ☐ | |
| **b)** 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 or life threatening injury, there is an obligation on the State to carry out an effective investigation | ☐ | ☐ | |
| **c)** The SHA determines that an adverse event warrants independent investigation, for example is there concern that an event may represent significant systemic service failure, such as cluster of suicides? | ☐ | ☐ | |
| **1.6.2** If "yes" to any of the above, please continue to **STAGE TWO**. | | | |

| STAGE TWO | |
|---|---|
| **Part 1. Assessor's summary** | |
| **2.1** In your opinion, what further action is needed to comply with the requirements of HSG (94) 27 and why? | |
| Assessor | Date |

| **Part 2. Peer reviewer's summary**[3] | |
|---|---|
| **2.2.1** Critique the assessor's summary outlined in 2.1, i.e. do you agree with the assessor's recommendation for further action? | |
| **2.2.2** Please provide any additional information (including possible omissions by the assessor). | |
| Peer reviewer | Date |

[3] Process of peer review: 1. Read relevant papers; 2. Read through the assessor's comments and conclusions; 3. Answer 2.2.1 and 2.2.2

**Part 3. Proposed action following discussion between assessor and peer-reviewer**

**2.3.1** What further *independent* action do you (assessor and peer-reviewer) propose?

| | |
|---|---|
| A Wide-ranging investigation by a team examining a single case | ☐ |
| B1 Narrowly focused investigation by a team examining a single case | ☐ |
| B2 Narrowly focused investigation by a team examining a group of themed cases | ☐ |
| C1 Single investigator (with peer reviewer) examining a single case | ☐ |
| C2 Single investigator (with peer reviewer) examining a group of themed cases | ☐ |

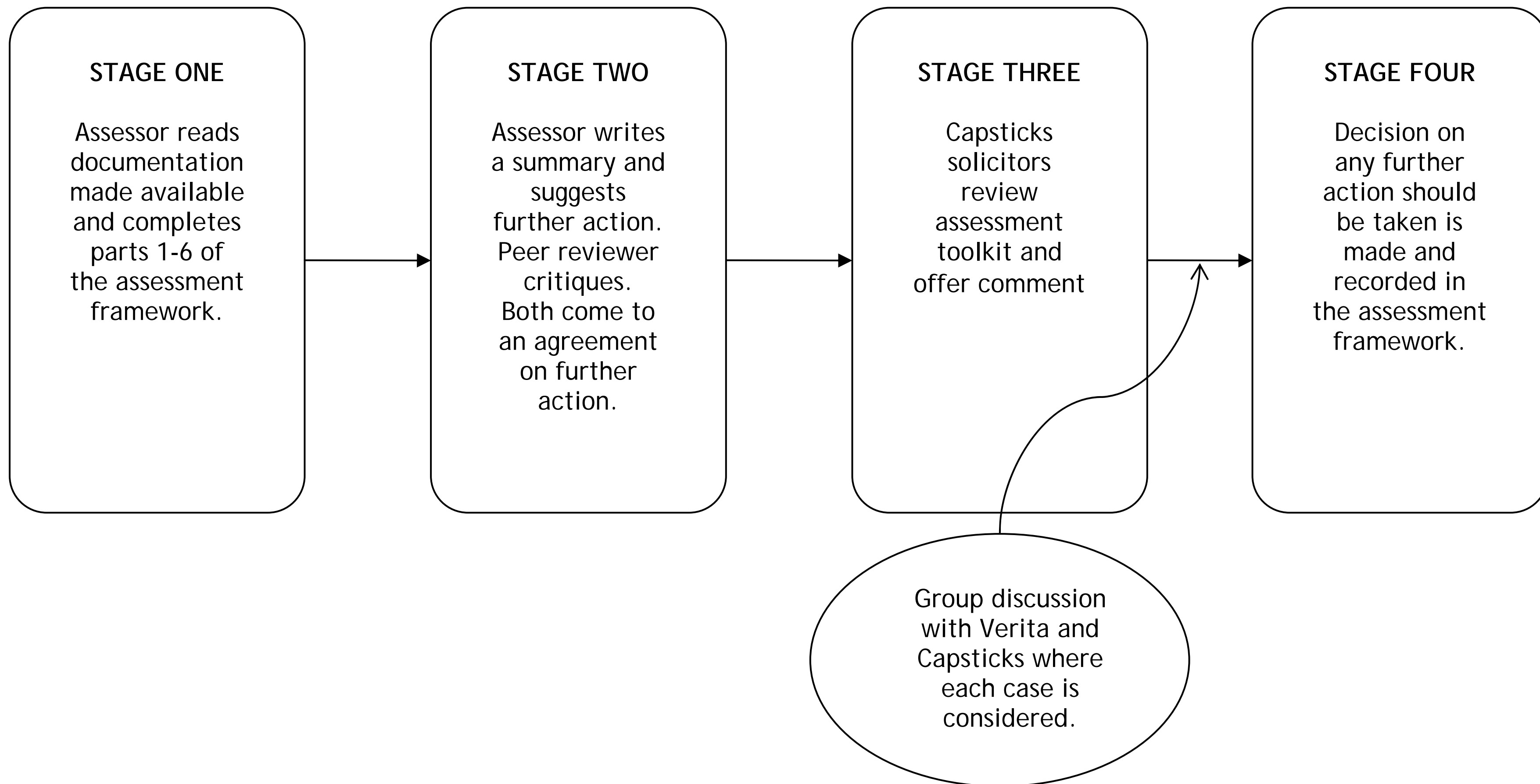
**2.3.2** Comments

| Assessor | Date | Peer reviewer | Date |
|---|---|---|---|
| | | | |

| STAGE THREE | |
| --- | --- |
| **Legal assessment** | |
| **3.1** What are the legal issues arising from this case? | |
| Lawyer | Date |

| STAGE FOUR | | | |
|---|---|---|---|
| **Outcome of group discussion** | | | |
| **4.1** Comments | | | |
| **4.2** What further action on this case was agreed at the group discussion of all cases? (for detailed description of each, please see 2.3.1)<br>A Wide-ranging investigation by a team examining a single case ☐<br>B1 Narrowly focused investigation by a team examining a single case ☐<br>B2 Narrowly focused investigation by a team examining a group of themed cases ☐<br>C1 Single investigator (with peer reviewer) examining a single case ☐<br>C2 Single investigator (with peer reviewer) examining a group of themed cases ☐ | | | |
| Verita | Date | Capsticks | Date |

Process flowchart



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# Appendix B - Detailed methodology

The overall process of the assessment of each case was undertaken in two stages.

*Stage 1*

1. A team of two was assembled to act as assessors and peer reviewers for all cases together with two solicitors from Capsticks.
2. A confidential log was compiled and maintained of all the documents received.

*Stage 2*

1. Team members received a comprehensive briefing about the work, the timescales, the use of the assessment toolkit and the peer review process.
2. Each case was individually assessed and the relevant sections of the assessment toolkit completed.
3. Each case was peer reviewed and a summary of the critique of the assessment included in the assessment toolkit.
4. A consensus was reached between the assessor and the peer reviewer about their initial recommendations for further work.
5. Each case was reviewed by a lawyer and the assessor and a legal comment was added to each assessment toolkit.
6. A meeting took place to check the consistency, proportionality and the reasonableness of the draft recommendations and to ensure that no potential themes had been missed.
7. Each assessor included the recommendations from the joint discussion in the assessment toolkit.

# Appendix C - Biographies of team members

**Chris Brougham**

*Biography*

With a particular expertise in root cause analysis, Chris heads up Verita's training programme, working additionally across the range of our investigative work. She has over 25 years of senior nursing and general management experience in both operational and strategic positions within the NHS and was latterly a patient safety manager at the National Patient Safety Agency.

*Mental health background*

Chris was for several years director of mental health services for older people and acting director of nursing in the former Leicestershire Mental Health Service NHS Trust. In this post she was a member of the trust's senior management team.

With Verita, Chris has undertaken systematic incident training sessions in a range of mental health settings and has spoken at a number of conferences and seminars. She is currently working on two homicide investigations as well as a review of the discharge arrangements within a trust for patients with dementia.

**David Watts**

*Biography*

David is a registered mental health nurse with qualifications in counselling and psychotherapy. David has worked in the NHS for over 20 years, first as a practitioner and, for the last 10 years in management where he has dealt with investigations relating to complaints, staff practice, employment issues and serious untoward incidents. Before joining Verita he was the deputy operations manager (national division) at the South London and Maudsley NHS Trust.

*Mental health background*

David has been project manager for Verita on one homicide investigation, conducted on behalf of NHS South East Coast. As part of a small team he has participated in two further independent homicide investigations for NHS London under the HSG (94)27 and reviewed an internal investigation commissioned by NHS North West.

### David Mason

David Mason is a solicitor and became a partner at Capsticks in 1990. He has advised NHS bodies involved in investigations under the HSG (94)27 since the guidance came out. This work has been both for those commissioning the investigations and for those whose services have been the subject of investigations. High-profile mental health inquiries with which he has been involved include Michael Stone and John Barrett.

David Mason has also provided training on behalf of the Department of Health, Healthcare Commission and National Patient Safety Agency on the conduct of mental health serious police patient incident investigations, and has assisted in the drafting of the National Patient Safety Agency's guidance notes (as yet unpublished) on carrying out investigations under the HSG(94)27.

### Ashley Irons

Ashley Irons is a solicitor and partner at Capsticks who specialises in mental health related issues. He has been involved in all manner of investigations and inquiries involving mental health services during the last 17 years. This includes, representing Ashworth Hospital during the course of two judicial inquiries - an investigation into complaints in 1992, and an inquiry, chaired by Judge Fallon, into the Personality Disorder Unit in 1999.

He is an advocate at inquests and mental health review tribunals. He is a well-known speaker at national conferences, including on risk issues for forensic and non-forensic audience.