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Around 100 families a year will have a loved one killed by someone with mental illness

Is Scotland investigating Homicides by patients of Mental Health Services effectively?

A briefing paper for the Scottish Government and MSPs

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EXECUTIVE SUMMARY

- **Despite high numbers of homicides committed by people with mental illness in Scotland, there is little evidence that responsible organisations are investigating these cases effectively.**
- **There is little evidence that Scottish Health Boards are fully aware when their patients have committed a homicide.**
- **Healthcare Improvement Scotland has no remit for the review of patient homicides**
- **The Mental Welfare Commission for Scotland appears to have ceased commissioning and publishing independent investigations of mental health homicides in Scotland.**
- **As a result there is little evidence to show that lessons are being learned effectively to protect patients and the public and to prevent further tragedies in future.**
- **Better, more frequent, and more transparent investigations could improve mental health care by preventing avoidable errors, and potentially save dozens of innocent lives in Scotland**

Official figures show that 136 recent mental health patients have been convicted for homicides in Scotland in the last 10 years.[i]

INDEPENDENT INVESTIGATIONS

In England it is common for homicides committed by patients to be investigated initially by the local mental health trust, and then, if the case meets certain criteria, to be investigated independently by an outside panel.[ii]

The purpose of these investigations is to ensure that if there have been any problems with the care and treatment of the perpetrator before the homicide occurred, they can be identified and acted upon, to prevent similar problems in future and to avoid further preventable deaths.[iii]

These reports are usually published in the interests of accountability and transparency and to facilitate wider learning.[iv]

Evidence from the English investigations suggests that anything between 20 – 35% of all mental heath homicides are preventable.[v]

In Scotland this would translate to between 31 and 54 avoidable deaths over the last ten years.

MH HOMICIDE INVESTIGATIONS IN ENGLAND & SCOTLAND

In England over the last 10 years 576 patients have been convicted of homicide. As a result some 321 independent investigation reports have been published.[vi]

In Scotland over the same period 136 patients have been convicted of a homicide and two independent investigation reports have been published. [vii]

Not a single independent investigation into a patient homicide has been published in Scotland in the past five years.[viii]

HEALTHCARE IMPROVEMENT SCOTLAND

Healthcare Improvement Scotland (HIS) was established to drive improvements in the quality of healthcare in Scotland through scrutiny of clinical services, by providing clinical standards and advice, and by supporting health boards improve the quality of their care and investigations.[ix]

In September 2013 they established a National Framework (*Learning from adverse events through reporting and review*),[x] to promote a consistent national response to reporting across Scotland, which recommends that such events should be *'reviewed using best practice investigative techniques and technologies.'*[xi]

Although HIS receive and monitor reports of patient suicides from Health Boards, currently they have no remit for the scrutiny or review of patient homicides.[xii]

- **Significant Adverse Event Reviews**

HIS recommends that the most serious incidents should result in a comprehensive adverse event analysis and review - commonly known as Significant Adverse Event Reviews (SAERs).[xiii]

Recent Freedom of Information requests to all 14 Scottish Health Boards reveal that of the 40 patient homicides recorded in Scotland over the last three years,[xiv] fewer than 10 have been the subject of a Significant Adverse Event Review, or similar investigation.[xv]

There is little evidence that NHS Health boards in Scotland are systematically conducting SAERs after patient homicides.

Only two of these SAERs have been released,[xvi] but in such a heavily redacted form as to be practically useless as a means for sharing learning. (Example attached).

- **Reporting to the National Confidential Inquiry**

The HIS National Learning Framework also notes that Health Boards must report specific serious incidents to external regulators, including to UK wide national audits and enquiries.[xvii] This includes the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, which is responsible for collecting and analysing statistical data from such incidents across the UK.[xviii]

Evidence from recent Freedom of Information requests reveals that of 74 patient homicides in Scotland reported to NCISH over the last five years,[xix] only two cases were actually known to NHS Health Boards.[xx]

NHS Health Boards in Scotland do not appear to know how many of their patient homicides have been reported to the National Confidential Inquiry. Freedom of Information requests show there is little evidence that NHS Health Boards are fully aware of the numbers of their patients who commit homicides.[xxi]

If Scottish Health Boards do not have appropriate systems in place to record patient homicides, they cannot review or learn from them effectively.

MENTAL WELFARE COMMISSION

In Scotland the Mental Welfare Commission for Scotland (MWCS) has powers to independently investigate homicides by mental health patients.[xxii]

In theory, the MWCS should be contacted by Scottish NHS Health Boards following a patient homicide.[xxiii] The MWCS say they are not always informed by Health boards of such incidents.[xxiv]

- **NHS Health Board Investigations**

When Scottish NHS health boards do undertake reviews or investigations into patient homicides, there is little evidence they aid learning, as they are internal documents and not usually published.

The quality of these internal investigations can sometimes be poor.

The MWCS has itself said, *"We found some internal reports did not investigate possible failures thoroughly and impartially".*[xxv]

In another case they said, *"Our investigation found that the [internal] critical incident review related to Mr F's case fell well short of an expected standard."*[xxvi]

Healthcare Improvement Scotland has also acknowledged that the quality of some NHS Board's adverse event reviews can also be very poor.[xxvii]

Poor internal reports, where health trusts are essentially investigating themselves, are also a common problem in England. (See Appendix A for examples).

Internal Reports are therefore not always the best method of uncovering problems or learning effective lessons from serious incidents in mental health services.

- **MWCS Homicide investigations**

When MWCS are informed about a patient homicide, they say will look at the case, and decide if there appears to be any failings worth investigating, or if there is anything to learn.

It is unclear, however, how they can determine if there are any lessons to learn in advance of any rigorous investigation.

In the last ten years MWCS has only published two independent investigations out of 136 patient homicides recorded in Scotland.[xxviii]

As of early this year MWCS said were not undertaking any full investigations into patient homicides.[xxix]

We are aware of at least 17 Scottish mental health homicides since 2007 which all raise serious questions about the adequacy and effectiveness of mental health care delivered, and where no independent health service investigation has been undertaken at all. (See Appendix B)

The MWCS does review a few mental health homicides, (usually after contact from the Scottish government) but these are not full and robust investigations, and appear to rely solely on Board's own internal Reviews, which can be problematic.

The MWCS does not routinely publish these findings; they do not involve victims' families (who may have highly relevant patient information), and in some cases anonymise the reports to such a degree as to make them practically meaningless.[xxx]

WHY ROBUST PUBLISHED INDEPENDENT INVESTIGATIONS ARE NECESSARY

- They can uncover problems in care that internal investigations fail to address
- They can aid learning and help prevent avoidable deaths
- They can provide much needed support and information to victims about how and why their loved ones died
- They can highlight areas where care was good and effective
- They can promote greater transparency and accountability in health services
- They can promote greater patient and public safety
- They can lead national learning to promote safer services
- They can help inform Fatal Accident Inquiries
- They can provide reassurance to the public of the ability of mental health services to learn lessons effectively and prevent further deaths
- They can help reduce the Stigma against people with mental illness, which is often exacerbated following violent acts by patients.[xxxi]

WHAT NEEDS TO BE DONE

1. Scottish NHS Boards need to improve their record keeping of patients who commit homicides and share this information better with the MWCS and other agencies.

2. MWCS needs to conduct and publish more robust and independent mental health homicide investigations.

3. Healthcare Improvement Scotland should establish a patient '*Homicide Reporting and Learning System*,' similar to that in operation for patient suicides.

4. NHS Health boards, HIS and MWCS should engage with victims to learn how they can better improve their investigations and services.

We suggest a national conference of all Scottish Health Boards, the MWCS, the Crown Office and Procurator Fiscals Office, Scottish Government and Victims to discuss potential barriers and opportunities to achieve this programme.

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Appendix A - Problems with internal reports in England

A number of Independent Mental Health Homicide Inquiries have commented on the poor quality of internal reports by Mental Health Trusts in England:

NHS England - Kayden Smith (July 2014)
"*There are a number of important omissions [in the internal investigation] and there was a lack of depth to the understanding of what some of the problems were"* (p 62)

NHS England – Joshua Anderson (2014)
"The trust's serious incident investigation and report was inadequate as a means of reviewing the care of JA and DL. It was also inadequate as a means of learning for the trust. (p9)
The people [who commissioned and conducted the investigation] were managerially responsible for the services they were investigating (p37)
The trust report includes significant gaps…. It does not address a number of key issues" (p38)

NHS England – Derek Lindley (2014)
"The [internal] investigation was limited in its scope …and no objective analysis of the information found in the clinical records took place. The care and service delivery problems, contributory factors, root causes, lessons learnt, a summary of the recommendations and the arrangements for shared learning are not specifically identified The report made one recommendation… However it was not clear how it linked to the issues identified within the report "(p 32)

NHS England – Shane Farrington (2013)
"The Internal Investigation …. in relation to Mr A's care was at best 'cursory'…the Internal Investigation did not seek to fully establish what had been the issues involved in Mr A's care. This is a cause for concern" (p 14)

NHS South of England – Shea Maclean Inquiry (2013)
"The internal serious incident investigation process was flawed and did not contain the appropriate level of objective qualitative analysis, and this has resulted in the relevant lessons for improving practice not to have been learned and implemented in a timely manner." (p 10ff)

NHS Yorks and Humber / NHS London - Ahmed Ali Inquiry (2012)
"The conclusions drawn by the panel are not linked clearly to the evidence presented nor are they related back to the terms of reference. One of the terms of reference (risk assessment and risk management) is not discussed at all… there is no reference to his CPA status or MHA status…. The lack of analysis of the care and delivery issues also leaves gaps in the report…The single recommendation is poorly written…and does not get to the heart of what that report discovered as system failures"

NHS London – Westley Ibe Inquiry (2012)
"The analysis of the Trust's own investigation did not reveal information consistent with an effective investigation process."

NHS London – Omar Parado-Blanco (2012)
"The report actions do not adequately address poor practice in relation to risk management, care planning (including activities in both ward and community settings), medication management; non-compliance with drug testing and knowledge of dual diagnosis patients; carers assessment and the involvement of families" (p 6)

NHS North West - Jonathan Mills Inquiry (Sept 2011)
"The process and the conclusions of the [internal] investigation were very limited… There was a lack of analysis of the care and treatment of Mr Y and a failure to identify learning from the incident…of the two recommendations made in the report one was not justified by the evidence in the case. The service

manager responsible for the team had not seen the report and was not interviewed as part of the process. …Neither the perpetrator's or the victim's family were contacted by the Trust [which] caused considerable resentment…We found the conclusions of the report had not been disseminated to staff and there had been no learning from the incident" (p132ff)

NHS East of England - Anne Marie Janczuk Inquiry (2011)
"The Trust's internal investigation does not provide a complete list of care and service delivery problems" (p75)

NHS London – Malachai Adam Smith Inquiry (Mar 2011)
"The internal review report did not provide a fully detailed analysis of the care and treatment provided to Mr XY" (p7)

NHS London - CH Inquiry (2011)
"The scrutiny team found that the internal review report was not a well balanced review of Mr CH's treatment." (p6)
There was no demonstrable analysis of the evidence that facilitated links between findings and recommendations. (p21)

NHS London - Philip Theophilou Inquiry (2010) p 200.
"The findings of the internal inquiry in the PT case were neither accurate nor reliable".

NHS Yorkshire and Humber - George Garnett Inquiry (2008) p3:
"The internal report … was not at all analytical and did not evidence the degree of critical appraisal expected in the level of investigation."

NHS East Midlands - Khalid Peshawan Inquiry (p124/5)
"The internal review did not adequately explore all of the issues relating to the care and treatment of Mr. X…..None of the Internal Review Team members had been involved in an exercise of this kind before" [The findings were] *'a little superficial*'

NHS East of England - John McFarlane Inquiry (p11) Nov 2011
"The Trust investigation process was sub-optimal… The processes were not robust, staff felt out of their depth and a robust Serious Untoward Incident Investigation was hampered by lack of multi-agency working with Suffolk Police."

According to **Verita**, (a company which has carried out many independent investigations)
"We… know from first-hand experience that the quality of the internal incident report is sometimes poor, making it difficult for providers to learn from past mistakes…"

Appendix B – 17 Scottish mental health homicides 2007 – 2013 with no independent investigation

1. **Ross Allen** fatally stabbed his father Sandy in what was described as 'a frenzied knife attack' at the family home in Dalkeith in July 2007. He had a nine-year history of serious mental illness during which time he'd been an inpatient at a psychiatric hospital on a number of occasions

2. **John Bryceland** was suffering from paranoid schizophrenia and had a history of mental illness when he battered, slashed and fatally stabbed his partner Jacqueline Hughes thirteen times in Glasgow in August 2007. The attack was witnessed by her two young children aged 3 and 6. Doctors had noted his worsening condition and that he was abusing drugs and was failing to take his medication. Concerned about the state of his health, Jacqueline had repeatedly tried to contact doctors treating Bryceland in the weeks before the killing. She was told they couldn't discuss his condition with her for reasons of 'patient confidentiality'. The family said - *'The system has failed Jacqueline and left four kids without parents. It must never happen again'*

3. **Anil Kumar** fatally stabbed his stepfather Satpal Ghusar thinking he was Dracula and then attempted to kill his brother Akash outside their home in Bishopbriggs in May 2008. Seriously psychotic he launched the attack just days after absconding from the psychiatric hospital where he was being detained.

4. **Ian Bryson** battered his wife of more than fifty years, May, and fatally strangled her at their home in Bellshill in October 2008. Their daughter Jan Campbell told a court she begged medical staff to assess her Dad after his mental health lapsed in the weeks before the incident. Nothing effective was done. She said when a psychiatrist did see him a week after May died, it was "too late".

5. **Mark MacDonald** repeatedly and fatally stabbed his mother Veronica in Dundee in July 2009 because he thought he was a gangster and that she was giving secret signs to the Mafia driving in taxis outside his house, was plotting to kill him, and was poisoning him with weed-killer. He had a long history of mental health problems and had been released from a psychiatric hospital just three days before the attack, despite a psychiatrist saying he was 'very, very unwell'. He had previously been sectioned several times before but had left hospitals and often had little insight into, and minimized the extent of, his serious mental health problems. After killing his Mum, he drove back to the psychiatric unit that had just released him.

6. **Ann Geddes** was battered to death with a hammer axe by her husband, Roger, at her home in Carnoustie, in February 2010. She had recently sought help from the GP about his behaviour but was just advised to contact a mental health carers group that was no longer in existence. There was a long history of domestic abuse that the medics did not uncover. He had been diagnosed with anxiety and depression and was seen by a psychiatrist just 3 days before the killing but was not assessed as being a risk. The family were not given full access to the subsequent serious case review and do not consider that justice has been served.

7. **David McNeil** suffered from schizophrenia and was not taking his medication when he battered his elderly mother, Mary, to death with a metal pole and tried to remove her brain in Rothesay, Isle of Bute in June 2010. He had a history of serious mental health problems and said that 'Egyptians' had made him do it.

8. **Walter Weir** suffered from paranoid schizophrenia and believed everyone in his neighbourhood was out to get him when he repeatedly and fatally stabbed a grandmother, Margaret Burke, in Blantyre in July 2010. Hours before his family had called the emergency services extremely concerned about his deteriorating mental health but they thought he was unable to be detained as he refused to go to hospital voluntarily.

9. **Christopher O'Reilly** fatally stabbed his partner Karen Gallagher following a row about holding a baby in Thornliebank in November 2010. He had a history of mental health problems and had been released from a psychiatric hospital in East Kilbride six months before the killing.

10. **Carol Craig** was suffering from a recurrence of a schizo-affective disorder and under the care of a local community mental health team when she fatally stabbed her mother 60 times in Glasgow in March 2011. She had a long history of mental health problems, and social workers and a psychiatrist became concerned about her deteriorating condition in the days before the assault. She was sobbing, distressed and not making sense. Early on the morning of March 7 she was found walking along Dumbarton Road with her 19-month-old son and a young nephew wearing blood stained pyjamas, which led to the discovery of her mother's body. The children appear to have witnessed the attack.

11. **Melanie Stephenson** had a twenty-five year history of mental health problems and was severely unwell when she repeatedly and fatally stabbed her former partner, Robert Brereton, in Forfar in March 2011. She said he was a *'kind and decent man.*'

12. **John Padden** (49) was diagnosed with schizophrenia aged 17 and had a long and enduring history of mental health problems that were so severe he'd been previously detained twice before at the State high security psychiatric hospital at Carstairs. In May 2011 he fatally battered his 84-year-old father, Michael, at a sheltered housing block in Dumbarton as he believed, (erroneously) that he was poisoning him. He told psychiatrists he sees vampires, gods, aliens and spaceships and had died a couple of times and had come back. He had a history of not taking his medication. The court found he was insane at the time of the killing, and sent him back once more to Carstairs.

13. **Neil Cumming** was insane when he fatally stabbed his wife, Jane, 36 times at their home near Dundee in July 2011. Just three days before the incident his wife had called doctors because she was so concerned about his deteriorating mental health. He had a twelve-year history of mental health problems and had been released from psychiatric hospital just months before the assault. On the day of the killing he saw his psychiatrist who thought he was paranoid and should be admitted to hospital. Bed shortages meant there was no place available and it was decided to 'monitor' him in the community until a bed did become free. Medics thought he was a 'low risk.' A day later he repeatedly stabbed his wife.

14. **Mark Jarvie** was suffering from schizophrenia when he fatally strangled and stabbed Jane Kelly at his home in Powmill in October 2011. Days before the killing, following family concerns about his deteriorating mental health, he'd been referred for a mental health assessment, but despite having serious concerns, his GP did not think he was ill enough to merit being detained. Jane's family said they still have many unanswered questions about why their daughter died.

15. **Douglas Lawrence** (29) battered and fatally stabbed his former girlfriend, Carolyn Ellis, 45 times with such force that the blade of the knife broke off in her head. He had a long history of schizophrenia since first being diagnosed aged 15 and also suffered from Asperger's syndrome. The court was told he'd '*struggled with aggressive thoughts over many, many years*'. Two months before the killing, in Edinburgh in January 2012 he warned doctors about his thoughts of harming her, not once but twice. Nothing was done other than asking him to come back in three months, during which time he'd killed her. NHS Lothian carried out an internal investigation into their handling of the case, which was not published. Reportedly it found no concerns and no action was taken.

16. **Marlene Torlay** was suffering from severe depression when she threw boiling water then and fatally battered her friend Marie McCracken with a hammer in East Kilbride in October 2012. She'd missed taking her medication and the court questioned whether she'd been receiving the proper treatment. The family said they were the ones given the life sentence.

17. **Lawrence Patrick** had a twenty-year history of serious mental health problems and had previously been violent towards his mother. In August 2013 he fatally stabbed a complete stranger, Alexander Glassford, whilst riding on a bus. So far the internal investigation promised by NHS Greater Glasgow Health Board has not been published.

Footnotes

[i] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (NCISH) Annual Report, July 2014, (hereafter NCISH 2014) - Patient Homicide in Scotland page 112/3. It is important to understand that these figures are for mentally ill perpetrators in touch with secondary services who were convicted. They do not include cases where an offender killed themselves after the homicide, cases in which there were multiple victims, or perpetrators who were just receiving help from primary care services; as such the NCISH figures underestimate the total number of mental health homicides in Scotland.

[ii] Department of Health Guidance HSG 94 (27) and amendments; NPSA Independent Investigation in Serious Patient Safety Incidents in Mental Health Services, 2008

[iii] DH guidance *op. cit*. – NHS England Serious Incident Investigation Framework (forthcoming)

[iv] NPSA 2008 *op. cit*. p15ff

[v] NCISH 2006 p138; SANE http://www.sane.org.uk/resources/media_centre/archive/archive_show_news/149

[vi] NCISH 2014 p55; Dave Shepherd Associates analysis – March 2014 Bulletin p 83/3.

[vii] See footnote 1 above for numbers. The two investigations are Mr L (James Smith) published in March 2006 and Mr F (Gary Ward) published in November 2009. Both investigations were only undertaken after direct representations from Government Ministers: The Gary Ward investigation after a request from Minister of Public Health (See Mr F Full investigation p 2); the James Smith Investigation after an invitation from the First Minister. (Mr L investigation p 1).

[viii] The last one Mr F (Gary Ward) was in November 2009

[ix] http://www.healthcareimprovementscotland.org/about_us.aspx

[x] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx

[xi] *ibid* – paragraph 3.33 page 19

[xii] E-mail from Senior Programme manager, Healthcare Improvement Scotland 20 October 2014 and letter from Robbie Pearson, HIS Director of Scrutiny & Assurance to Scottish Parliament Health and Sport Committee, 29 October 2014

[xiii] *ibid* – paragraph 3.28 page 17

[xiv] NCISH 2014 - See Footnote 1

[xv] Freedom of Information Requests from 22 October 2014 found ten health Boards had conducted no SAERS (Ayrshire & Arran, Borders, Dumfries and Galloway, Fife, Forth Valley, Grampian, Lanarkshire, Orkney, Shetland, & Western Isles); one had no record of any (Highland); one wouldn't say (Tayside); one wouldn't give an exact number but said it was "less than five" (Lothian); and ne said they had five SAERs of which two were still on-going. (Greater Glasgow & Clyde)

[xvi] They were released as a result of the Freedom of Information Request by this organisation. A search of all 14 NHS board websites could not find any SAER publically available relating to a patient homicide.

[xvii] HIS National Framework for learning from adverse events, *op cit.* paragraph 3.15, page 14

[xviii] http://hqip.org.uk/national-confidential-inquiry-into-suicide-and-homicide/

[xix] NCISH 2014 - See Footnote 1

[xx] Freedom of Information requests to all 14 Scottish health boards, were submitted on 22 October 2014. Seven Boards said no patient homicides were reported to NCISH (Borders, Dumfries and Galloway, Fife, Grampian, Orkney, Shetland, & Western Isles); four Boards said they didn't hold the information (Forth Valley, Greater Glasgow & Clyde, Lothian & Tayside); one said they had had no such cases over the last three years, but would have to do a manual check of all individual patient records for cases further back, which was impractical. (Lanarkshire); one said they had had two cases in 2010. (Highland). One said although they work with NCISH, they do not report directly to them. They said they did not hold a central register of enquiries from NCISH. (Ayrshire & Arran).

[xxi] See the evidence on Serious Adverse Event Reviews and reporting to the National Confidential Inquiry, above. Additionally Freedom of Information requests by this organisation last year to all 14 Scottish NHS Health Boards revealed they were only aware of around 20 of the 136 homicides committed by patients in Scotland over the last ten years. The other 116 cases were unaccounted for, and presumably no lessons have been learned from them.

[xxii] Section 11 of Mental Health (Care and Treatment) (Scotland) Act 2003. The MWCS has around 53 employees and annual budget of £3.6 million. They do not appear to consult with victims.
See also Letter '*In Scotland Mental Welfare Commission inquires into homicides by psychiatric patients.*' from JAT Dyer, Director MWCS to the BMJ. BMJ Vol 314 April 1997, p 1131
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2126465/pdf/9133916.pdf
[xxiii] MWCS Notifying the Commission http://www.mwcscot.org.uk/good-practice/notifying-the-commission/
[xxiv] Personal Communication Sept 4 2014
[xxv] MWCS 2010 – 'A thorough Internal Investigation' p 1
http://www.mwcscot.org.uk/media/51983/Mr_A.pdf
[xxvi] MWCS 2009 – Gary Ward – Mr F investigation p 8
[xxvii] E-mail from Senior Programme Manager, Healthcare Improvement Scotland, October 24 2014
[xxviii] See footnote 7
[xxix] Information from MWCS 4 February 2014
[xxx] eg MWCS report, The care and treatment of Ms FG (Mark Jarvie) changed the perpetrator's gender, and didn't even mention there had been a homicide.
[xxxi] Stigma and Violence: Isn't it time to join the Dots? September 2011 37 (5) p 892-896 Schizophrenia Bulletin http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160234/