# Thematic review of homicides and attempted homicides 2019 – 2023

Nottingham Healthcare NHS Foundation Trust

[redacted]

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## Introduction

This review was commissioned by Diane Hull (Chief Nurse). The Trust wanted to establish whether appropriate learning has happened from previous homicides and attempted homicides. The full terms of reference outline the scope of the review but the Trust was clear that the purpose of this review was not to reinvestigate the incidents, rather it was to focus on what learning could be extracted from existing reviews and improvement plans.

[redacted] was appointed to chair a panel of external and internal experts who reviewed each of the incident reports (a full list of participants is available in the appendices). Each report was reviewed by the entire panel and feedback given at bi-weekly meetings. A final full day meeting was held in person where themes and challenges were agreed – it is these that make up this report.

Seven reports were identified as meeting the criteria for inclusion of the review (five homicides and two attempted homicides). There are three further reports which have not yet been completed which fell within the timeframe of this report.

## Context

Research studies show that there is an increased risk of violence in those living with schizophrenia, however little is understood about the relationship between the two and complicating factors such as drug and alcohol abuse and genetic and early environmental factors in mediating the link between psychosis and violence.

On average there are approximately 60 homicides a year carried out by mental health patients. Of these about 49% were non adherent with drug treatment in the month prior to the homicide, 74% abused alcohol, 78% abused drugs and 25% had severe mental health problems and co-morbid alcohol/drug abuse.

In terms of characteristics most were male (86%), not married (79%) and unemployed (83%). They also had a history of violence (52%) and previous convictions (78%).

Whilst the sample size in this report is too small to draw any firm conclusions, the characteristics match the national trend, for example, 85% were male (n=6), a number had previous convictions, a history of violence and/or drug/alcohol abuse (85%). In terms of ethnicity 85% were white. No one team stood out with each of the seven cases being under a different team. Two of the cases were cared for by Local Mental Health Teams (LMHTs), one in Early Intervention in Psychosis (EIP), one by Child and Adolescent Mental Health Services (CAMHS) forensic services, one in Crisis Resolution and Home Treatment (CRHT) and finally one by Liaison and Diversion. In three of the five homicides the victim was known to the perpetrator.

## Quality of reports

The prerequisite to fulfilling the terms of reference was having high quality, well written reviews from which to draw themes and understand learning. We were aware from the start that the small sample size of seven would limit our capacity to draw generalised themes but felt that this would be possible.

We were also hopeful to see good evidence of organisational learning via the Quality Improvement Plans (QIPs). We were disappointed to find that several of the reports were of poor quality and not delivered or finalised in a timely fashion. Many had panel members without the appropriate expertise or a limited scope and remarkably two consisted only of a desktop notes review. I have outlined some of the details below.

## Timeliness, sign off and scope

| **Report level and incident type** | **Date of Incident** | **Time from incident to sign off** | **Sign off by whom** | **Scope** |
|---|---|---|---|---|
| Homicide. Comprehensive | [redacted] | 16 months | Exec Director | 3 months prior incident |
| Attempted murder. Concise | [redacted] | 19 months | General Manager | Case notes only |
| Homicide. Case Note review | [redacted] | 16 months | General Manager | Case notes only |
| Homicide. Comprehensive | [redacted] | 8 months | Exec Director | Full care |
| Homicide. Comprehensive | [redacted] | 13 months | Associate Director of Nursing | 15 days prior incident |
| Homicide. Comprehensive | [redacted] | 14months | Exec Director | 3 months prior incident |
| Attempt Homicide. Comprehensive | [redacted] | 13 Months | Associate Director of Nursing Nursing | 7 months (starts whilst AWOL from ward) |

The quickest report completed was the most complicated and by far the best of the reviews. Undertaken with an external chair the report had the widest scope and was by far the most comprehensive of the reports. Two and possibly three of the reports were of such poor quality that the panel felt that they should be reconsidered in their entirety. Only one of the incidents investigated had a scope that incorporated the whole of the care received by the patient – some of the timescales seemed completely arbitrary, for example, one of the cases started when the patient was absent without leave (AWOL) from the ward, another one consisted of only 15 days prior to the incident. Two of the reports contained so many typographical errors it is hard to understand how it managed to pass through any internal or external processes.

There was a lack of family involvement in several of the reports with reasons cited as 'not wanting to cause further distress' and that they had already been involved in a safeguarding review. None of the reports showed engagement with families from the point of incident, including input into the terms of reference and ensuring that they had adequate support and information. Overall, we felt that the engagement of the family members was poor with the panel's view that investigators did not see the importance of involvement.

For learning to be made by the individual team and the wider Trust, reviews need to be timely as well as of high quality. None of the reports were delivered in the 60 days' timeframe expected. Whilst reports of this nature are complicated by police involvement, it is the experience of a few of the panel members that with good liaison with senior police colleagues and joint working around terms of reference and interviewees, that reports can be completed without hindering police investigations.

We were unclear as to the process of how the completed reports were challenged and signed off. Most trusts reports of such serious incidents would go to either the Trust Board or to its Quality Committee and reported via the Chair of the committee to the full Board. This does not seem to have happened except for the last report.

It is also hard to understand how the reports were signed off by the commissioning body. It is beyond the scope of this review to investigate this, but it is hard to understand how some of these reports were approved by commissioners. The panel has recommended that at least two of the reports are revisited to ensure that at least some learning is extracted from the report.

The panel understands that the Trust has commenced a significant review of the Serious Incident Policy and accompanying procedures in line with the Patient Safety Incident Review Framework (PSIRF). This work includes changes to the sign off process, dedicated investigators, new governance processes and two new oversight groups (Homicide and Attempted Homicide Group and Patient Safety and Learning from Deaths Group). In line with PSIRF, safety action plans have replaced QIPs. These changes are welcome, and we recommend that the Trust develops a number of outcome measures to ensure that the process changes outlined are resulting in the changes required.

We also understand that the Trust has commissioned a review of the two incidents the panel viewed as inadequately investigated.

## Emerging themes

Given the limited number of reports and the inadequate quality of a least three of the reports, it has been difficult to draw out clinical themes with any confidence, however the panel felt there were some commonalities. One of the panel members has spent considerable time reviewing the LMHTs/EIP and crisis team and some of the themes emerging from those reviews are also evident in these reports.

## Poor engagement, lack of follow up and risk assessment

In five cases poor engagement and noncompliance was evident in a variety of ways. In two cases patients were discharged due to non-engagement with community teams, one at their own request and one due to lack of contact. In both cases there had been concerns about violence to others.

In another case a patient was taken off their depot medication due to the risk to staff when administering it. They were known to be non-complaint with oral medication and had a long risk history (described in the report as the most serious case on the Dr's case load). This is despite being on a Community Treatment Order (CTO). There appeared to be no contingency plan and no consideration given to the risk to the public.

The panel felt that risk was often viewed through the lens of self-harm and risk to staff rather than risk to the wider public. As well as this report we saw evidence in other reports of minimising risk of domestic violence, and of only carrying out two person visits due to risk to staff, but no consideration given to the risk to families or to the wider public.

We saw early discharge from inpatient care on two occasions with discharge meetings tokenistic.

A further case was discharged back to the GP following non-contact for a period of months – it is unclear what the purpose of this discharge was and what the team expected the GP to do that they could not. We saw other examples of use of 'opt in' letters for patients with known history of non-compliance and Serious Mental Illness, in one case this was following a two-day admission on a Section 2 which included one move of ward.

In summary the panel felt that poor engagement was viewed as an opportunity to discharge someone rather than a possible relapse signature – this is despite several of the patients having disengaged previously prior to relapse.

Risk was viewed through the lens of self-harm and risk to staff with little consideration given to the wider risk to the public. This is a troubling finding, and we make a recommendation regarding the follow up of all patients who have been discharged following a period of disengagement.

## Delays and waits

The panel felt that delays and waits were evident in four of the reports. In one example a referral was received on [redacted] and an initial appointment for assessment as [redacted] (a three month wait) – following the initial assessment a decision was taken to refer the patient to stabilisation skills which at the time had a further one year wait. During this period, the patient was re-referred by the GP and was making threats to kill – each time an agency re-referred they were signposted to the fact that they had assessed, and the patient would be managed on the waiting list. The report made light of the issue of the 15 months wait from referral to possible treatment noting that letters had been sent to the patient giving information of how to contact the crisis team if needed. The patient committed their offence before being seen.

The review of LMHTs carried out by one of the panel members noted significant waits and pressure within that environment and that review was carried out four years post this incident; little seems to have changed or been learnt from this tragedy.

A further incident notes a patient held in a Section 136 suite for a significant period, moved to a private Psychiatric Intensive Care Unit (PICU) and then transferred to another private PICU from which they were abruptly discharged. The report goes on to describe the patient as less willing to engage following that experience.

The reviewers understand the pressure on services and the inevitability of some waits and delays in treatment – the current lack of inpatient beds is causing untold distress to patients and relatives. However, we could see little evidence of any stratification of risk regarding waits and delays, even where other agencies requested that a patient was seen early nothing changed. It is only recently that the Trust has reviewed the process for managing patient waits in a more coherent and consistent way. The reviewers are of the view that this is important work and that the Trust should continue to refine its process for understanding who is waiting and any escalation in the risk profile of those patients and ensure there are ways to 'fast track' those most at risk.

## Multi-agency working including safeguarding.

Two of the reports viewed by the panel were also accompanied by full safeguarding reports, [redacted]. The panel was struck by the quality of the safeguarding reports compared to the internal reports. These cases highlighted the lack of knowledge or understanding of the family system that the patient was a part of outside of their attendance at the hospital/clinic.

We saw on several occasions a lack of curiosity of the patient's social situation, this was especially evident in two of the cases where there was an over reliance on what the clinicians were told and a minimising of risk, for example domestic violence was described as relationship difficulties and a lack of understanding or responding to domestic abuse indicators.

In three of the reports there was a lack of understanding of the potential safeguarding issues for children. In one there was a reliance on the history of the patient regarding the living arrangements and reassurance taken that the child was with [redacted] (they were not). We also saw a lack of interagency working and information sharing – this was especially evident in the two cases where a safeguarding report was also available to the panel and a third case involving a CAMHS patient.

The panel was of the view that there was a theme around a lack of understanding of the 'Think Family' approach particularly in adult mental health services where the focus of the care seemed to be the patient in front of them rather than the system that they were a part of.

## Quality Improvement Plans

We reviewed the QIPs for the reports. In many of the updates the actions bore little resemblance to the recommendations, actions included appointing of a safeguarding champion following a domestic violence homicide, the discontinuation of the opt in letter and it being replaced with a discharge letter and additions to standard operating procedures or various changes to processes. The panel is of the view that few of the changes cited will have any meaningful change in the practice of the staff involved in the incident, let alone the wider Trust. We could find no evidence of the Trust measuring or understanding the changes in practice that were recommended having happened outside of changes to forms, polices, procedures and Standard Operating Procedures (SOPs).

## Summation

The panel was asked to draw out themes from seven reports over a four-year period of patients convicted of homicide or attempted homicide.

The panel reviewed all seven reports and accompanying documents. The panel was of the view that four of the seven reports were of poor quality and that two of the reports needed to be revisited in their entirety. We were surprised to see any 'tabletop' reviews given the seriousness of the incidents.

In terms of process there seems to be only limited executive oversight with delays common and limited scopes which further restrained the quality of the reports. It is unclear who and how reports were signed off, and what scrutiny they had. This is evidenced by at least two of the reports having numerous typographical errors and a further report using the full name of the patient in places.

In terms of clinical themes, we felt there were three main emerging themes:

1. Poor engagement, lack of follow up and risk assessment.
2. Delays and waits.
3. Multi-agency working including safeguarding.

We have seen evidence in other reports of the impact 1 and 2 has on teams, particularly the Local Mental Health Teams. We have given examples under each of the themes.

We further reviewed the accompanying Quality Improvement Plans. We were disappointed to see that many of the actions bore little resemblance to the recommendation and there was no measurement strategy to the action or understanding if the action had led to any meaningful change at all.

## Recommendations

1. The Trust's Serious Incident Policy needs to be re-written and should include process for Executive oversight of the most serious incidents and include the following:
    a. Process for sign off of incidents.
    b. Process for the appointment of panel members
    c. Understanding when a 'tabletop' review is acceptable
    d. A method of approving the recommendations and the accompanying QIP
    e. QIPs should include:
        i. What are we trying to accomplish?
        ii. How will we know a change is an improvement?
        iii. What changes can we make to result in an improvement?

    The panel understands that much of this work has started as described in the relevant section above. We therefore think that the Trust should develop a number of outcome measures to ensure the changes are leading to the desired outcomes. This should include embedded learning as well as process compliance outlined in the new policy.
2. The Trust should revisit two of the incidents in their entirety to ensure that the opportunity for learning is maximised. We understand that this has been commissioned by the Trust and will be a good test if the new measures outlined by the Trust are starting to embed.
3. That an audit is designed to identify those patients who have a risk history and have been discharged following a period of disengagement so they can be identified, re-reviewed and options considered.
4. The panel is aware that notable change has been undertaken around waiting lists and the waiting well process. It is important, given the demands this places on clinical staff, the Trust assures itself that these changes have resulted in an improvement.

5. The Trust revisits its approach to 'Think Family' as the current education package does not seem to have resulted in a change in practice.

## Appendix 1 – Terms of reference

**Terms Of Reference Draft v3**

**Internal Thematic Review of Homicides and Attempted Homicides**

**Scope of work**

To review the care and treatment provided to people in receipt of care from the Trust or within 12 months of discharge who have been charged or convicted of a homicide or attempted homicide.

**Proposed Panel Members**

- [redacted]

- [redacted]

**Purpose**

1. The purpose of the thematic review is to establish whether there are service related themes / wider issues or links recurring across the designated range of mental health homicides or attempted homicides.
2. The review will focus on emerging themes and not the reinvestigation of individual incidents or an examination of Trust policies and procedures unless these are directly pertinent to the review.
3. To review and identify any areas of learning omitted from the original investigations.
4. To make recommendations about what further actions are required going forward to address any identified gaps from Board to ward.

**Thematic Review**

1. Review of each internal and where applicable external investigation following a mental health homicide or attempted homicide from January 2019 to January 2024. This will include establishing if there are any themes in relation to age, gender, clinical team, diagnosis, cultural needs, engagement, family involvement, care and risk management and where relevant discharge.

2. To use this information to identify themes and trends and any common contributory factors. Information about patterns in these incidents may help to identify key indicators of risk. Such information will be summarised to inform the Trust of any key policy, organisational and/or training development requirements.

**Reporting Governance Framework**

1. Internal management – nominated individuals will act as the link within the Patient Safety Team to panel members to facilitate the panel requirements.

2. Monthly progress meeting with panel members, Interim Patient Safety and Learning from Deaths Lead and Chief Nurse.

3. Draft report to Interim Patient Safety and Learning from Deaths Lead and Chief Nurse.

4. Report to be presented to the Quality Committee prior to being presented to the Trust Board

5. Learning event co- facilitated by the Patient Safety Team and members of the panel.

**Sharing of report**

1. Following review and sign-off the report will be shared with the Trust Board and Integrated Care Board.

**Timescale**

1. First draft to be available four months from the date of commencement.

2. Final draft to be available six months from the date of commencement.

## Appendix 2 Panel Members

[redacted]