The Mental Welfare Commission for Scotland Proposals for the Investigation of Mental Health Homicides

Final report to the Scottish Government

April 2022

mental health homicide reviews

mental welfare commission for scotland

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1 Table of Contents

2 Acknowledgments

The Mental Health Homicide Review process has brought together a large group of health and social care professionals, representatives of the third and independent sectors and the public. Members and contributors are listed in Appendix 1 including organisations represented. Colleagues contributed with commitment and enthusiasm throughout and have consulted widely with their peer groups developing a range of shared and specific opinion which has been captured in the Mental Health Homicide Reference Group Summary Report[1]

We would also like to acknowledge the substantial learning from NHS England's Serious Incident Framework[2] and thank the NHS England Regional Leads for meeting with the Commission team. We are grateful to Professor Hilary McCallion and Paul Farrimond in particular for the insights and inspiration they provided to the Commission in their review of MHH investigations in England[3] which have been instrumental in shaping these proposals.

We are indebted to all those who participated in the Mental Health Homicide Review and we are particularly grateful to those who shared their personal stories. This was made all the more challenging due to the impact of COVID-19 and our ability to meet directly. Their accounts have been moving and influential. An outstanding contribution.

[1] **Mental Health Homicide Reference Group Summary Report -** The Mental Welfare Commission formed the Mental Health Homicide Reference Group to acknowledge the need to share learning across agencies and to move towards the Commission presenting workable options for a new system of investigating Mental Health Homicides to the Scottish Government by March 2022. The Summary Report will be available on the Mental Welfare Commission website from April 2022.

[2] NHS England » Serious Incident framework

[3] NHS England and NHS Improvement South East » An independent review of the Independent Investigations for Mental Health Homicides in England

3 Language and Terminology

3.1 Abbreviations

CLO	Commission Liaison Officer
COPFS	Crown Office and Procurator Fiscal Service
COVID-19	Coronavirus Disease 2019
CQC	Care Quality Commission
DPIA	Data Protection Impact Assessment
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
FAI	Fatal Accident Inquiry
GDPR	General Data Protection Regulation
HB	Health Board
HIS	Healthcare Improvement Scotland
HRBA	Human Rights-Based Approach
HSCP	Heath and Social Care Partnership
IMP	Information Management Portal (MWC Internal Data Management System)
MHH	Mental Health Homicide
MHHRG	Mental Health Reference Group
MOU	Memorandum of Understanding
MSP	Member of the Scottish Parliament
MWC	Mental Welfare Commission for Scotland/ The Commission
NHSCR	NHS Central Register
NHS-NSS	National Health Service-National Services Scotland
PF	Procurator Fiscal
SAER	Significant Adverse Event Review
SFIU	Scottish Fatalities Investigation Unit
SPS	Scottish Prison Service

4 Executive Summary

In 2015, the Scottish Government called for the Commission to develop a model for Scotland for independent investigations of care and treatment prior to Mental Health Homicides.

The Commission is in a unique position to carry out this work as it is an independent organisation with powers to carry out investigations into an individual's care, require that records are presented to it for inspection and to hold an inquiry for the purpose of carrying out an investigation. The Commission also has an established system of hospital visiting which would enable it to ensure that recommendations are implemented.

Whilst in Scotland the number of Mental Health Homicides (MHH) per year is small, the impact on those involved is devastating. In Scotland, there is no established system to ensure that MHH are investigated independently and to a consistent high standard. Nor are the perpetrator and the families of both victim and perpetrator routinely offered the opportunity to be involved in the investigation and to have any questions they have about care answered. There is no current system to ensure that identified learning which could prevent future homicides is shared across mental health and other involved services.

The Commission's proposals take account of feedback from the Scottish Government consultation in 2017[4] and from a short life Reference Group established in 2021.

There has also been substantial learning from NHS England's Serious Incident Framework (SIF) and a review[3] of the SIF has provided inspiration for the Commission's proposals.

The Commission has developed a proposed pathway for Mental Health Homicides that we believe is innovative, inclusive and human rights compliant. We believe the proposals laid out in this document are ambitious but necessary and will require funding support from the Scottish Government.

[4] Supporting documents - Homicide report by Mental Welfare Commission for Scotland: review and consultation - gov.scot (www.gov.scot)

4.1 Proposals

4.1.1 Notification process

There should be a single, streamlined digital process for notifying adverse events across Scotland to both the Commission and Healthcare Improvement Scotland.

The Commission will:

- Work to ensure services across Scotland are aware of the requirement to notify the Commission of a potential MHH and streamline the notification process
- Proactively work with NHS Scotland forensic services to identify new admissions and monitor reporting omissions.
- Further develop a system for the sharing of pre-trial psychiatric assessment reports between Crown Office and Procurator Fiscal Service and the Commission.

4.1.2 Definition of Mental Health Homicide

A Mental Health Homicide is ‘any homicide where the perpetrator had a mental disorder at the time of the offence and was under the care of Specialist Mental Health and Learning Disability services or under their care within the last six months’

Those who meet the above definition will usually have a full investigation by the Commission

4.1.3 Mental Health Homicide Pathway

The Commission will appoint a ‘Commission Liaison Officer’ who will be a single point of contact between the wider Commission investigation team, families and involved agencies and will provide expertise and experience working with involved families.

Key features are:

- Involvement of perpetrator and family throughout the investigation process where appropriate.
- Involvement of victim's family throughout the investigation where appropriate.
- Cooperative working with third sector and faith/spiritual organisations to provide support for involved families.
- Collaborative working with COPFS throughout investigation process
- Case by case legal view on extent of report disclosure and subsequent level of publication by Commission
- Feedback on draft investigation report from involved staff, families and perpetrator
- Health and Social Care Partnerships or Heath Board (HB) management present and publish a local action plan
- Commission provides an assurance system for recommendation implementation
- Feedback of investigation process collated from key stakeholders
- Commission reports annually to Scottish Government

4.1.4 Investigation process

There will be a single investigation, with an independent chair and a second investigator from the Commission forming an investigation team with senior HSCP or Health Board personnel.

A 'homicide group' within the Commission will quality assure and provide robust, independent oversight of investigation reports

The investigation will be systems based and reference a human rights framework. It will be sensitive to the needs of the staff involved in the incident. Where required, there will be a multiagency investigation. This is likely to require a Service Level Agreement and /or Data Sharing Agreement between the Commission and involved agencies.

5 Background

5.1 Background

In 2015, the Scottish Government asked the Commission to develop a model for Scotland for independent investigations of care and treatment prior to MHH. The context included a briefing paper that went to the Scottish Government in December 2014 which held research done by the Hundred Families organisation[5], who had found that Scottish Health Board reviews and independent investigations by the Commission were rare.

This is in contrast to the well-embedded system of independent investigations in England, where mental health homicides are amongst the highest priority for investigation within the NHS framework for significant incident investigations. The National Confidential Inquiry into Suicides and Homicides (NCISH) research[6] has indicated that MHH have disproportionately affected Scotland in comparison with the rest of the UK.

During the Parliamentary passage of the Bill for the Mental Health (Scotland) Act 2015, concerns were expressed[7] about the existing system of investigation of those homicides committed by people who had recent contact with mental health and learning disability services. The Minister for Sport, Health Improvement and Mental Health agreed that the system was in need of improvement and advised the Scottish Parliament's Health and Sport Committee that the Commission and Healthcare Improvement Scotland were discussing how best to streamline the current system for reviewing these homicides[8].

5.2 Remit of Phase 1 and Phase 2

Subsequent to the parliamentary enquiry, in phase 1 of their work, the Commission developed detailed proposals in consultation with HIS and with COPFS From August

[5] Microsoft Word - SGMHH BRIEFING Dec 14.docx (hundredfamilies.org)
[6] NCISH | Annual report 2018: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk)
[7] Thank you for your clarification,...: 12 Mar 2015: Scottish Parliament debates - TheyWorkForYou
[8] We need to consider the issue...: 12 Mar 2015: Scottish Parliament debates - TheyWorkForYou

to November 2017, Scottish Government ran a consultation on the Commission's proposals.

In response to feedback from the 2017 consultation, phase 2 of the Commission's work included the development of a human rights framework to underpin all Commission investigations, legal advice on data protection, a literature search from Commonwealth countries and 'tests of change' to improve the identification of MHH following an initial data sharing agreement reached with COPFS. The Commission also had discussions with NHS England, Victim Support Scotland (VSS), Police Scotland (SPS) and the Scottish Courts and Tribunal System (SCTS)

5.3 Phase 3 - Final Proposals

Phase 3 has involved the development of revised options for MHH investigations and the establishment of a Mental Health Homicide Reference Group (MHHRG) who provided feedback on the proposed options.

The Commission are currently undertaking investigation of two MHH cases, adapting the usual investigation methodology to reflect best practice and learning from phases one and two.

6 Human Rights Considerations

6.1 Requirements of Human Rights

The Commission sourced legal research on the requirements of human rights law for investigations of support, care and treatment in the context of MHH.

The pertinent main human rights treaties are the European Convention on Human Rights (ECHR)[9] and the Convention on the Rights of Persons with Disabilities (CRPD)[10].

6.2 The Right of Life

6.2.1 The Right to Life

The right to life identified in Article 2 ECHR is one of the ECHR's most fundamental provisions from which there should be no derogation under Article 15 ECHR (derogation in the time of emergency). Article 10 CRPD also identifies the right to life

Article 2 ECHR requires

- the general obligation to protect by law the right to life; and
- the prohibition of intentional deprivation of life (subject to some exceptions)
- A procedural obligation to carry out an effective investigation into alleged breaches of its substantive limb.
- This positive obligation to protect life requires the State to take appropriate steps to safeguard the lives of those within its jurisdiction and there are two aspects to this:
- the duty to provide a regulatory framework; and
- the obligation to take preventive operational measures.

6.2.2 The Positive Obligation to take Preventive Operational Measures

[9] European Convention on Human Rights (coe.int)
[10] Article 10 CRPD states *'States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.'*

This duty requires State authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another

It must be established that the authorities:

1. knew, or ought to have known, at the time that there was a real and immediate risk to the life of an identified person/persons from the criminal acts of a third party; and
2. failed to take such action (within the remit of their powers) which might have been reasonably expected of them to avoid that risk.

What constitutes a real and immediate risk and what is reasonable preventive action very much turns on the facts of the particular case.

The positive duty cannot be interpreted as imposing an impossible or disproportionate burden on the authorities.

The authorities must also respect Article 5 (liberty) and 8 (respect for private and family life). Articles 5 and 8 must be considered in terms of preventive restrictions of the third party.

Perpetrators of MHH will be entitled to the right to a fair trial in accordance with Article 6 ECHR. The comments above concerning Articles 5 and 8 ECHR and enjoyment of rights without discrimination should also be taken into account. Articles 12 (equal recognition before the law), 13 (access to justice) and 14 (liberty) CRPD are the corresponding CRPD rights.

The Criminal Justice (Scotland) Act 2016[11] introduced a specific duty on the State to provide support to 'vulnerable persons' who are involved in any way in criminal investigations and proceedings to assist with understanding of what is happening and with communication. A 'vulnerable person' is defined in the Act as an adult who, because of mental disorder, is unable to understand sufficiently what is happening or communicate effectively.

[11] Criminal Justice (Scotland) Act 2016 (legislation.gov.uk)

7 Commission Powers to Investigate

7.1 Discharging our Functions

The Commission, in carrying out its functions, is required by section 4(2A) of the Mental Health (Care and Treatment) (Scotland) Act 2003[12] to *'…act in a manner which seeks to protect the welfare of persons who have a mental disorder'.*

Section 11 of the 2003 Act gives the Commission the power to carry out investigation as it considers appropriate into a patients case and to make such recommendations as it considers appropriate as respects the case.

Section 16 of the 2003 Act gives the Commission the power to require that any patient records, including medical records, are presented to it for inspection. The power in section 16 to require the production of records for examination is in connection with any of the Commission's functions in the 2003 Act or the 2000 Act. The duty to afford all facilities under section 17 is to enable the Commission to discharge the Commission's functions under the 2003 Act only.

Under section 12 of the 2003 Act, the Commission can hold an inquiry for the purpose of carrying out an investigation. The chair of such an inquiry has the power to require people to attend to give evidence; administer oaths and examine witnesses under oath. Inquiry proceedings have the privilege of court proceedings and refusal to attend or give evidence at an inquiry is a criminal offence."

The Commission has extensive powers in relation to a "patient" meaning a person who has, or appears to have, a mental disorder as defined in sections 328 and 329 of the 2003 Act. A "patient" does not require to be a person admitted to hospital. If the records are held by authorities listed in section 17, the Commission can request copies.

The nature and scope of the duty in section 17 affords the Commission all facilities to enable the Commission to discharge the Commission's functions under the 2003 Act. In respect of section 17, all relevant bodies must do what is necessary to help the Commission carry out its duties, including Scottish Ministers, police forces, care services, and prisons and young offenders' institutions.

[12] Mental Health (Care and Treatment) (Scotland) Act 2003 (legislation.gov.uk)

Medical or “other records” includes care and social work records. Medical or other records of a patient cover all records of all types including documents, videos, messages, records on mobile devices, scans, notes, test results, care and social work records, records created for criminal justice processes about a patient, (being a person who has or who appears to have a mental disorder,) and include records which contain significant information about offences.

The Commission can make the formal requirement in terms of section 16 to produce those records for inspection to each and every one of the persons listed at section 17(2)(a) of the 2003 Act. If making the formal requirement, the Commission has to refer to the statutory function or functions in connection with which they are making the section 16 requirement.

The Commission can make the section 16 requirement not only to the persons listed in section 17(2) (a) (being the persons who are to afford “all facilities”) but to any person holding the records of a patient.

The purpose for which the person is holding the records does not matter if section 16 applies. The Commission can request access to records about a patient that are not health or social care records, for example records of the authority’s own investigations or reports.

7.2 Inquiries

The Commission can give consideration to (and discuss with COPFS) whether to carry out an investigation and when, if there is to be or has been an FAI or any of the other proceedings set out in section 3(2) of the 2016 Act[13] and if the Commission is satisfied that the circumstances of the death have been sufficiently established during the course of an FAI or such proceedings.

A protocol will be established so that the timing of any investigation by the Commission does not interfere with or prejudice any investigation by the police or any other reporting agency under the direction of COPFS. Lessons may be learned for the Commission from the terms of the COPFS Family Liaison Charter in terms of section

[13] Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (legislation.gov.uk)

8 of the 2016 Act and we make reference below to section 11 of the 2016 Act which makes provision for the persons who may participate in an FAI.

The Commission will be subject to judicial review if it acts unlawfully in carrying out its activities including in relation to the investigation of mental health homicides by acting unlawfully, irrationally or unfairly. Illegality can arise where the Commission fails to do what the common law or enacted law, including the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Human Rights Act 1998[14] require, or where it exceeds it powers, or where it makes an error of law.

In carrying out the investigation of MHH the Commission will have to act in a manner that is substantively and procedurally fair.

Accordingly, the Commission requires to have in place a methodology for the management and evaluation of evidence that includes a fair way of identifying and resolving the principal important controversial questions of fact, including conflicts in evidence where issues of credibility and reliability arise or where disputes arise between those with expertise. It may be necessary for the Commission to instruct its own experts or assessors, or to have certain experts or assessors sit with it.

The Commission may have to consider principal important controversial questions of law. Ordinarily, such controversies can be resolved by allowing the parties to the legal controversies to make written submissions. The Commission can instruct its own legal experts, or have certain legal experts sit with it when hearing submissions on the legal controversies. The Commission can confer with its legal advisers in private but, if that advice bears upon a controversy of interest to a party, that advice received by the Commission should be shared with that party who should be given the opportunity to comment.

The Commission will be producing an investigation report which will need to have adequate and proper reasons for its findings, decisions and recommendations which identify the controversial questions of fact and law that arose and how the Commission went about resolving these fairly. Accordingly the report must leave the informed reader in no real and substantial doubt as to what the reasons for their findings,

[14] Human Rights Act 1998 (legislation.gov.uk)

decisions and recommendations were and what material considerations were taken into account in reaching these.

7.3 Summary

It is clear that the Commission is afforded a wide discretion in the exercise of its powers in relation to the receipt of 'facilities' from third parties and in the inspection of documentation in the hands of third parties, provided that the use of those powers is sufficiently linked to a core function of the Commission.

In respect of the powers under section 16 of the 2003 Act specifically, the Commission is also afforded a wide discretion as to whom those powers may be exercised against.

In any circumstance where the Commission seeks to obtain information from a third party using those powers or any other powers at its disposal, consideration will require to be given to various other legal obligations including those arising under the common law duty of confidentiality, data protection law and the human rights regime.

The current Scott review[15] on mental health and incapacity legislation reform will allow the Commission to ensure that further duties, powers and functions are "updated" to reflect changes in practice across Scotland.

[15] https://consult.gov.scot/mental-health-law-secretariat/review-of-mental-health-law-in-scotland/

8 Duty of Candour

8.1 Duty of Candour

Duty of Candour (DoC) regulations came into effect from 1 April 2018. The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act)[16] and The Duty of Candour Procedure (Scotland) Regulations 2018[17] set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm.

Organisational DoC guidance from the Scottish Government[18] focuses on the implementation of the legal duty of candour procedure for health, care or social work services. Organisations are required to be open and honest when something goes wrong that is not related to the course of the condition for which the person is receiving care.

The Scottish Government has made available Organisational Duty of Candour in Scotland leaflets[19] for organisations to distribute to the patient, service user or person acting on their behalf (and in easy read formats):

The organisational DoC procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death, to apologise and to meaningfully involve them in a review of what happened.

When the review is complete, the organisation, in its capacity as 'responsible person' should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) – the 'relevant person', what those actions are and when they will happen.

[16] Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (legislation.gov.uk)
[17] The Duty of Candour Procedure (Scotland) Regulations 2018 (legislation.gov.uk)
[18] Introduction - Organisational duty of candour: guidance - gov.scot (www.gov.scot)
[19] Duty of Candour: leaflets - gov.scot (www.gov.scot)

They must also publish a publicly accessible annual report on how they implemented DoC procedure for adverse events which resulted in harm.

Organisational DoC reflects Professional Duty of Candour, whereby individual healthcare professionals were already obligated to be open and honest with patients when things went wrong, culminating in the publication of a professional duty of candour[20] in 2014.

8.2 Relevance to Mental Health Homicides

Where a potential MHH has occurred a Duty of Candour response should be triggered. This must be followed as soon as possible after an organisation providing health, care or social work services receives confirmation that, in the opinion of an independent health professional, a person has experienced an unintended or unexpected incident which appears to have resulted in harm or death. The death or harm should not be related to the natural course of the illness or underlying condition for which the person is receiving treatment or care. In cases of MHH, both the perpetrator and the victim's families are 'relevant persons' to whom separate DoC responses are owed.

The learning outcomes of any investigative review of a MHH must be included in anonymised format in the annual DoC report published by the Board.

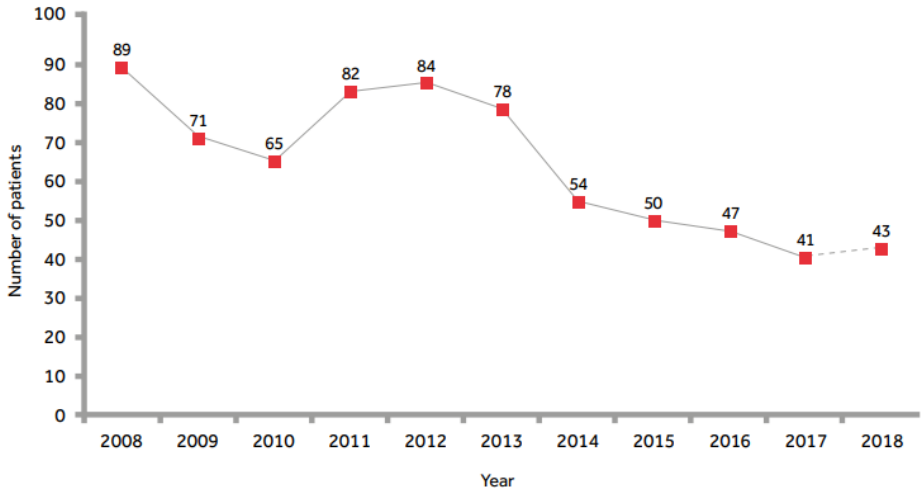
[20] NMC/GMC (June 2015, updated June 2019) Openness and honesty when things go wrong: the professional duty of candour https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand pdf-61540594.pdf

9. Methodology

9.1 Mental Health Homicides in Scotland

The National Confidential Inquiry into Suicides and Safety (NCISS, formerly NCISH) 2021 report[21] includes UK figures for MHH from 2008-2018 (figure 1). The rate of MHH across the UK had been falling steadily in recent years. However, evidence from NHS England[22] indicates that between 2019 and 2021, numbers of MHH have increased.

Figure 1: Patient homicide in the UK: Numbers per year



Across the UK, 11% of people convicted of homicide were patients under mental health care. This figure was higher in Scotland and Wales where the general population homicide rates are also higher[21] (figure 2)

[21] NCISH | Annual report 2021: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk)
[22] B0923_Independent-investigations-2019-21-annual-report_December-2021.pdf (england.nhs.uk)

Figure 2: Number of homicide offenders by UK country (2008-2018)

	England N (%)	Northern Ireland N (%)	Scotland N (%)	Wales N (%)	UK N (%)
General population	5,261	146	715	261	6,383
Patients under mental health care	541 (10%)	13 (9%)	114 (16%)	36 (14%)	704 (11%)

* Northern Ireland data between 2008-2014

In Scotland, the number of MHH fell to an estimate of 5 in 2016. Fig 2 indicates that there were 114 MHH in Scotland between 2008 and 2018, an average of 11 per year. The figures above suggest that the number of MHH in Scotland is likely to be between 5 and 12 per annum over this period.

The briefing paper to the Scottish Government in December 2014 by the Hundred Families organisation stated that, based on Freedom of Information requests to all 14 Scottish Health Boards:

- Of the 40 patient homicides recorded in Scotland in the previous 3 years, fewer than 10 had been the subject of a SAER or similar investigation. These are usually internal documents and not published
- HIS and the Commission acknowledge that the quality of these SAERs may be poor.
- NHS Health Boards in Scotland did not appear to know how many of their patient homicides had been reported to NCISH
- NHS Health Boards in Scotland did not appear fully aware of the numbers of their patients who commit homicide.
- The Commission has powers to investigate homicides by mental health patients, however in the previous 10 years had only published two independent investigations out of 136 recorded mental health homicides in Scotland.
- HIS have no remit for the scrutiny or review of patient homicides.

The COPFS investigate all MHHs in Scotland and may hold a discretionary Fatal Accident Inquiry (FAI) where they think this necessary. A recent report indicated that average time from the date of death to FAI was 763 days[23] the timeline where there

[23] Fatal Accident Inquiries: follow up review - gov.scot (www.gov.scot)

was ‘substantive criminal investigation’ prior to an FAI tended to be longer. The report recognised the delay adversely impacted on the momentum of the investigation, the wellbeing of potential witnesses, the distress of nearest relatives, public confidence and delayed the implementation of recommendations.

Estimated costs to COPFS and Scottish Courts and Tribunal Service (SCTS) in 2015-19 ranged from £23,122 for a week long FAI to £184,701 for a lengthy FAI.[24]

9.2 Consultation Model 2017

The Scottish Government ran a consultation on the Commission’s proposals for a new system for investigation of mental health homicides in 2017. We will call this the 2017 model, summarised below:

- Stage 1: The Commission will receive the psychiatric assessment(s) (undertaken by the Crown Office and Procurator Fiscal Service (COPFS)) and review to determine whether there has been recent contact with mental health or learning disability services. The Commission will liaise with COPFS to ensure there are no issues with proceeding with an investigation and will notify the health board of the homicide.
- Stages 2 and 3: In exceptional circumstances, the Commission will move straight to an independent investigation of the events (stage 5). In all other cases, the health board will undertake a serious adverse event review (SAER) and send the SAER report to the Commission. The health board will make early contact with the victim’s family and the perpetrator.
- Stage 4: The Commission will review the SAER report to determine whether or not it adequately identifies any learning points, and then obtain any further information considered necessary to reach a view on the case.
- Stage 5: The Commission’s senior management team will consider the case, and in some circumstances it will open an investigation.
- Stage 6: In certain circumstances, the Commission will appoint a team to investigate, which may be internal or external. There will be engagement with the families of the victim and service user.

[24] Fatal Accident Inquiries 2002-2012 (copfs.gov.uk)

The Scottish Government created analysis of the 2017 responses. The aim of the analysis was to identify the main themes raised by respondents in their free text comments. The report says (paras. 7 to 12):

“In the main, respondents were positive about the aims of the revised process but had concerns about its scope and implementation.

Respondents generally agreed with the definition of “contact” in the proposed process while commenting on a number of potential difficulties with this offering suggestions for further thought.

There was a largely positive response to the Commission’s proposals for involving families in homicide reviews but respondents were split on the level of information which should be shared with families, and several called for more detail on how any information would be passed to families. There was some concern that personal privacy could be infringed without clear guidance and appropriate frameworks for the sharing of information on the perpetrator and victim(s).

Several responses reflected the view that the Commission was well experienced in such investigatory work.

Respondents agreed that the proposed process adequately provides for independent investigation but this was frequently caveated by the need for more detail on how such independent investigations would be carried out. There was concern that restricting reviews to care provided by relevant Health Boards was too narrow a focus and that there should be learning from other involved services and agencies.

Data protection was also an important area of concern amongst respondents to the consultation.’’

The Mental Welfare Commission have been able to use the detail from the responses to help influence and shape their ongoing work.

9.3 Notification of Mental Health Homicides and tests of change

SAER reports submitted by Health Boards to the Commission are fundamental to the notification process for possible mental health homicides in the 2017 model. However, between 2015 and 2020, SAER reports were available on the Commission’s IMP system for only three homicides.

As the estimated number of homicides over this period is between 25 and 55, it is possible that SAERs may have been carried out for only 5% to 12% of mental health homicides in those five years.

Following a review, we concluded that none of those SAERs appeared to meet the majority of HIS' standards for SAERs, or to fully meet human rights obligations to investigate 'non-natural' deaths.

It is therefore apparent that the current notification process for mental health homicides to the Commission is inadequate. Ensuring robust and comprehensive notification of these incidents to the Commission will be essential to any new system of investigation.

One of the first steps to improving notification of possible mental health homicides was to explore closer working links with COPFS. The Commission's Information Governance Manager (IGM) provided the project with legal advice on data protection, including advice towards a data protection impact assessment and substantial advice towards an information sharing agreement with COPFS. We also sought independent legal advice on complex areas of data protection in the context of the independent investigations of mental health homicides.

A main implication of the advice received was that whilst the Commission has a right to request pre-trial psychiatric assessment reports from COPFS as one source of notification of mental health homicides, data protection requirements on COPFS greatly restrict the potential usefulness of these reports for the Commission.

COPFS need to redact these reports and seek consent for their sharing with the Commission and the redaction by COPFS is not carried out by professionals with mental health expertise. COPFS were able to provide the Commission with information on whether there was contact with mental health services within the 12 months prior to the homicide if this was recorded in the pre-trial psychiatric assessment report as they interpreted it, or if there was relevant information elsewhere in their system.

In the first test of change, the data which COPFS provided for the Commission for 2015-2016 included extracts from pre-trial assessments for only half of all perpetrators of murder or culpable homicide.

Data from these reports cannot therefore be relied upon as a comprehensive source of information for the Commission about possible MHH. There is a risk that relying on

data which COPFS holds on contact with mental health services in the 12 months prior to the homicide would lead to false negatives (cases missed).

A second test of change was to cross check data from COPFS with information on the Commission's Information Management Portal[25] (IMP) system. In stage 1 of this test of change, COPFS sent the Commission a list of all accused 46 persons convicted of murder or culpable homicide in 2015-2016. In stage 2, the Commission checked whether it held data on care and treatment provided to these perpetrators. Whilst there were files on the Commission's IMP system for 5 perpetrators, none of this referred to recent care within the 12 months prior to the homicide for any of the 46 perpetrators (including the five identified).

The Commission was also unable to ascertain from any of the data available to them, either from COPFS or from NCISH how many MHH occurred in Scotland between 1st April 2015 and 31st March 2016. Therefore, it was not possible to know with any certainty whether or not all perpetrators of MHH between those dates were detectable from the Commission's IMP database. There is therefore a risk that relying on data which the Commission holds on contact with mental health services in the 12 months prior to the homicide would also lead to false negatives.

9.4 International Literature review

Alexandria Research were commissioned to produce a review of practice in other jurisdictions on the investigation of homicides committed by people who have had contact with mental health services across the UK and the Commonwealth.

Alexandria Research found that 'methods for investigations of homicides committed by people who have had contact with mental health services were often difficult to source because of the range of different agencies that investigate these deaths including the Police, Coroner's reports, local Trusts and the third sector and information is published by Charities, Governments and think-tanks. 'Academic literature can be highly focused but insightful. Grey literature on this topic can be very specific but is often difficult to source'.

[25] IMP – The Information Management Portal is the MWC internal database.

9.4.1 Public perception

Academic literature tends to focus on the public perception of psychiatric patients who commit homicide as being 'exaggerated', the rarity of these events and the consequent difficulty of arriving at any reliable conclusions about best practice. Press publications increase stigma by focussing on the rare event of a homicide. However, this can underestimate the impact of these homicides on communities and in particular on involved families. Any policy for reviewing these incidents needs to balance the needs of families, communities and stigma.

9.4.2 Involving families

Family members including partners are often victims. Domestic violence literature provides detailed insight into this topic. Investigation procedures need to be 'clearly set out and time limited' so that families are aware of the procedure, what outcomes can be expected and which other agencies are involved. Clear, concise and sensitive content in a range of accessible formats is vital to ensuring families are included in the investigation.

9.4.3 Risk assessments and prevention

'Academic literature presents a poor picture of risk assessment methodology and the inability to accurately predict homicides.' 'The WARRN programme[26] in Wales is a suite of risk assessment training…that has been well received by many professionals'

9.4.4 Publication, Data Sharing and Learning

There are many different methods of publication. In Australia, reports are published by the Coroner's Office, NHS England has a dedicated website[27]. There are an 'array of other reporting methods most of which are available online'. Boundaries between different investigation bodies are not always clear. Recommendations often apply to a range of different agencies but timelines for implementation, follow up of implementation and measurement of improvement are often unclear.

[26] WARRN – a formulation-based risk assessment process: Its implementation and impact across a whole country -ORCA (cardiff.ac.uk)
[27] NHS England » Independent investigation reports

9.4.5 Information Governance and Data protection

Australia tends to publish full Coroners' reports including names and patient history. NHS England redacts names and identifying details in public reports any policy for reviewing homicides needs to balance public interest, professional/system learning and individual right to privacy. Local laws including GDPR, Data Protection Act and Freedom of Information must be observed when considering publication.

In Canada, 'the Domestic Homicide Review Committee in Ontario works jointly with the Coroner's Office to collect demographic information on domestic homicides with the aim of forming risk assessments to predict and prevent'. The Coroner's Office publishes reports of all homicides.

From Australia, the Victoria's Coroner's Office reports are searchable, with links to actions taken. A set of recommendations on mental health homicides, rather than good practice, were reported from New South Wales: Families need access to relevant, dedicated support groups. Websites and leaflets should contain transparent and appropriate language.

In New Zealand, reports of deaths 'deemed to be in the public interest' are published by the Coroner.

9.5 NHS England – The Serious Incident Framework (SIF)

Members of the project team met with several NHS England regional leads with responsibility for commissioning Independent Investigations into Mental Health Homicides in September 2020 and January 2021.

A description of the main stages in the SIF[2] follows and gives an insight into both the complexity of the SIF and the comprehensive approach to these investigations taken by NHS England.

NHS England assumed responsibility for the commissioning and oversight of independent investigations in 2013. Mental health homicides have since been given a high priority for investigation in the SIF which states that:

- All providers of mental health services are required to report all apparent/actual/suspected homicides meeting the criteria below on the

Strategic Executive Information System (StEIS). StEIS is an electronic incident management database that enables NHS providers and clinical commissioning groups (CCG's) to record, track and monitor the progress of individual serious incidents.

- Regional investigations teams (RIT) commission an independent investigation **of a 'homicide when committed by a person who is subject to the Care Programme Approach, or either under the care of specialist mental health services or under their care in the 6 months prior to the event.'**

In **stage 1,** an initial 72-hour review is completed by the provider. The aim of the review is to cover necessary immediate action with respect to

- Identifying and providing assurance that the safety of staff, patients and the public is protected
- Assessing the incident in more detail, and to confirm if the incident requires a full investigation
- Proposing the appropriate level of investigation; and
- Communicating with relevant individuals and organisation including the families (of victims and perpetrators), Police, Care Quality Commission, Coroner, Health and Safety Executive, and others as required.
- Providers actively seek the details of all victims and their families through the appropriate channels at an early stage.

At **stage 2**, the relevant commissioner ensures that the service provider undertakes a robust and thorough internal investigation.

- The RIT can help develop the terms of reference with the Commissioner and other stakeholders as necessary. Opportunity must be given to the family members of the victim and the alleged perpetrator to have input in to the terms of reference and raise concerns where possible
- The internal investigation should be completed within 60 working days (from the date in which the incident is reported)
- In addition to local reporting procedures, the 60 day report is also shared with the Commissioner, sub-region quality lead, the Investigation Team and affected families

Stage 3 relates to the Independent Investigations Review Group (IIRG) established by each NHS England RIT.

The IIRG determines which cases require independent investigations. Each IIRG will have representation from experts in the field of mental health and/or investigation as well as lay members.

- Upon receipt of the 60 day report the RIT will arrange for a review by the IIRG to take place. They consider the scope and quality of the internal investigation and determine whether an independent investigation is required
- There is no automatic bar on conducting independent investigations whilst criminal proceedings are underway. There should be an early discussion with relevant partners (e.g. police, Coroner) to ensure that investigations can commence at the earliest opportunity

9.5.1 Commissioning the Independent Investigation

Where required, NHS England commissions the independent investigation from one of several consultancy firms.

- The RIT ensures that the families are fully informed about the investigation and its parameters, what they can expect from it and how they can contribute.
- The RIT draws up terms of reference for the independent investigation following liaison with all appropriate stakeholders.
- Next, a tender process takes place to identify a suitable independent investigator to conduct the investigation, and the RIT seeks the consent of the perpetrator for access to their medical records to be released to the independent investigators.

9.5.2 Conducting the independent investigation

- The RIT arranges a start-up meeting with key stakeholders to be involved in the investigation process.
- The independent investigation should be completed in 6 months from the date it is commissioned, in practice it is 6 months from the date at which the investigators have all data they require.

- Throughout the investigation process, monthly reports are provided to the RIT and bi-monthly reports to all stakeholders.

9.5.3 Information Governance

In undertaking and commissioning investigations, personal information and records are shared as necessary by providers, CCGs, NHS England and independent investigators. Personal information relating to patients and staff will be treated in line with NHS England's policies on confidentiality, data protection and information governance.

- Access to personal identifiable information about patients is restricted to staff working in investigation teams, the legal advisors and internally within NHS England when necessary for the purposes of the investigation.
- Internal and independent investigation reports will be shared with stakeholders, including the family of the victims involved. Independent investigation reports and action plans will be published, so issues concerning anonymity and consent for disclosure of personal information must be considered at an early stage.
- Advice from the Caldicott Guardian and Information Governance Leads should be sought about the disclosure of patient identifiable information, particularly where patients have expressed views about access to their information.

9.5.4 Legal Opinion

The final draft independent investigation report is sent by the RIT for legal review to consider a number of issues, including whether:

- Terms of reference have been met;
- Conclusions are supported with evidence;
- The report is defamatory; and
- Confidentiality and data protection protocols have been followed.

The final report will then be submitted to the IIRG for acceptance on behalf of NHS England.

9.5.4 Pre-publication

The RIT arranges a pre-publication meeting with stakeholders to ensure that, prior to the report's publication;

- Legal issues have been addressed; recommendations and action plan have been considered by all parties
- Victim's, families, perpetrators and their families have had an opportunity receive a hard copy of the report to review and understand its findings
- Individuals cited in the report have had the opportunity to comment;
- A communications, media handling plan and publication date have been agreed
- A date for sign off and closure have been agreed.

9.5.5 Sign off and closure

- A meeting with relevant commissioners, NHS England Regional and Sub-regional leads is convened which the victim's family or their advocates are invited to attend.
- The perpetrator and the family and/or their representatives should also have an opportunity to discuss the sign-off and closure of investigation with relevant parties.
- The Commissioners advise the providers senior leadership team that they will be required to attend to present their action plan for sign off
- The closure of the investigation does not mark the end of the case. Providers and commissioners must ensure there are robust processes for monitoring the implementation of long term actions
- Reports are made public in the interests of learning and transparency. Anonymised independent investigation reports and action plans are published by NHS England on its website and by the provider organisation.

NB: NHS England has begun the process of moving towards a new approach for investigating serious incidents from 2022 - the Patient Safety Incident Investigation

Framework (PSIRF) [28] in which Root Cause Analysis is replaced by the Human Factors approach for investigations.

9.6 Learning from NHS England

In many ways, NHS England's Serious Incident Framework is the gold standard for MHH reviews:

- A nationwide digital notification system for adverse events is well established although the most recent annual review[29] notes variability in the quality and accuracy of recording by NHS providers.
- The involvement of families of both victims and perpetrator and the perpetrator is integral to the SIF throughout the investigation process - this has been improved by the engagement of family representative organisations
- An independent review of care is assured by the Commissioning of private consultancy firms where deemed necessary
- A systematic, case by case approach to information governance and legal advice enables publication of the majority of independent reports, ensuring public scrutiny.
- Since 2016, there is an assurance process for implementation of action plans by the independent investigators who return to the NHS Trust 6 months after completion of the report.

However, recent reports[3, 22] suggest that there are potential areas for improvement in other areas, in particular with regard to the two tier investigation system, the lack of multiagency involvement in investigations and the use of private consultancy firms for the independent investigation report.

9.6.1 Two tier system

In 2018, an independent review team (McCallion et al) was asked to report on 'how well NHS England responds to and learns from MHH investigations'[3]. The review included the examination of all 57 independent investigations (35 published, 22

[28] NHS England » Patient Safety Incident Response Framework
[29] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

unpublished) carried out between 2013 and December 2017 and a consultation process across NHS organisations, individuals and families who had been involved in the process.

The SIF comprises a 2 tier investigation process – an internal, provider/Health Board report is followed by a second independent investigation where this is deemed necessary.

'Timeliness was identified as a key issue by all involved in the investigations. It can take several years between the event taking place and the publication of a report.'

In the most recent annual report[22] (Independent investigation annual report IIAR 2019/21) by NHS England, the average time between StEIS notification and submission of the 2nd report (2013 – present) was 2.5 years.

'Trusts identified repetitive interviewing of staff and the impact of a second investigation long after the event as creating stress for staff. There is duplication of costs in internal and external investigations'[3]

'Access to staff was more difficult for the investigation companies as they had often moved from the organisation. Families questioned the relevance of the report to present day services and delay in changes taking place. Revisiting the event for families could cause further distress and delay the grieving process.' The review also highlighted the lack of additional learning from the second investigation, 'the benefits of the second investigation could not be established in all the independent reports reviewed.' The majority of the independent reports used the NHS Trust internal investigation as the basis for the second investigation.[3]

9.6.2 Multi agency involvement

McCallion recommended that there should be a formal, strategic approach to working alongside other involved agencies using the principles of Domestic Homicide reviews[28] or Serious Case Reviews[30] to enable policy and recommendation implementation and wider impact of investigations.

[30] Serious Case Reviews | The Crown Prosecution Service (cps.gov.uk)

9.6.3 Private consultancy investigations – cost, quality and sustainability

In England, the IIGC undertakes a national oversight and assurance role for independent investigations.

The IIAR 2019/21 [22], states that budget planning is based on an assumed average per case cost of £23,530 however, 'there is an upward trend in case costs directly related to the nature and complexity of cases'. In 2019/2020, average total costs including legal fees for each commissioned independent investigation ranged from £17,000 to £60,000 in different regions of England. Comparable figures for 2020/2021 ranged from £26,000 to £69,000 per independent investigation.

There has been a reduction in the number of private consultancy firms tendering for MHH investigation work[3]. The IIAR 2019/21 found that 'all regional teams experienced significant challenges obtaining a varied breadth of companies tendering for investigative commissions. This had a direct impact on timeliness of investigations.

McCallion rated 80% of independent reports as good or satisfactory and the remaining 20% were poor. 74% of the reports had full biographies of the investigation team – thought important by the authors to establish credibility for the report. The authors recommended a standardised investigation methodology and template used by all the companies would be beneficial as well as the inclusion of a lay person/advocate on the investigation panel on behalf of the families.

9.7 Revised proposals

Over the summer of 2021, in Phase 3 of the project, the Commission drew up revised proposals for Mental Health Homicide Reviews. These options took into account learning from phase 1 and 2 of the project.

The Commission presented the proposals to a Reference group (Appendix 1) at a virtual meeting in October 2021 and then again the following month (November) with a workshop event held in Edinburgh.

The purpose of the Reference group meetings was to receive feedback on the proposals from key stakeholders and third sector organisations including those with lived experience. The Commission also invited written feedback after both events.

The revised proposals included a definition for MHH, a pathway for the investigation process and three options for the investigation process itself (figure 3)

Feedback from the meetings is described in the MHHRG Summary Report. The report does not attempt to draw conclusions – rather to impartially reflect the varied and often contradictory views and comments expressed at the meetings and in their aftermath.

Figure 3: Investigation options – pros and cons

Option 1	Single investigation Commission independent chair and co-investigator + minimum 2 senior staff from HSCP form review team	**Pros:** • Single investigation reduces timescales, duplication, costs • Collaborative approach improves embedding recommendations • HSCP/HB staff provide local knowledge and experience • Independence and credible expertise ensured by Commission Chair and Commission Homicide Group oversight **Cons:** • Collaborative approach may appear to compromise independent viewpoint
Option 2	Single investigation by Commission investigation team	**Pros:** • Single investigation reduces timescales, duplication, costs • Fully independent investigation **Cons:** • No local experience on review. Negative impact on HSCP learning culture • Recommendations 'imposed' on HSCP by external agency – may impact on embedding of recommendations • Commission responsible for all costs
Option 3	2017 consultation model – HSCP conducts SAER, Commission reviews SAER and conducts graded 2nd investigation	**Pros:** • Retains established process for HSCP SAERs • 2nd report by Commission provides independent view **Cons:** • 2 tier process increases delays, duplication, costs and impacts on involved families and staff • Most SAERs focus on HSCP care • Commission investigation based on selective information in SAER

10 Findings

10.1 Requirements

A Scotland wide system for a Mental Health Homicide process requires:

- Reliable notification of potential Mental Health Homicides
- Effective collaboration between agencies with statutory investigatory roles
- Involvement of the perpetrator, victim and perpetrators families throughout the investigation process
- Timely, multiagency investigations using a standardised approach
- Credible, independent expertise
- Legal advice on disclosure of information to families and publication of reports to ensure public scrutiny
- Effective learning at a local and national level
- Review of the process using feedback from key stakeholders

10.2 Reliable Notification Process

This is a fundamental prerequisite for a MHH review system. Improved notification is likely to require more than one strategy particularly until the process is established. Notification criteria for Mental Health Homicides should be clearly defined.

A future system for the review of MHH must ensure that where a DoC response is triggered, the duties which care and treatment providers have under the DoC Regulations Scotland 2018 are completed in full.

10.3 Effective collaboration

The COPFS, Commission and Police Scotland all have statutory roles in the investigation of deaths. Working effectively together will require an established pathway and process for interagency working, the development of data sharing and service level agreements (SLAs) and will be helped by a ‘single point of contact’ for all homicide reviews.

10.4 Family Involvement in the Investigation Process

The perpetrator, victim and perpetrator families have a statutory right to involvement in investigations[8], [31] and to have their questions answered about care. They can also provide valuable information and insight into the incident.

Families' want[32]

- An apology
- Accountability
- Recognition and respect
- Effective learning

However *'families often have a poor experience of reviews. They are not always treated with kindness, respect and sensitivity*'.'[32] Independent advocacy support was identified as helpful in supporting families through the process and as a communication link if involved in the investigation[3].

In many cases (45%), victims of mental health homicides are acquaintances in which case the family of the victim and perpetrator may know each other. In a further 40% of cases the victim is a family member including spouse[6], in which case victim and perpetrator families may be one and the same or part of a single extended family group, further complicating the emotional trauma and grieving process experienced by those involved.

The expectations of an inquiry for the victim's family, the perpetrator, individual professionals, different local services and central government will all be different[33]. Investigators in NHS England identified the working relationship with families as requiring extensive time and the differing expectations of the families of victims and perpetrators was highlighted.[3]

The authors concluded that the purpose of the investigation should be identified and consistently communicated to families so there is no misunderstanding.

[31] Victims and Witnesses (Scotland) Act 2014 (legislation.gov.uk)
[32] Julian Hendy, Founder of Hundred Families' presentation to the Mental Health Homicide Reference Group 2021

Involving perpetrator and families throughout the investigation process will require considerable expertise and experience and should be supported by the involvement of third sector organisations.

10.5 Timely, Multiagency Investigations using a Standardised Approach

The time from incident reporting to report publication will be depend on many factors, many of them external to a Commission investigation. In particular, the delay in starting the investigation pending any criminal process.

'External factors and constraints such as ongoing police or other investigations, affected family and perpetrator considerations, obtaining clinical notes and pre-publication legal scrutiny may adversely affect timescales'[22]

The McCallion review recommended considering an independent chair of Trust internal investigations as a single investigation model in place of the current 2 tier system to reduce delays, costs and duplication.

There was multiagency involvement in pre incident care in 96% of NHS England cases reviewed between 2013 & 2018[3]. Issues with interagency working are recurring themes in reviews of learning from homicides[33,34,35]. There was strong support from the Scottish Government consultation in 2017 and from the MHHR group in 2021 for multiagency reviews.

However, the McCallion review recognised the 'complexities and challenges of sharing learning and implementing improvement across the wider systems' and suggested that approaches used in Domestic Homicide Reviews and Safeguarding reviews could be considered when there is multi-agency involvement.

10.6 Credible, Independent Expertise

There are identified issues (see under Learning from NHS England) with the use of private investigation companies to provide an independent investigation in NHS England, in particular with cost, quality and sustainability of this approach.

[33] John.H.M Crichton. (2011) A review of published independent homicide inquiries in England into psychiatric patient homicide, 1995-2010. Journal of Forensic Psychiatry and Psychology, 22:6, 761-789
[34] Parker, C & McCulloch, A. (1999) Key issues from homicide inquiries. London. MIND
[35] Hendy, J. (2018). Thematic Reviews of Independent MH Homicide Investigations. hundredfamilies.org.

The outcome of many adverse events in mental health services depends on clinical judgement and decision making by staff from different disciplines with varied levels of training and experience, working in a range of different circumstances. An investigation team requires sufficient expertise to give an informed view of whether reasonable care was given, taking all of these factors into account.

The relatively small number of Mental Health Homicides each year in Scotland means that these are infrequent occurrences at a HSCP level. This makes it difficult for any HSCP to build the expertise required to investigate and report on these often complex incidents to a consistently high standard as evidenced by MHH SAERs submitted to Commission

In NHS Greater Glasgow and Clyde (GG&C), a dedicated pool of senior clinicians 'chair' homicide reviews and more complex SAER's across all sectors of NHS GG&C mental health services. These 'Chairs' meet monthly as part of a multidisciplinary group which further quality assures all mental health service SAERs. This model enables the development of expertise and experience investigating the most complex incidents together with providing peer support.

10.7 Legal Advice on Disclosure of Information to Families and Publication of Reports

Information relating to the perpetrator and staff remains anonymous in NHS England published reports[22.] 'This was highlighted by families as being difficult as there is often a public record through the court case or the media. Reasons for anonymity may include the protection of the family of the perpetrator, the victim's family and staff and should be made clear to the families.'

'Reports should be made public in the interests of learning and transparency' however, the McCallion review found that only 35 reports of the total 57 reviewed reports had been published. 'The public interest aspect of publishing a report in full must be balanced with the right to confidentiality and the right to a private life under Article 8 of the Human Rights Act 1998. This applies equally to both sets of affected families and service users[22].

If alternative publication formats and processes are required, the decision making process must be 'well-evidenced and well-reasoned'[3]. In Stone vs Southeast Coast

Strategic Health Authority and others (2006), the judge held that a redacted report was not workable and that the public should be able to know what had occurred and should be able to form an intelligent understanding of the conclusions reached[33]. It was also noted that a great deal of information relating to the background was already in the public domain.

Legal advice on disclosure to families and publication of reports will therefore be required on a case by case basis

10.8 Effective Learning at a Local and National Level

In terms of preventing future patient homicides, anywhere between 21– 65% of incidents may be preventable.[36,37,38] The lower figure is based on feedback by clinicians to NCISH in 2006. Clinicians were able to identify factors that would have made the homicide less likely. The factors most frequently mentioned were better patient compliance, closer contact with the patient's family, closer patient supervision, improved staff communication and better staff training. 'Different powers under the Mental Health Act' were thought to make homicide less likely in several cases. The higher figure is from a review of NHS England inquiry findings in 2000.

These percentages could translate into anywhere between 11 and 78 potentially avoidable deaths in the last 10 years in Scotland.

Learning is more likely to be effective if it is timely. Monitoring timescales and analysis of how these can be reduced should be a priority in a new system.

To be effective, recommendations need to be implemented. Since 2016, there has been an assurance process for implementation of action plans in NHS England by the independent investigators who return to the Trust 6 months after completion of the report. See figure 4 below.

[36] Inquiry (manchester.ac.uk)
[37] Role of risk assessment in reducing homicides by people with mental illness | The British Journal of Psychiatry | Cambridge Core
[38] thematic-review-vol1.pdf (england.nhs.uk)

Figure 4: Example of The Niche Investigation Assurance Framework[39] developed by an independent investigation company

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

However, feedback[3] from these companies is that the organisational size of Trusts creates a challenge to provide full assurance of embedding of learning in the time allocated to achieve this. McCallion recommends that monitoring the embedding of recommendations could be done by either the CCG (Clinical Commissioning Groups) or CQC (Care Quality Commission) in NHS England through their regulatory visits. The Commission is well placed to take on this role in Scotland.

In NHS England, some investigation companies develop recommendations and discuss them with Trusts. 'Whilst this retains independence of the panel, it does not ensure Trusts engage in the recommendation development process. However, some companies develop recommendations with the Trust, ensuring that recommendations are achievable, realistic and good practice. This approach may be effective in enhancing the embedding of recommendations[3]'

On reviewing recommendations made by independent investigators in England in terms of SMART (Specific, Measurable, Achievable, Realistic, Timely) criteria, McCallion found 33% were specific, 5% were measurable, 21% were achievable, 2% were realistic and 5% were timely. The 2% of recommendations that were realistic were developed in tandem with the NHS Trust. This approach seemed to the authors

[39] Niche-NTW-assurance-review-v7-final-for-publication-280521-no-watermark.pdf (cntw.nhs.uk)

to have assisted in ensuring that recommendations could be implemented. Further, no recommendations were assessed to be nationally strategic and the authors suggested that 'demarcation of recommendations into local, regional and national would assist with the implementation and embedding at the regional and national level[3]'.

Reviews of learning themes[3, 32, 34] usually include all investigation recommendations, some of which may have impacted on the outcome, but others which are incidental to outcome. Whilst the latter recommendations may be valuable at a local level, their inclusion with recommendations that may have impacted on outcome could cloud efforts to identify potential preventive learning. Caring solutions[37] (NHS 2016) recommended that reports 'should aim to produce not more than 3 high impact, key recommendations' to establish the priority areas of focus. HIS advocate the use of 4 'review outcome levels' in the Adverse Events Guidance[40]. An outcome level 1 indicates that appropriate care was given and the outcome was found to be unavoidable, whilst a level 4 outcome indicates that a different plan or delivery of care would, on balance of probability, have been expected to result in a more favourable outcome. In the IIAR 2019/21, thematic analysis was undertaken using the Human Factors Analysis and Classification System (HFACS)[41] which categorises data as either having a strong causal factor, a contributing factor or a risk factor to the incident.

Key themes identified which are consistently highlighted are:

- Care planning
- Risk management
- Engagement with families/carers
- Communication and information sharing
- Implementation of CPA
- Record keeping
- Multiagency working

Reviews of learning from, investigations[3,22,32] have found that required data is not always available in the investigation reports. In NHS GG&C, a learning template is used by SAER reviewers to ensure comprehensive data collection. The template was

[40] Learning from adverse events through reporting and review - A national framework for Scotland: December 2019 (healthcareimprovementscotland.org)
[41] HFACS, Inc | The HFACS Framework

developed with a focus on learning from suicides and from NCISH findings but could be adapted to include learning from mental health homicides.

The Commission is well placed to be a repository for learning from MHH across Scotland. However, in view of the small numbers of mental health homicides, learning lessons will also depend on cooperative working with HIS, NHS England and others to share data and to disseminate learning. Key performance indicators could provide assurance of regional adherence to quality[3]. 'Measures should be developed to demonstrate the impact and outcomes of the independent investigation process with particular regard to learning, service improvement, policy development and the experience of affected families and carers.'

10.9 Review of the process using feedback from key stakeholders

A new process should systematically gather feedback from all involved agencies and families.

10.10 Appeals process

Where learning issues and recommendations cannot be agreed between COPFS, HSCPs, other agencies involved in care, involved families, perpetrator and Commission, there should be an appeals process. The COPFS could consider a Fatal Accident Inquiry and the Commission have powers to instigate an independent inquiry where required.

11 Proposals

11.1 Notification process

- Health Boards/HSCPs are required to notify adverse events to both the Commission and to HIS.
- To improve adherence, there should be a single, streamlined digital process for notifying adverse events across Scotland to both the Commission and HIS
- The Commission will raise awareness across services of requirement to notify the Commission of potential MHH
- Health Boards /HSCPs have a statutory duty to report admissions to NHS secure units under the Criminal Procedures (Scotland) Act 1995. As an additional safeguard, the Commission will proactively screen NHS secure units for new admissions on a monthly basis.
- The Commission will monitor and feedback reporting omissions to Health Boards/HSCPs.
- Further development of a system for the sharing of pre-trial psychiatric assessment reports between COPFS and Commission.
- Regular screening of press reports by Commission – this already occurs but could provide additional information.
- The Commission is in the process of replacing its current data base. The new database should have improved functionality enabling identification and tracking of current and previous homicide investigations and reporting on delays both to the Commission and feeding back to key stakeholders

11.2 Definition of Mental Health Homicide

A Mental Health Homicide is **'any homicide where the perpetrator had a mental disorder[42] at the time of the offence and was under the care[43] of Specialist Mental Health and Learning Disability services or under their care within the last 6 months'**

[42] As defined under the Mental Health (Care and Treatment) (Scotland) Act 2003
[43] Either referred to Specialist services by Primary Care or a period of inpatient care

Those who meet the above definition will usually have a full investigation by the MWC

11.2.1 Why this definition?

Firstly, this is an established and accepted definition across the UK and so this should allow sharing of data and learning with other services. Secondly, whilst the focus of this definition is relatively narrow, it should capture the majority of learning in Scotland for those with moderate to severe mental disorder whilst excluding homicides associated with substance misuse alone.

However, at the first Reference group, there was concern that this definition excluded those with a mental disorder at the time of a homicide who had NOT been referred to Specialist Mental Health services for some reason e.g. seen in Primary care and not referred or seen by Addiction services with a dual diagnosis and either not referred or refused care by Specialist services.

The Commission therefore propose that:

NB Where the criteria are met except care provided by Specialist Mental Health Services, the Commission will ask for a review from any involved services/agencies including Primary Care and investigate further as necessary.

11.3 Mental Health Homicide Pathway

We propose that the Commission develops a new role of a Commission Liaison Officer (CLO). The purpose of the role will be to help improve the involvement of, and communication with, families and carers during investigations of deaths. The role will involve:

- Providing continuity of contact with the family and carer(s) from the outset of the investigation through to report publication.
- Keeping the family and carer(s) fully informed about the progress of the investigation
- Explaining any legal requirements and processes which underpin the investigation – including the role and powers of the various contributors to the investigation, and any specific issues relating to possible criminal prosecutions

- Ensuring that any questions, points or contributions which the family and carer(s) wish to ask or make are communicated – and responded to – in a timely fashion
- Signposting family and carer(s) to appropriate support services (e.g. bereavement counselling)

The post will require the holder to display sensitivity, compassion, respect, empathy at all times, and to take account of any special communication requirements that family members or carers may have.

In addition the Commission Liaison Officer role will work to:

- Develop and promote standards for good practice in engaging with families.
- Network across Scotland with boards and other agencies to ensure that barriers to family participation in local reviews are addressed
- Ensure learning from individual reviews about family involvement is fed into national level learning reports and actions

We propose dual deployment, with the proposed Commission Liaison Officer role(s) working across both deaths occurring during compulsory care and treatment and also across investigations of homicides where the perpetrator has a mental disorder.

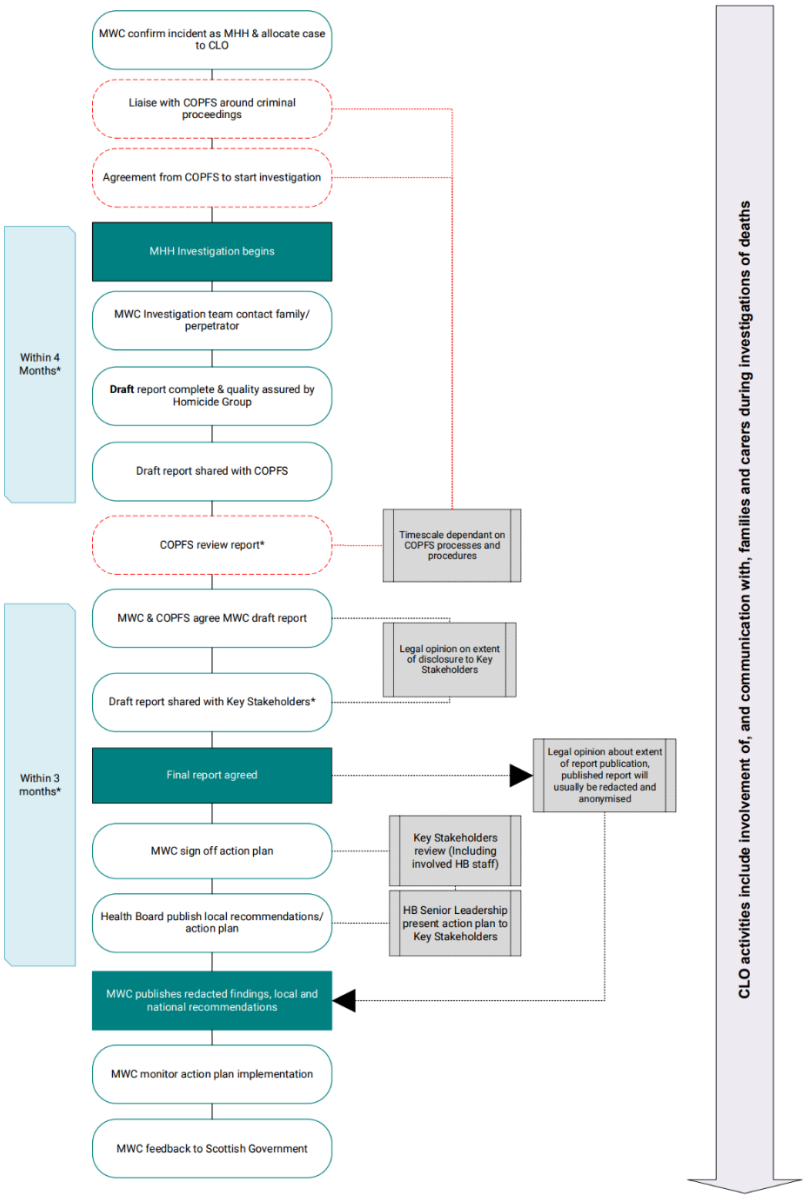
The CLO for Mental Health Homicide reviews will also be a single point of contact between investigating agencies and Health Boards. (figure 5)

Figure 5: Functions of the Commission Liaison Officer

Functions of the Commission Liaison Officer
1. Single point of contact between MWC and other agencies
• Health Board/HSCP • COPFS • Police
2. Expertise working with involved families*
• Provide support for and inform patients/families at the outset and during the investigation • Promote local HSCPs and third sector support for patients and families during the investigation including advocacy • Provide support for engagement of patients and families in the investigation

From Patient Safety Incident Framework

Figure 6: The proposed pathway for Mental Health Homicides



Key features are:

- Appointment of Commission Liaison Officer where definition criteria met
- Investigation commences after liaison with COPFS with regard to criminal process
- Involvement of perpetrator and family, victim's family throughout process where appropriate

- Draft report quality assured by ‘expert homicide group’ within Commission
- Draft report shared with COPFS
- Case by case legal view on extent of report disclosure and subsequent level of publication
- Feedback on draft report from involved staff, families and perpetrator
- HB/HSCP management present and publish local action plan
- Commission oversee implementation of action plans
- Collate feedback from key stakeholders - HB/HSCP, COPFS, perpetrator, involved families
- Commission annual report to Scottish Government- published on the Commissio website

Additionally, the Commission will work with third sector organisations and faith/spiritual organisations to draw together information on how to seek bereavement support, advice, advocacy and support for the investigation process following a MHH.

11.4 Investigation process

A single investigation, with an independent chair and a second investigator from the Commission forming an investigation team with a minimum of 2 senior Health Board personnel.

11.4.1 Rationale

A single investigation should reduce the timescale to action plan implementation, avoid duplication and reduce the negative impact of the investigation on involved staff and families.

The independent investigation Chair and quality assurance by an ‘expert Homicide group’ within the Commission ensure an independent viewpoint.

The Commissions expert Homicide group will comprise a dedicated group of senior HSCP staff recruited from across Scotland with significant experience investigating significant adverse events. They will receive accredited training, build expertise in MHH reviews, meet monthly to quality assure and give robust oversight to investigation reports and to provide peer support.

The Chair and a deputy from the Commission will work collaboratively with senior HSCP staff on the investigating team. Senior Health Board staff on the team ensure local knowledge and experience. This approach will optimise local HB/HSCP learning and enhance embedding of recommendations.

This was one of 3 options for the investigation process considered by the Reference group in November 2021. There was strong support for this option

The investigation will be systems based and reference a human rights framework. It will be sensitive to the needs of the staff involved in the incident.

11.4.2 Governance of Independent Chairs and MHH reports

The Independent Chairs are independent of the service where the homicide occurred.

There is also much to be learned from the experience within Child and Adult Protection Committees in Scotland about the role of the independent Chair/Convenor and multi-agency cooperation.

The Adult Support and Protection Act 2007, requires the convener to be appointed by, but be independent of, the council. The individual must be seen to be independent in thought and action as well as someone who has the necessary skills and knowledge.

The MHH Independent Chairs will be employed by the Mental Welfare Commission and have a background in medicine, law or other relevant profession and extensive experience of chairing and carrying out investigations at a senior level.

The independent chairs will lead on individual investigations with support from the Commission investigation staff and also attend regular meetings of the Commission Homicide Group.

Final reports will be reviewed and agreed by the Commission - the Commission Homicide Group and final approval will be from the Commission Board.

Investigations will be carried out using the Commission powers under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003[12] and in some circumstances, if necessary, Section 12

11.4.3 Multiagency investigations

The proposed model for multiagency involvement in Mental Health Homicide reviews is based on the Domestic Homicide Review Process[28]

- Lessons for interagency working
- Risk of harm not recognised by agencies, not shared with others or acted upon in accordance with recognised professional practice
- National or local agency protocols may need to change or are not adequately understood or followed,
- Any involved agency/professional considers their concerns not taken sufficiently seriously
- Concerns or questions about agency involvement are raised by involved families or perpetrator.

For all investigations the investigating team should:

- Consider if indications for a multi-agency investigation (above) are met
- If met, investigating team commissions an Individual Management Review (IMR) from the involved agencies stating the terms of reference for that review
- Include any questions by the perpetrator or families about agency involvement in the terms of reference.
- Agree the IMR findings with the agency once complete
- Complete an 'Overview report' which includes both draft MHH investigation report and IMR findings

11.4.4 Individual Management Reviews (IMRs)

Provide the investigating team with a chronology of agency involvement with the perpetrator and/or victim

- Address the terms of reference specified by the investigating team
- Identify any changes required to individual or organisational practice with timeframe for action
- Reports should be anonymised and are not publicly available
- Timescale is 2 months from date of request

- Reports should be quality assured by the agency senior manager responsible for ensuring recommendations are implemented

This process is likely to require a Service Level Agreement and or Data Sharing Agreement between the Commission and involved agencies

The Commission will request an agency update report on recommendation implementation after report closure.

11.5 Assurance and Feedback

The Commission will develop an assurance process for recommendations at both a local and national level. There will be a clear escalation policy to the Scottish Government when it considers that local services have not complied with recommendations made or there has been an unacceptable response to recommendations made.

We propose that that the Commission should be responsible for producing and disseminating an annual report on the results of the investigations, with a focus on the lessons learned. All reasonable efforts will be made to ensure anonymity of individuals.

There will be a feedback process for all those involved in investigations, with outcomes and actions to address these in the annual report.

12 Appendix 1 - Reference Group Membership & Programme Support

12.1 Reference Group Membership & Programme Support

Mental Health Homicide Reference Group

Dr Andrew Watson	Associate Medical Director, Psychiatry, NHS Lothian
Beatrice Jones	Founder & CEO, The Moira Fund
Sgt Colin Convery	Partnerships, Prevention & Community Wellbeing Division, Police Scotland
Dr David Hall	Psychiatrist & MWC Board Member, Mental Welfare Commission
Deborah Demick	Crown Office and Procurator Fiscal Service (COPFS)
Gael Cochrane	Learning Development & Innovation Lead, Community Justice Scotland
Iain Waitt	Mental Health Representative, Social Work Scotland
James Carnie	Head of Research, Scottish Prison Service
Teresa Medhurst	CEO, Scottish Prison Service
Jenna Murphy	Resilience Learning Partnership
Julian Hendy	Founder & CEO, Hundred Families
Kate Wallace	CEO, Victim Support Scotland
Kathleen Taylor	Engagement & Participation Officer, Mental Welfare Commission
Lyndsey Main	Office Manager, Petal Support
Mairi Campbell-Jack	Senior Public Affairs Manager, Scottish Association of Mental Health (SAMH)
Mark Richards	Director of Nursing, NHS State Hospital Board for Scotland

Moira Manson	Senior Inspector/Reviewer, Healthcare Improvement Scotland
Neil Moore	CEO, Petal Support
Nicola Moffat	Senior Analyst, Major Crime Team, Police Scotland
Paula John	Investigations Practitioner , Mental Welfare Commission
Dr Peter Lerpiniere	Associate Director of Nursing, NHS Borders
Dr John Crichton	Royal College of Psychiatrists, Scotland
DI Sarah McArthur	Partnerships, Prevention & Community Wellbeing Division, Police Scotland
Shumela Ahmed	Educator & Managing Director, Resilience Learning Partnership
Mrs Tracy Gilles	Medical Director, NHS Lothian

Mental Health Homicide Final Phase Programme Support*

Alison Thomson	Executive Director (Nursing), Mental Welfare Commission
Andy Grierson	Head of Project, Mental Welfare Commission
Anne Birch	Researcher, Mental Welfare Commission
Carolin Walker	Project practitioner , Mental Welfare Commission
Iain Cairns	Project practitioner Mental Welfare Commission
Dr Ruth Ward	Consultant Psychiatrist, Mental Welfare Commission

From spring 2021*

Programme Support - Phase one & two

Alison Thomson	Executive Director (Nursing), Mental Welfare Commission
Anne Birch	Head of Project, Mental Welfare Commission
Anne Buchannan	Nursing Officer, Mental Welfare Commission
Callum Macleod	Systems Analyst, Mental Welfare Commission

Dr Moira Connolly	Consultant Psychiatrist, Mental Welfare Commission
Kathleen Taylor	Engagement & Participation Officer, Mental Welfare Commission
Mark Manders	Casework Manager, Mental Welfare Commission
Martin McKee	Research Officer, Mental Welfare Commission
Paloma Alvarez	Information Governance Manager, Mental Welfare Commission
Paula John	Investigations Practitioner, Mental Welfare Commission
Dr Peter LeFevre	Consultant Psychiatrist, Mental Welfare Commission
Dr Simon Webster	Human Rights Policy Advisor, Mental Welfare Commission

13 References

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