VERITA

IMPROVEMENT THROUGH INVESTIGATION

Lessons from independent homicide reviews

A Verita perspective

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Agenda

- A brief introduction to independent homicide reviews and Verita's reports
- Care and service delivery themes evident in Verita's work
- Are we able to learn from reviews, and if not, why not?
- What can we do better to derive value from a review?
- How can we ensure that families are involved and supported?

A brief introduction to independent homicide reviews and Verita's reports

Government requires NHS England to commission IHRs.

An independent inquiry should happen:

“when a homicide has been committed by a person who is or has been under the care of specialist mental health services in the six months prior to the event.”

Independent homicide review (IHR)

Independent

- The review is carried out by people who were not involved with the victim, perpetrator or services involved

Homicide

- The investigation examines the care and treatment of a patient who has killed someone

Review

- The internal investigation carried out by the organisation responsible for the persons care is also taken into consideration

Independent homicide reviews

- Are NOT about blaming people
- Are about examining care to identify if there were any issues of concern
- Are about providing assurance of local Serious Incident investigations and action plans
- Are about engaging families of both the victim and the perpetrator in the process

A lot has happened in mental health over the past 25 years

Lets test your memory- when were the following introduced?

- Independent homicide reviews?
- When did IHR commissioning change from Strategic Health Authorities to NHS England Regional Offices?
- Care Programme Approach?
- Risk assessment?
- MAPPA? (and MARAC?)
- If you are from a trust, when were electronic records introduced (if they have been)?
- … and when was the last trust service changes?

How did you do?

- **Independent homicide reviews.**
  - Introduced with guidance in 1994*. Guidance amended in 2005
- **When did IHR commissioning change from Strategic Health Authorities to NHS England Regional Offices.**
  - NHS England London Region took over IHR commissioning in July 2006
- **Care Programme Approach.**
  - Introduced in 19991 following inquiries into homicides. Mandatory since 1996. Simplified in 1999 and again in 2008
- **Risk assessment.**
  - Again, first formal introduction in 1990's. Much debate continues about risk assessment#

**The Discharge of Mentally Disordered People and their Continuing Care in the Community* (HSG (94)27), Department of Health

See "Risk, Safety and **Recovery**" (http://www.imroc.org/wp-content/uploads/ImROC-Briefing-Risk-Safety-and-Recovery.pdf)

How did you do?

Although not mental health specific, services also feed into other community safety initiatives:

- **MAPPA and MARAC**
  - **Multi-Agency Public Protection Arrangements**. Coordinated by police and probation for supervision of sexual and violent offenders in the community. Introduced in 2000 and strengthened in the Criminal Justice Act 2003.
  - **Multi-agency risk assessment conferences**. Piloted in 2003, meetings where statutory and voluntary agency share information about high risk victims of domestic abuse to produce a co-ordinated action plan. There are approximately 250 MARACs currently in operation across England and Wales

The Verita Perspective

Getting a Verita view

- For today, we collated the details of 60 IHRs into a database
- This was then discussed within the core team of Verita staff
- A member of the Verita mental health advisory panel who has experience in analysis also provided feedback

Consider this...

- In 2007 Verita conducted an IHR into the care and treatment care of Mr Q

- Mr Q had killed an acquaintance while under the care of a community mental health service

Our conclusions were the following:

"The trust community mental health teams made assertive, positive and consistent attempts to engage with Mr Q. They worked in flexible ways by offering outpatient appointments, home visits and day hospital placements to maintain Mr Q's engagement, with some success."

"Mr Q's care was delivered in accordance with national CPA guidance and local policies."

"We found no indicators that the homicide was predictable and no actions or inactions by trust staff that would have prevented the incident occurring."

And as to recommendations…

There were none

60 IHRs conducted by Verita

- The review we have discussed was the only one which had no recommendations
- There were 53 which had some area of concern which required action, but where the homicide was not considered predictable or preventable
- These 53 cases still range from ‘good’ care, or care with minor issues, to care with major issues that should have been addressed
- There were six cases where the homicide was deemed to be either predictable or preventable

Verita definition of “Predictable”

“The homicide would have been **predictable** if there was evidence from the patient’s words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.”

Verita definition of “Preventable”

“The homicide would have been **preventable** if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

(Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.)”

Care and service delivery themes evident in Verita's work

Overview

- "The best way of reducing error rates is to target the underlying systems failures, rather than take action against individual members of staff."

  National Patient Safety Agency, "Seven steps to patient safety" July 2004

- As we have seen, an IHR can give assurance about the care of a person has committed homicide

- It is worth considering care and service delivery themes that undermine this assurance

What do you think

Our analysis has identified themes from our IHRs that affect care delivery

Take a minute to consider what you think they will be.

Verita Themes

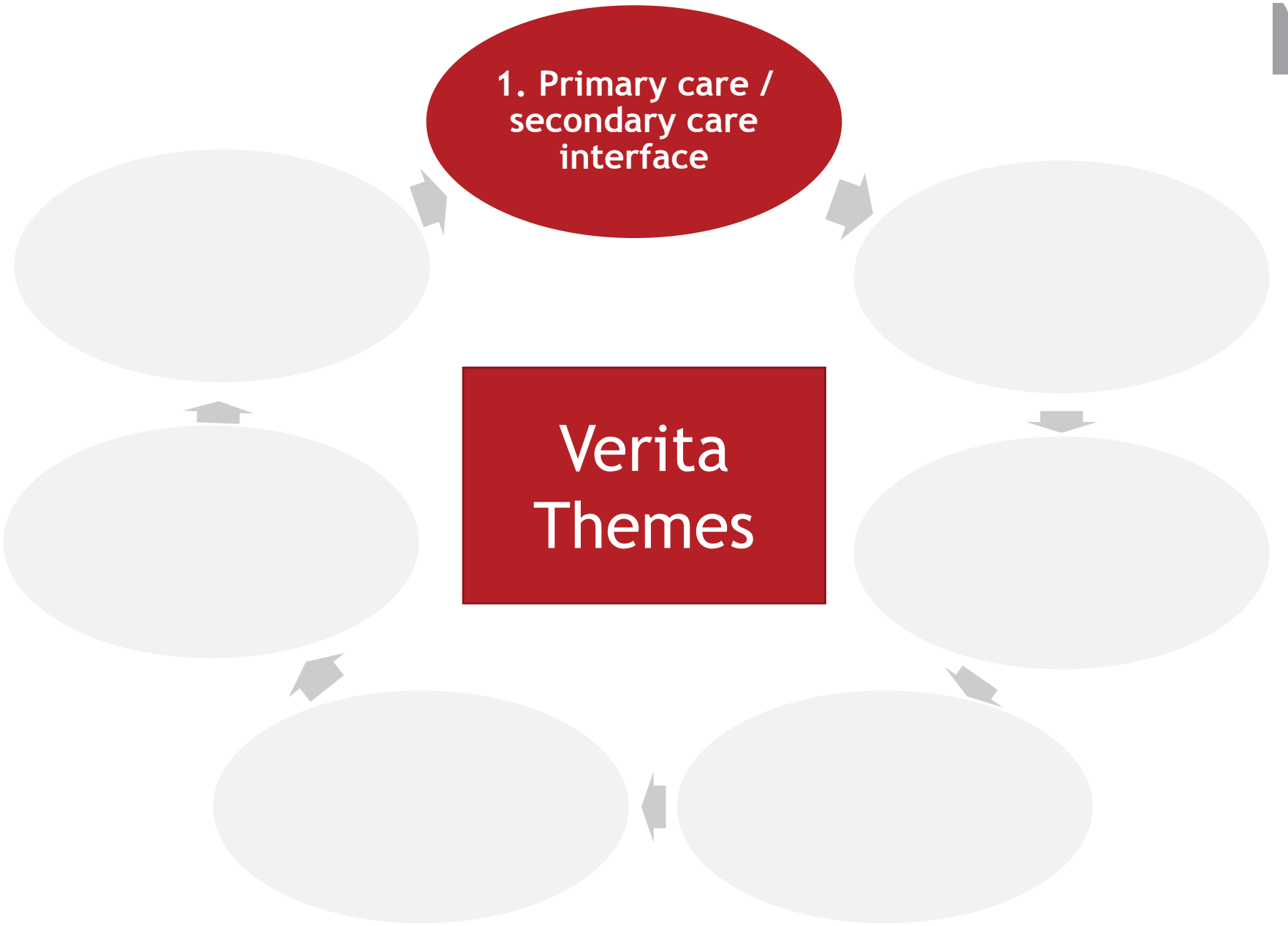
1. Primary care / secondary care interface
2. Issues with care programme approach/care planning
3. Issues with risk assessment and management
4. Dealing with non engagement and disengagement
5. Communication and multi-agency working
6. Getting the right diagnosis and right service
7. Pressures on services

More detail on the themes.

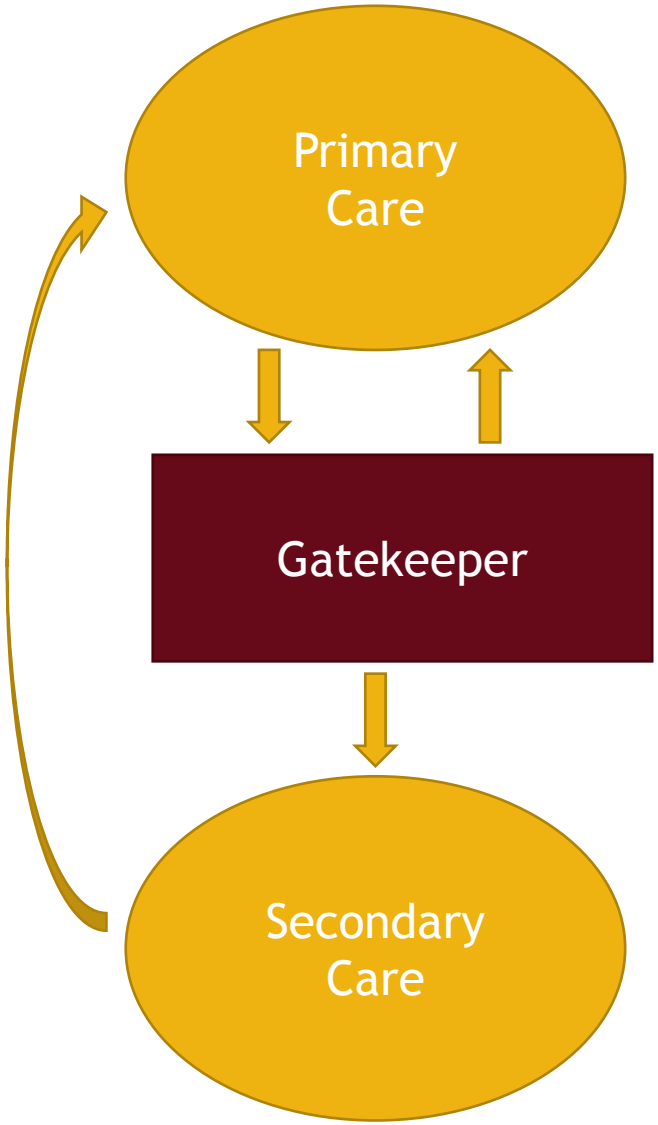
The following slides outline why we have considered these themes.

There are two slides for each;

- An overall slide with general points on the theme.
- Quotes from Verita IHRs about the theme


1. Primary care / secondary care interface
Verita Themes

1 Primary care/secondary care interface



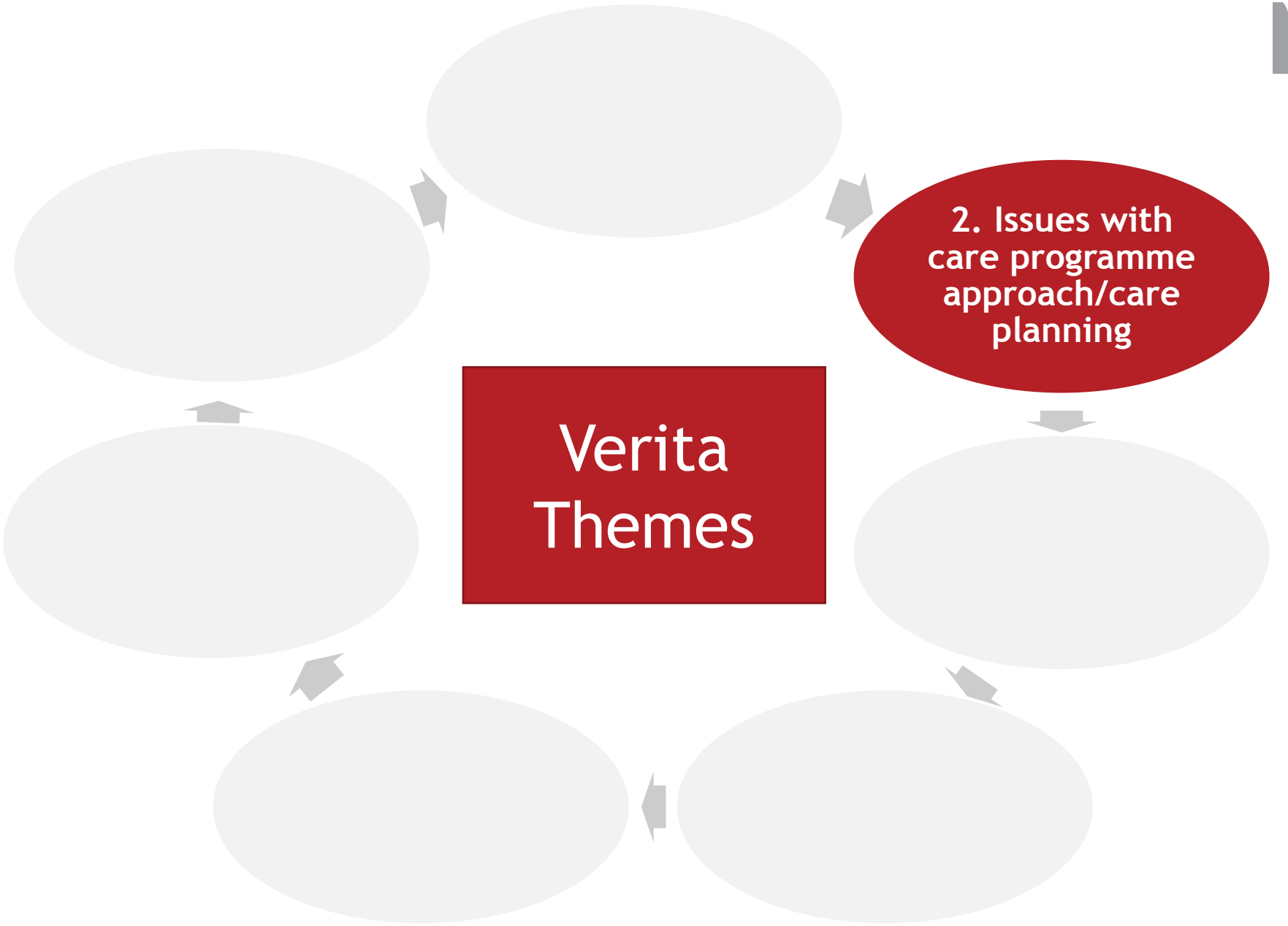
Primary care/secondary care interface issues

- Quality of GP referral
- Gatekeeper overload
- Appropriate return to primary care

Primary care/secondary care interface

"On two occasions GP considered referring Y for further assessment of her depression but failed to do so."

"The decision to refer X back to the GP without support from the trust after his [inpatient] stay was not appropriate. He should at least have been offered some limited home assessment and support from the CRHTT or the community mental health team."


2. Issues with care programme approach/care planning
Verita Themes

Issues with care programme approach/ care planning

- Policy established, but practice variable
- Delay in allocation from primary care
- The struggle with complex presentations
- Identifying family/carers and responding to concerns

Issues with care programme approach/ care planning

"Mr X was eligible to be cared for under CPA. This would have ensured a more formal approach to his care and support."

"We recommend a review of the criteria used when allocating care coordinators. They should be allocated against objective criteria such as their experience, case load and the complexity of the case to be managed. The review should also consider what additional supervision is required when recently qualified professionals are appointed as care coordinators."

"The trust should ensue registration/admission forms and care plans identify a) if there is a carer and b) what support is being offered to the carer and c) what contact there is with the family if there is no carer. The trust should ensure that all teams … identify carers and the involvement of families in accordance with trust policy."


Verita Themes
3. Issues with risk assessment and management

Issues with risk assessment and management

- Again, policy not translating into practice
- Risk assessment – is it a tick box exercise?
- Risk management plans less accepted than care plans – is there a block in practice?

Issues with risk assessment and management

"The … team did not carry out risk assessment and risk management processes thoroughly. This failure led to the lack of an effective risk management plan."

"Mr X's risk was regularly reviewed by trust staff ... However, information contained in these documents was often copied from previous assessments making it difficult to identify new or relevant information."

"The trust board should commission a report that will provide it with robust evidence of the quality and compliance level of risk assessments."


Verita Themes
4. Dealing with non engagement and disengagement

Dealing with non engagement and disengagement

Dealing with non engagement and disengagement

- CPA and risk assessment are more likely if client is insightful, in agreement with care and has a less chaotic lifestyle
- Again, policies on “Did Not Attend” and non-engagement, but practice variable

Dealing with non engagement and disengagement

"The trust should ensure that all staff adhere to the policy and procedure for managing formal and informal service user's non-compliance with treatment and managing DNA [did not attend] or cancelled appointments."

"When the CMHT care coordinator was informed that X [was refusing to attend] services, he failed to ensure that X's refusal to attend was assessed as part of ongoing mental state assessments."


Verita Themes
5. Communication and multi-agency working

Communication and multi-agency working

- Communication across agencies is a common and ongoing theme
- Complex cases with previous criminality, substance abuse, chaotic lifestyles can mean multiple agencies needing to work together
- IHRs question if MAPPA or other multi-agency sharing always considered

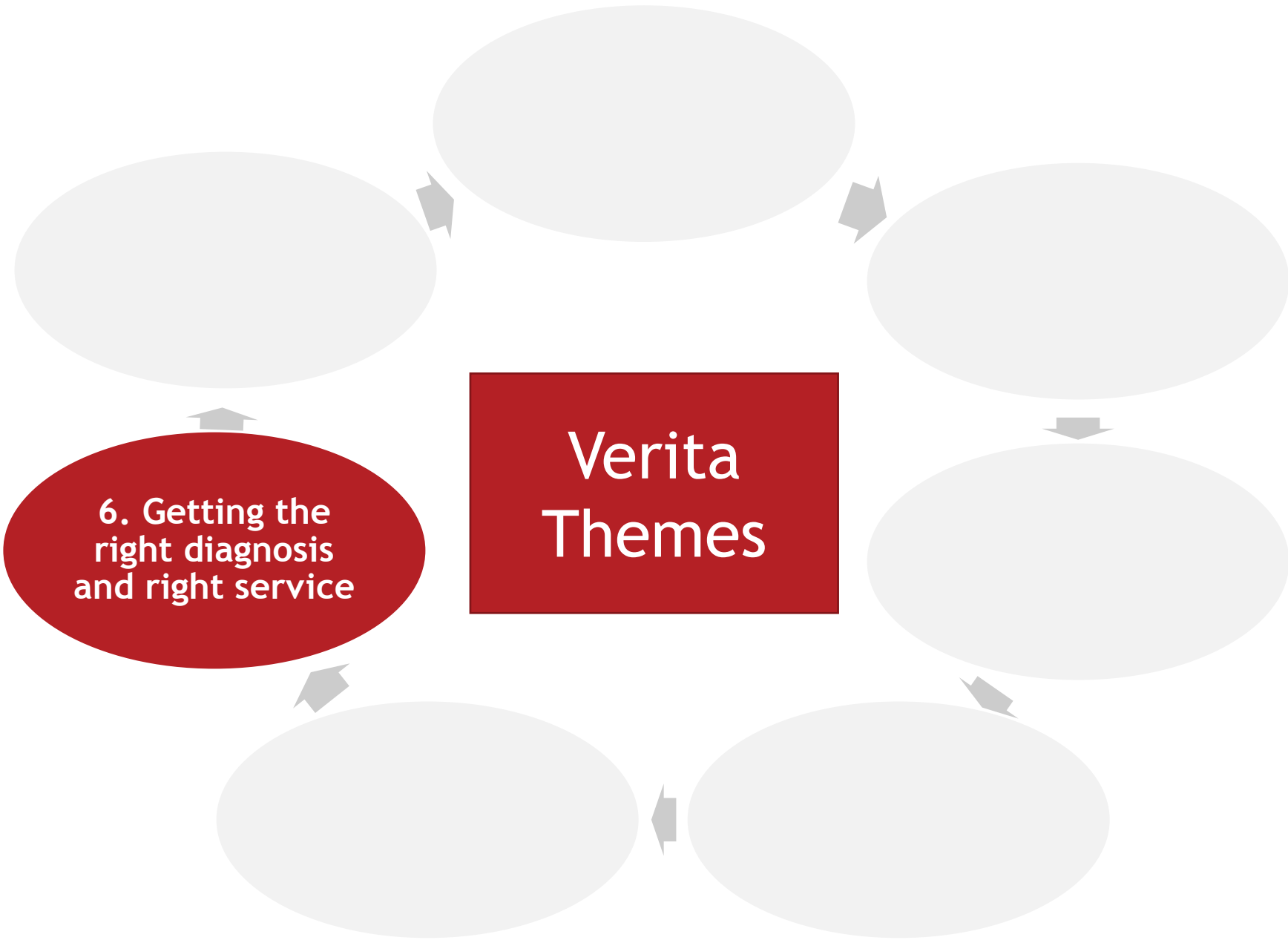
Communication and multi-agency working

"General psychiatry teams in the trust should liaise with the multi-professional forensic specialist service offering ongoing advice and support regarding clinical management, in addition to a basic consultation service. It would be helpful to pair particular forensic and general psychiatric teams."

"[The trust did not]have a procedure for immediate notification to the police when a patient has committed a serious criminal offence. [there was an]apparent lack of understanding of the duty of care to vulnerable people, particularly when the Mental Health Act was not applicable and the risk of a serious offence was demonstrably high."

"Every trust should have a protocol for trust liaison with the multi-agency protection panel, including referrals and seeking advice. "

"Whilst the records are now much better and the CPA is clear, it would seem to be appropriate for the trust to review its protocols for urgent information-sharing, particularly in high-risk cases."


Verita Themes
6. Getting the right diagnosis and right service

Getting the right diagnosis and right service

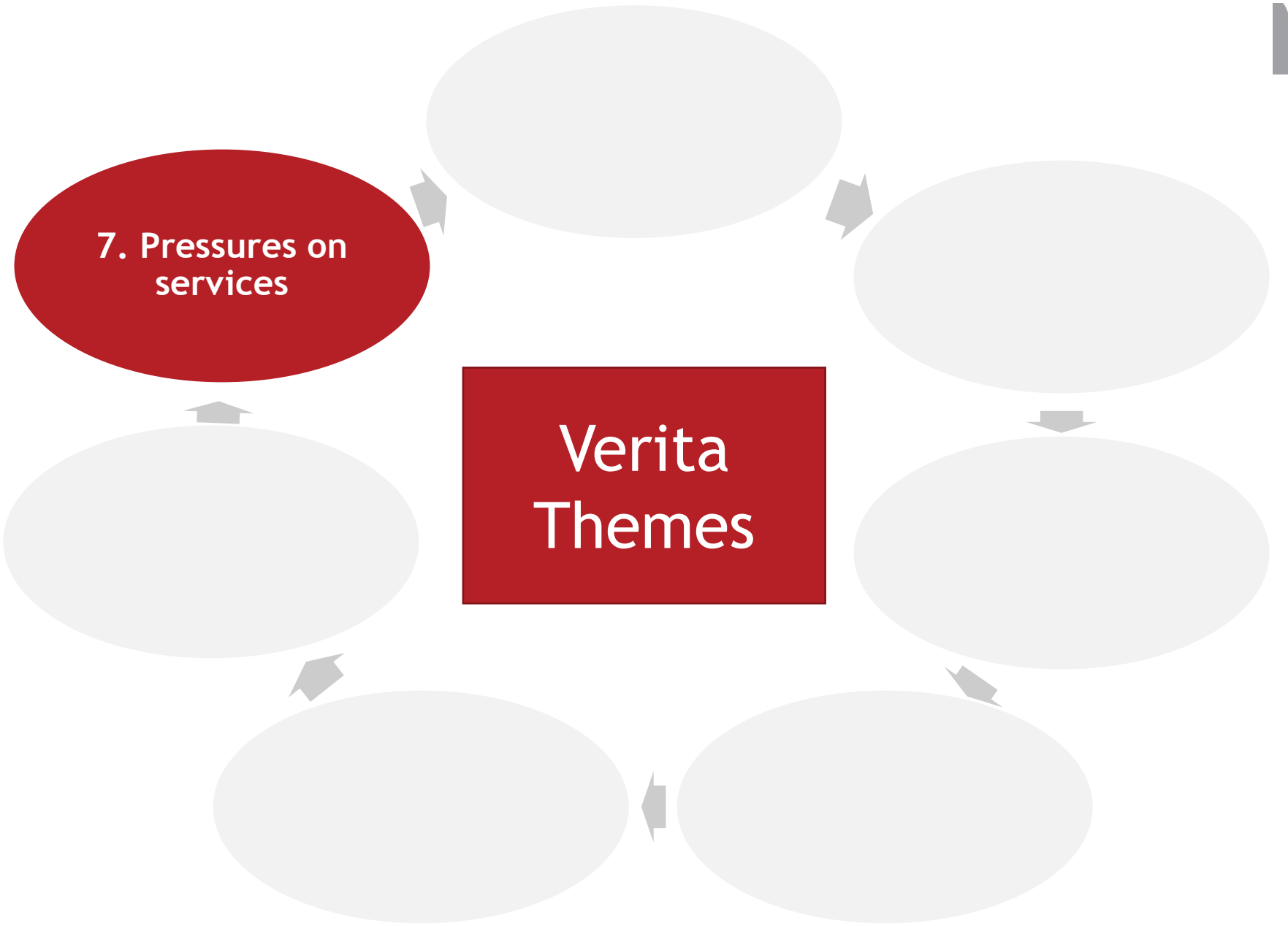
- Perhaps a sub theme of CPA, but deserves separate consideration
- Understanding of diagnosis can change over time - too often diagnosis becomes set and inflexible
- Drug and alcohol misuse is a confounding factor
- Complex cases can involve a number of agencies

Getting the right diagnosis and right service

"The team appear to have focused on his immediate presentation rather than giving sufficient weight to the well documented history of violence, aggression and impulsivity evident from Y's clinical records… If this information had been analysed, an emerging personality disorder may have been identified behind what may have been drug-induced psychotic episodes."

"There was no attempt by trust staff to re-evaluate Mr X's diagnosis despite evidence that at least some of his behaviour and symptoms may have had an alternative explanation."

"While it remains important to all concerned that voluntary sector resource are independent of the local mental health service, all CMHT's …develop protocols for regularly recording and sharing information about individuals in contact with them…"


7. Pressures on services
Verita Themes

Pressures on services

- Many service changes, realignments, reconfigurations
- It is unusual to start an IHR without being told “The service is different now”
- Bed pressures, caseload sizes, teams with multiple changes/temporary staff

Pressures on services

"X was being cared for and treated by an organisation that was experiencing significant problems... To summarise, they included a chronic shortage of nursing and medical staff, a sometimes unsafe inpatient environment, poor linkage between inpatient and community services and a [CPA system] that was not operating effectively."

"The trust team were struggling with operational changes, staff sickness, a pressure to keep patients moving through the system and limited resources given the large geographical area it was expected to cover."

"The trust should maintain and improve on current performance in delivery of psychological therapies to ensure that 18 weeks is the maximum waiting time rather than, as at present, the average. Commissioning bodies should ensure the trust is adequately resourced to … enable it to comprehensively achieve the 18 week target."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7 Pressures on services

Good practice

Although we have identified a range of themes, reports also contain good practice examples.

For example:

- Care and risk management plans communicated across agencies
- Support for teams managing complex cases; risk panels, forensic liaison offering advice and support, joint working protocols with the police

Good practice

"In other respects the management of xxx now appears to be well-structured and operating with a style which combines clarity of expectation with good person-centred management, sensitive to the demanding and sometimes stressful nature of the work [in this service]."

"The trust should continue to encourage risk panel meetings..."

Are we able to learn from reviews, and if not, why not?

We think that there are some positive signs

In terms of a care system, we would argue that these changes have made a difference

- The firming up of the policy base (CPA, Safeguarding, Memorandum of understanding.)
- The (partial) introduction of shared electronic record systems
- Local and IHR themes in training and induction (keeping an organisational memory)

But challenges still remain

What is the block to producing good risk management plans?

How do we get better integration for complex cases (violence, dual diagnosis)?

How do we deal with the continual pressures on services?

What can we do better to derive value from a review?

What can we do better to derive value from a review?

- Get good quality local investigations.
- For Verita, the creation of the Verita Mental Health Advisory Group.
- Dissemination of findings directly to clinical areas – direct feedback from IHR team, learning events, incorporation of IHR themes in training and induction.
- Include an independent follow up process for IHR recommendations. (NHS England Southern region has commissioned 5 such follow up reviews for homicides.)

How can we ensure that families are involved and supported?

Not just mental health considering this question

Review into the needs of families bereaved by homicide

Louise Casey CB, Commissioner for Victims and Witnesses

July 2011

Review conducted a survey of 400 bereaved families. Here are some findings:

- 80%+ had suffered trauma-related symptoms - 3/4 suffered depression
- One-in-five became addicted to alcohol
- 44% who experienced relationship problems with a spouse said it led to divorce or separation
- A quarter (23%) gained sudden responsibility for children as a result of the killing
- The average cost of the homicide to each family was £37,000, ranging from probate, to funerals to travel to court, to cleaning up the crime scene. The majority got no help with these costs and some were forced into debt.

Review into the needs of families bereaved by homicide

"This is not about removing rights from defendants but balancing up the system so that it is humane and fair to the victims and their families, that it gives them due consideration and better information, some rights and decent support services. A sense that they are not alone and isolated – that there is someone on their side too."

Mental Health - “100 Families” website

“We had no connection with the mental health trust until …at least ten months [after Tom’s murder] and that was as a result of some local press coverage. We were able to find out a way of getting to get to talk to them, and we finally got a meeting with them I think fifteen months after [the murder] …

And that meeting was very awkward it was. I think they assumed we were going to start blaming them for various things that had happened. We were going there to find out what had happened, we just didn’t know.

It was that sort of situation where we felt that we were all the time meeting their needs and not our needs. And we were the victim’s family in this case. But in terms of what we needed, no, there was virtually nothing.”

The family of the perpetrator also need support.

" The offenders family is left to deal with his or her absence for an extended period of time. A good number of marriages end during that period. The emotional effects on children are not only disruptions in attachment and loss but also include … ridicule, teasing and ostracism ..."

Malmquist M, *"Homicide: a psychiatric perspective."* page 414.

In some cases the family is dealing with the homicide of a family member BY a family member

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report.” July 2014

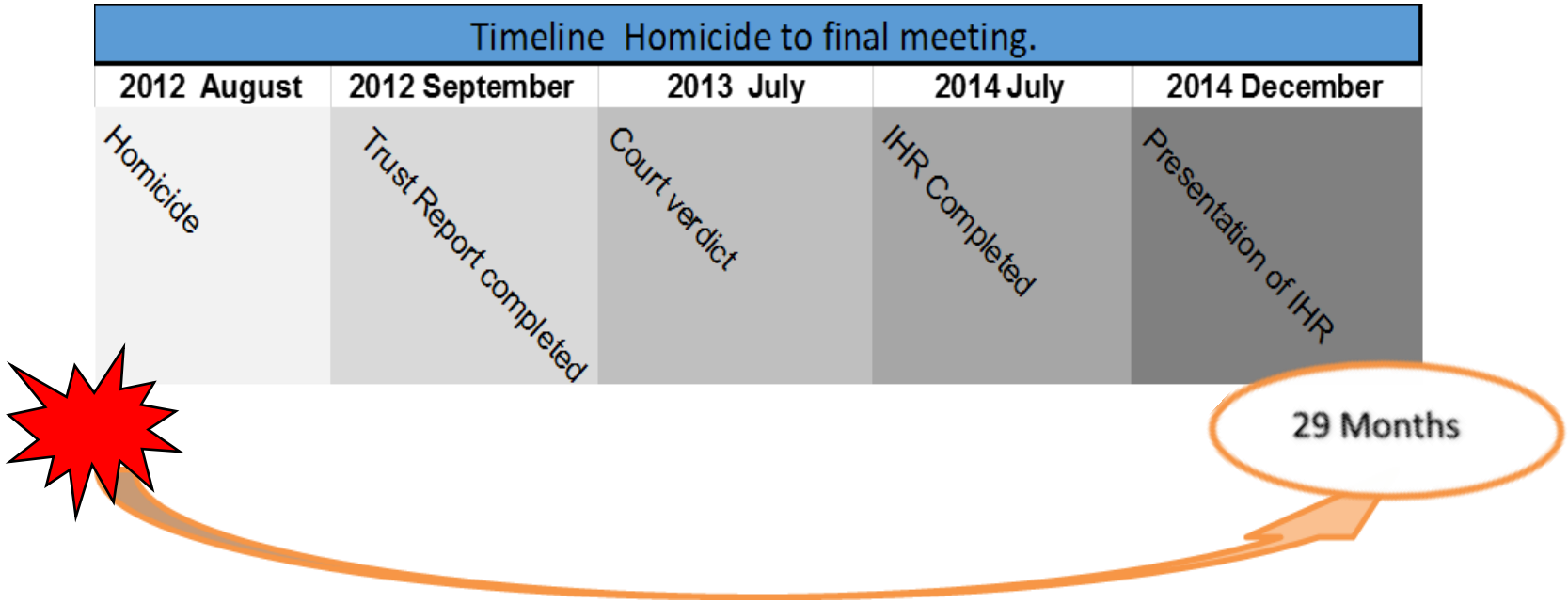
The report looked at 26 people convicted of homicide between 2000 to 2012 who were patients of mental health services in the 12 months prior to the homicide.

- 25% of victims were the spouse/partner (current/ex)
    - 21% of victims was another family member

Mental health services and families

- For services it is often easy to identify the family of the perpetrator but not the victim's family
- Too easy to defer to criminal justice to support victims families?
- Leads to confusion as to which agency is supporting families
- IHR teams are often told they are the first contact from services

Yet even a relatively simple process can mean trust/family engagement necessary for a considerable period



What can we do?

- Clearer coordination between agencies.
- Develop links and provide information about organisations that offer support (eg. Support After Murder & Manslaughter, Advocacy after Fatal Domestic Abuse)
- Should mental health think along the lines of a “family liaison officer”?

Summary

- IHRs are not about finding people to blame but providing assurance and increasing confidence in systems of care.
- Verita would like to do more IHRs which result in no recommendations.
- For this to happen we all need to work together.
- … and we all have to improve our dealings with the families.