A review of 26 mental health homicides in London committed between January 2002 and December 2006

A report for NHS London

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NHS London

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Appendices

1. Introduction

All homicides[1] committed by individuals in the care of mental health services in England are investigated by the mental health trust that provided their care. Strategic health authorities (SHAs) also have a responsibility to investigate these incidents. In their guidance on *The Discharge of Mentally Disordered People and their Continuing Care in the Community* (HSG (94)27) – and the amendment published in 2005 – the Department of Health set out what organisations should do following a mental health homicide. It says that mental health trusts and SHAs should:

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

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

Since July 2006 NHS London has been responsible for commissioning independent investigations in London, having taken over this role from the five previous London SHAs.

As part of the process of establishing the new SHA, NHS London carried out an audit of the status of investigations into homicides committed between 2002-2006 by patients receiving mental health care.

The audit identified 26 homicides committed between January 2002 and December 2006 by individuals known to mental health services where the perpetrator had been convicted of the offence but where no independent investigation had been commissioned.

NHS London moved swiftly to set up an independent review and subsequently commissioned Verita to work with the SHA's lawyers, Capsticks, to review these 26

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

cases with the purpose of recommending whether they met the HSG (94)27 criteria for an independent investigation and if so, the type of investigation required.

The purpose of this review is to build on the internal investigations already completed by mental health trusts by identifying common themes and issues. NHS London will use this information to improve the quality and consistency of mental health services across London.

NHS London made a public announcement about the commissioning of this work on 6 July 2007. A helpline was set up to deal with any enquiries from relatives.

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

2. Executive summary

NHS London carried out an audit of the reports of internal investigations into mental health homicide cases it inherited from the five former London SHAs.

The audit found 26 cases where a mental health patient had been convicted of homicide which had not been subject to independent investigation as required under the terms of the HSG (94)27. These homicides took place between January 2002 and December 2006.

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

The underlying purpose of the review was to provide NHS London with clear recommendations about what action it needs to take to learn the lessons from these cases and ensure that they are used to improve mental health services across London.

In order to conduct a thorough and proportionate review, we established a team of experts with management, mental health and legal experience to assess each case.

Assessors used an assessment framework (or toolkit) designed to ensure a consistent approach to all 26 cases. NHS London approved the assessment framework before the review started.

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

Based on an analysis of the internal investigation reports, we recommend that all 26 cases should be investigated further, but it appears that the same scale of investigation will not be necessary or appropriate in each.

Other than the need for an investigation to be independent, the HSG (94)27 does not stipulate what type of investigation is necessary in order to ensure that lessons from cases of mental health homicide are learned and then applied.

We identified three broad types of independent investigation that could be used. No one type of investigation is more important than another. Each has values that make it best suited to examining certain cases. The three broad types are:

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

One of these three types of investigation is recommended for each of the 26 cases requiring further work. The recommendations are based on the complexity of each case and on our analysis of the documentation we were given. Four cases are recommended for a type A investigation, 10 for type B and 12 for type C.

During the process of the review we alerted NHS London that four cases required a type A wide-ranging investigation. NHS London responded by commissioning independent investigations and the four investigations are now underway.

We also identified a number of themes arising from the internal reports from four mental health trusts. We suggest further investigation of these along the following lines:

- management organisation and delivery of adult mental health services for Barnet, Enfield and Haringey Mental Health NHS Trust
- application of the care programme approach for Oxleas NHS Foundation Trust
- homelessness for Central and North West London NHS Foundation Trust
- drug and alcohol services for North East London Mental Health NHS Trust.

We recommend a flexible approach in all further investigations. This will make it easier to make changes quickly if it becomes apparent once an investigation is under way that a different approach may be more appropriate. For this reason we recommend the lead for each investigation be appointed and the terms of reference agreed before the composition and required skills for the remainder of the team are specified.

3. The brief

The responsibility for making decisions about the further investigation of the 26 cases identified in the audit rests with NHS London. NHS London commissioned us to undertake the review in order to:

- confirm whether each of the cases met the HSG (94)27 criteria
- establish whether there are factors, other than the criteria expressed in the HSG (94)27, that NHS London may wish to take into account in deciding whether further action is necessary
- establish any common themes emerging from the internal investigations of these incidents
- recommend whether any further work is required
- in those cases where further work is required, to advise on the nature of the further work and the reasons for it in order to improve services and maintain public confidence.

We are aware of the need to ensure that recommendations for future work are proportionate to the scale and nature of the incident and to the extent and seriousness of the issues that need to be investigated. The work must also take into account satisfying a public interest in ensuring that services are as safe as possible, and where they are not, finding out why not and what can be done to improve them.

4. Methodology

Our approach to the task

The purpose of our review, as outlined in the brief, is to review all the cases and recommend a response that:

- enables lessons to be learnt
- as far as possible, satisfies the legitimate public interest in each case
- gives NHS London confidence about the actions it needs to take
- is proportionate.

Given the varying quantity and quality of the documents made available to us, it was essential to ensure that all the cases were reviewed in a consistent manner. We therefore developed an assessment framework (which we refer to as an "assessment toolkit") to be used by the team in reviewing each homicide case (see appendix A for a blank example of the document). The same assessment toolkit had to be completed for each case. This meant that all cases went through the same evaluation and ensured a thorough process and consistent recommendations for further work.

We used our knowledge of the application of the HSG (94)27 and our previous experience of advising SHAs about the appropriate and proportionate investigation of mental health homicides to inform the development of the assessment toolkit. We sought advice from a selection of mental health trusts about their interpretation of the term "under the care of mental health services". This ensured that our assessments were informed by established current practice.

The assessment toolkit included sections for the initial assessment, the peer review, the discussion between the assessor and peer reviewer, the legal assessment and the group assessment (see appendix B for full description of methodology).

The assessment toolkit was refined after piloting. Its format and content were agreed with NHS London before the review started.

Apart from a few cases where we spoke to relatives who made contact with either us or NHS London, no interviews were undertaken as part of this process. The recommendations are based solely on a review of documents made available to us. In several cases we have sought from individual trusts documents that we felt were necessary for us to complete our work and which were not included in the original documentation supplied to NHS London.

We selected an experienced team of assessors and lawyers to carry out this review. Between them they provided extensive experience of mental health services including management, clinical practice and the commissioning of independent investigations by SHAs.

5. General observations

Background information

It was important in conducting the review to see if the London homicide data bore any relation to national data.

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

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

We noted that the national data were based on homicides between 1999 and 2003. The 26 cases included in this review are between 2002 and 2006 and so no meaningful comparison could be drawn between the two. The National Confidential Inquiry did not collect data by region so no exclusively London-based information was available for comparison.

Summary data

We extracted from the documentation as much London-wide data as possible. We designed the assessment toolkit to include sections for collation of information about gender, age, ethnicity and other factors. Some of the information within the documentation made available to us was either incomplete or ambiguous (for example, ethnicity described as "Arab" or diagnoses recorded with two different opinions in the same case). As a consequence, the data that we could extract from the completed assessment toolkits were limited.

General information about the 26 cases appears below. Complete analysis of the data for these cases should be included in the National Confidential Inquiry's next five-year report.

Table 1: Number of cases by trust and year

	2002	2003	2004	2005	2006	Total number of cases
Barnet, Enfield and Haringey Mental Health Trust	1	2	2	0	0	5
Camden and Islington Mental Health and Social Care Trust	0	0	0	0	1	1
Central and North West London NHS Foundation Trust	0	2	0	1	0	3
East London and The City University Mental Health NHS Trust	0	0	1	0	2	3
North East London Mental Health Trust	0	0	3	1	1	5
Oxleas NHS Foundation Trust	0	1	1	1	1	4
South London and Maudsley NHS Foundation Trust	0	0	1	0	3	4
West London Mental Health NHS Trust	0	1	0	0	0	1
Total	1	6	8	3	8	26

Table 2: Gender and age of perpetrators and victims

Perpetrators

Age	Male	Female	Both
<25	6	0	6
25-34	7	3	10
35-44	8	3	11
45-54	1	0	1
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
Unknown	0	0	0
	22	6	**28** *

Victims

Age	Male	Female	Both
<25	2	2	4
25-34	5	0	5
35-44	3	1	4
45-54	4	1	5
55-64	2	0	2
65-74	0	0	0
75+	0	1	1
Unknown	6	0	6
	22	5	**27** **

* Two cases had two perpetrators
** One case had two victims

Themes

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

The summary of the analysis of the theme section of the toolkit is in the table that follows. Some themes were noted in the documentation made available to us and others were picked up by the assessor in the course of their work.

Table 3: Themes identified

Themes	Number of cases where theme was identified
Inadequate risk assessment and management	20/26
Poor communication between professionals agencies	18/26
Inadequate application of care programme approach (CPA)	10/26
Insufficient response to the patient's non-engagement	9/26
Lack of or inappropriate use of mental health act	6/26
Failing to listen to carers	6/26
Non-compliance with medication	4/26

Other information

In many cases the perpetrators had a complex presentation. Of the 28 perpetrators in the cases reviewed, 17 had a substance misuse problem. Of that 17, 15 had a dual diagnosis, i.e. mental illness and substance misuse. The services provided to these 17 perpetrators were split: in 14 cases, care was provided by the community mental health team and in three cases, care was provided by drug and alcohol services.

We found that a shared approach to care was not taken between mental health and substance misuse services. Care was often provided to the perpetrator by one service in isolation from specialist support from the other service. We took the view that the perpetrator and their care team would have benefited from the input of specialist support, ideally in the form of a dual-diagnosis worker. This might have raised the standard of care given to the perpetrator by increasing expertise and enhancing communication between mental health and substance misuse services.

6 Assessment criteria

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

The HSG (94)27 criteria

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

- *When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.*
- *When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death or life threatening injury, there is an obligation on the State to carry out an effective investigation.*
- *Where the SHA determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.*

Interpretation of the HSG (94)27 criteria

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

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

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

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

2. The first criterion says an independent investigation is needed if a person "who is or has been under the care […] of specialist mental health services in the six months prior to the event". In some of the cases we reviewed a perpetrator had not had contact with mental health services in the six months before the event.

[2] "The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care for people with severe mental health problems.

Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet published in 1999 sets out the current policy on the role and purpose of the CPA.

- The four main elements of CPA are:
- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care; and
- Regular review and, where necessary, agreed changes to the care-plan.

The policy booklet highlighted the importance of close working between health and social care services and the need to involve service users and their carers in the assessment" (The Department of Health 1999)

In some cases we recommend further work despite them being outside the stated time limit. We justify this decision for further independent action as falling under the third criterion of the HSG (94)27.

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

   Two of the perpetrators were diagnosed as having only a substance misuse problem. The substance misuse teams that cared for them operated in a mental health trust. The teams were not using CPA as a framework for patient care but each internal investigation recommended that CPA should be adopted by the teams. In these two instances we have taken this into account and recommend a themed approach to any future independent investigation. This decision was easier because the two patients were cared for by the same trust.

Other criteria

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

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

7 Recommendations

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

Recommending further work

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

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

We recommend a variety of different approaches to the conduct of further investigations. They are based on our experience of mental health homicide investigations and the criteria laid out earlier about a proportionate response. The recommendations for further action fit into one of the types outlined below.

Table 4: Types of further investigation recommended

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

No one type of investigation is more important than another. We set out below which type of independent investigation we think is appropriate for each case.

These recommendations are not of rigidly defined types and we suggest a flexible approach in all cases so that, for example, the nature of an investigation can be changed after consultation between us and the SHA if it becomes apparent that it is not suitable. The lead for the investigation should usually be appointed and terms of reference agreed before the composition and required skills of the remainder of the team are specified.

The brief required us to identify themes. We feel that London-wide themed investigations would be unlikely to produce tangible benefits on improving services and confidence because the organisational characteristics of each trust are so different. We recommend that some cases be investigated together around a common theme. This is appropriate where the cases are within one trust and where there appear to be benefits of such an approach. It may well be that once the themed investigation is complete the learning can be applied London-wide.

During the course of the review we alerted NHS London to the four cases where we recommend a type A wide-ranging investigation by a team examining a single case. NHS London commissioned independent investigations into the four cases and the investigations are underway.

Table 4: Summary of recommendations for further investigation for all 26 cases

Recommendation	Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
A	Ismail Dogan	Barnet, Enfield and Haringey Mental Health NHS Trust	23/12/2004
A	Philip Theophilou	Barnet, Enfield and Haringey Mental Health NHS Trust	15/04/2004
A	Phiona Davis	Barnet, Enfield and Haringey Mental Health NHS Trust	12/10/2003 and 13/10/2003
A	Mehmet Balla	East London and The City University Mental Health NHS Trust	07/07/2006
B1	Mohamed Osman	East London and The City University Mental Health NHS Trust	21/12/2006
B1	Russell Patterson	East London and The City University Mental Health NHS Trust	16/07/2004
B1	Mahmood Hussein	North East London Mental Health NHS Trust	25/06/2005
B1	Ezekiel Maxwell	South London and Maudsley NHS Foundation Trust	05/09/2006
B2 Functioning and robustness of adult mental health services	Isabel Coll/Lorraine Harrop	Barnet, Enfield and Haringey Mental Health NHS Trust	03/11/2003
B2 Functioning and robustness of adult mental health services	Simon Benson	Barnet, Enfield and Haringey Mental Health NHS Trust	11/10/2002
B2 Application of CPA	Jogomai Drammeh	Oxleas NHS Foundation Trust	02/07/2005
B2 Application of CPA	Nabeel Al Jubori	Oxleas NHS Foundation Trust	21/06/2003
B2 Application of CPA	Paul Boynes	Oxleas NHS Foundation Trust	27/07/2004
B2 Application of CPA	Sean Richardson	Oxleas NHS Foundation Trust	08/05/2006
C1	Malachi Adam Smith	Camden and Islington Mental Health and Social Care Trust	26/04/2006
C1	Timothy Speid	Central and North West London NHS Foundation Trust	22/05/2003
C1	Antoinette van Dungey	North East London Mental Health NHS Trust	23/08/2004
C1	Bradley John Allardyce	North East London Mental Health NHS Trust	23/04/2004
C1	Andrew Howlett	South London and Maudsley NHS Foundation Trust	27/02/2006
C1	Daniel Wilson	South London and Maudsley NHS Foundation Trust	04/10/2006
C1	Richard Norman	South London and Maudsley NHS Foundation Trust	11/03/2004
C1	Clive Whittington	West London Mental Health NHS Trust	22/10/2003
C2 Homelessness	Marvin Bartley	Central and North West London NHS Foundation Trust	05/04/2005
C2 Homelessness	Nicola Swan	Central and North West London NHS Foundation Trust	27/04/2003
C2 Drug and alcohol services	Edward Christie	North East London Mental Health NHS Trust	07/03/2006
C2 Drug and alcohol services	Leanne Terry/Steven Fullerton	North East London Mental Health NHS Trust	30/11/2004

*Key

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

Detailed recommendations

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

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

We recommend this type of investigation for the following cases:

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Ismail Dogan	Barnet, Enfield and Haringey Mental Health NHS Trust	23/12/2004
Philip Theophilou	Barnet, Enfield and Haringey Mental Health NHS Trust	15/04/2004
Phiona Davis	Barnet, Enfield and Haringey Mental Health NHS Trust	12/10/2003 and 13/10/2003
Mehmet Balla	East London and The City University Mental Health NHS Trust	07/07/2006

Three of these cases relate to one mental health trust. We therefore recommend that the investigation teams for the three cases have regular contact with each other. Formal discussion should take place before their reports are complete. We think it would help organisational learning and service improvement if a common and consistent set of recommendations were made to the mental health trust and other organisations.

Type B - Narrowly focused investigation by a team

An investigation of an individual case by a team of two or three people (with the ability to call on expert advice if needed) is recommended if the internal report has sufficiently highlighted the key issues. The further work would include a review of the key issues identified and focus on learning lessons. Cases suitable for this sort of independent investigation are generally less complex than those where we recommend a type A investigation (a wide-ranging investigation by a team examining a single case). We would expect this type of investigation to include fewer interviews than a type A investigation.

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

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

We recommend this type of investigation for the following cases:

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Mohamed Osman	East London and The City University Mental Health NHS Trust	21/12/2006
Russell Patterson	East London and The City University Mental Health NHS Trust	16/07/2004
Mahmood Hussein	North East London Mental Health NHS Trust	25/06/2005
Ezekiel Maxwell	South London and Maudsley NHS Foundation Trust	05/09/2006

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

Two themes were identified under this type:

1. For Barnet, Enfield and Haringey Mental Health NHS Trust – management organisation and delivery of adult mental health services
2. For Oxleas NHS Foundation Trust – application of CPA

1. Management organisation and delivery of adult mental health services

We recommend the following two cases are investigated together with the theme of the management organisation and delivery of adult mental health services forming part of the terms of reference. This will include examining CPA and risk assessment and management.

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Isabel Coll/Lorraine Harrop	Barnet, Enfield and Haringey Mental Health NHS Trust	03/11/2003
Simon Benson	Barnet, Enfield and Haringey Mental Health NHS Trust	11/10/2002

2. Application of CPA

Similarities were found in the four cases from Oxleas NHS Foundation Trust. We recommend a themed approach to the further investigation of these cases so as to build on good practice. The approach should relate to the trust's application of CPA. In particular, this would involve a review of the trust's CPA policy and procedure and how services in the trust interpret it.

We found that the internal investigation reports from this trust were completed to a high standard.

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Jogomai Drammeh	Oxleas NHS Foundation Trust	02/07/2005
Nabeel Al Jubori	Oxleas NHS Foundation Trust	21/06/2003
Paul Boynes	Oxleas NHS Foundation Trust	27/07/2004
Sean Richardson	Oxleas NHS Foundation Trust	08/05/2006

Type C – Single investigator (with peer reviewer)

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

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

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

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

We recommend this type of approach for the following cases:

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Malachi Adam Smith	Camden and Islington Mental Health and Social Care Trust	26/04/2006
Timothy Speid	Central and North West London NHS Foundation Trust	22/05/2003
Antoinette van Dungey	North East London Mental Health NHS Trust	23/08/2004
Bradley John Allardyce	North East London Mental Health NHS Trust	23/04/2004
Andrew Howlett	South London and Maudsley NHS Foundation Trust	27/02/2006
Daniel Wilson	South London and Maudsley NHS Foundation Trust	04/10/2006
Richard Norman	South London and Maudsley NHS Foundation Trust	11/03/2004
Clive Whittington	West London Mental Health NHS Trust	22/10/2003

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

Two themes were identified under this type:

1. For Central and North West London NHS Foundation Trust – homelessness
2. For North East London Mental Health NHS Trust – drug and alcohol services

1. Homelessness

We agreed it would be helpful to take a themed investigation approach to the following two cases. We found that both perpetrators were homeless at the time of the killings. We believe this is significant and that it warrants further investigation. In particular, the themed investigation will include an assessment of the team's response to homeless people with mental health problems.

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Marvin Bartley	Central and North West London NHS Foundation Trust	05/04/2005
Nicola Swan	Central and North West London NHS Foundation Trust	27/04/2003

2. Drug and alcohol services

There are similarities in two of the cases from North East London Mental Health Trust. Both internal reports identified issues relating to the application of CPA and risk assessment and management in the trust's substance misuse services. We think that reviewing these two cases together gives an opportunity to understand and comment on the wider application of CPA and the risk assessment tool used in the trust's substance misuse service.

Name of perpetrator(s)	Trust	Date of incident (as provided by the trusts)
Edward Christie	North East London Mental Health NHS Trust	07/03/2006
Leanne Terry/Steven Fullerton	North East London Mental Health NHS Trust	30/11/2004

Appendix A
Assessment toolkit

VERITA
INVESTIGATIONS – REVIEWS – INQUIRIES

Name of NHS trust:
Reference number:

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

List of documents seen when reviewing:

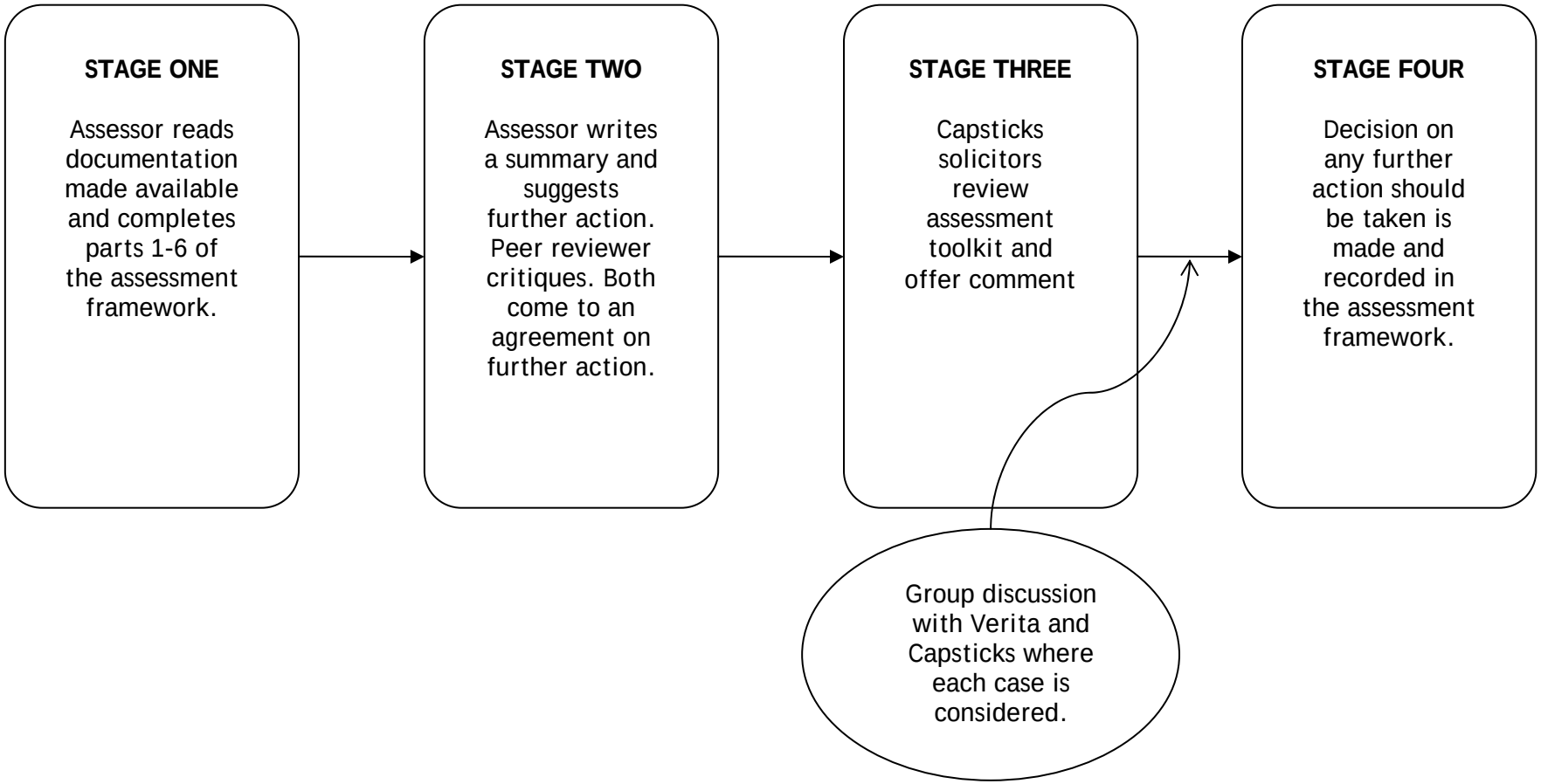
The assessment toolkit provides the criteria for:

1. Assessing the quality of individual internal investigation reports and associated reports and paper work

2. Identifying the themes from each investigation report and highlighting new themes that may need more investigation

3. Identifying cases that need more investigation.

Process flowchart



STAGE ONE

Part 1. Overview

1.1.1 Describe the nature of the incident:

- **a)** Name of perpetrator(s) _____
- **b)** Name of victim(s) _____
- **c)** What happened _____
- **d)** When it happened _____
- **e)** Where it happened _____
- **f)** Additional information provided about the incident

1.1.2 Information about the perpetrator:

- **a)** Age _____
- **b)** Sex _____
- **c)** Ethnic background _____
- **d)** Inpatient, community patient, absconded, on leave of absence, or discharged from services? _____
- **e)** Out of contact with services/non-engagement? (If yes, please specify if this was by patient choice or due to services not having followed up) _____

f) Please tick all applicable:

i. CAMHS ☐
ii. S117 ☐
iii. Enhanced CPA ☐
iv. Standard CPA ☐
v. Outpatient appointment ☐
vi. Primary care only ☐
vii. Contact with drug and alcohol services ☐
viii. Probation services ☐
ix. MAPPA ☐
x. POVA ☐

g) Primary diagnosis ☐

i. Schizophrenia or other delusional disorders ☐
ii. Affective disorder (bipolar disorder or depression) ☐
iii. Alcohol dependence ☐
iv. Drug dependence ☐
v. Personality disorder ☐
vi. Other (e.g. autism, learning disabilities) ☐

h) Compliance with medication _____

i) Type of accommodation (own property, hostel etc) _____

1.1.3 Information about the victim Is any available? If any is available:	**Y**	**N**
	☐	☐

a) Age _____

b) Sex_____

c) Ethnic background_____

d) Relationship to perpetrator (e.g. stranger, wife)_____

	Y	N
	☐	☐

e) In the care of any services (e.g. health, probation, prison, social services)

If no, please continue to Part 2.

If yes:

i. Inpatient, community patient, absconded, on leave of absence, or discharged from services? _____

ii. Out of contact with services/non-engagement? (If yes, please specify if this was by patient choice or due to services not following up)

_____

iii. Please tick all applicable:

1. CAMHS	☐
2. S117	☐
3. Enhanced CPA	☐
4. Standard CPA	☐
5. Outpatient appointment	☐
6. Primary care only	☐
7. Contact with drug and alcohol services	☐
8. Probation services	☐
9. MAPPA	☐
10. POVA	☐

iv. Primary diagnosis

1. Schizophrenia or other delusional disorders ☐
2. Affective disorder (bipolar disorder or depression) ☐
3. Alcohol dependence ☐
4. Drug dependence ☐
5. Personality disorder ☐
6. Other (e.g. autism, learning disabilities) ☐

v. Compliance with medication_____

vi. Type of accommodation (living at home, hostel etc)_____

Part 2. Additional information

1.2.1 Did the defendant plead guilty with diminished responsibility? _____

1.2.2 What was the outcome of any court case? _____

1.2.3 What was the outcome of the coroner's hearing on the victim? For example, was there a narrative decision? _____

1.2.4 Is this homicide linked to any other incident? If so, which?

Part 3. Internal investigation	**Yes**	**No**	**Don't know**	**Comments**
1.3.1 Has the trust carried out an internal investigation? If no: please go straight to Part 4.	☐	☐	☐	
1.3.2 Were there terms of reference? If no: please go to 1.3.3 If yes: Were they appropriate?	☐ ☐	☐ ☐	☐ ☐	
1.3.3 Who was in the investigation team **a)** Name the team members, their titles and which trust they work in: **b)** Was each member independent of the service where the incident took place? **c)** Were any members internal (to the trust)?	 ☐ ☐	 ☐ ☐	 ☐ ☐	

1.3.4 What time elapsed between the incident and the completion of the investigation report?				
1.3.5 Did the internal report indicate that: **a)** Staff were involved in the investigation? **b)** Staff were supported as necessary? **c)** Victim's families were involved in the investigation? **d)** Victim's families were supported as necessary? **e)** Perpetrators or their families were involved in the investigation? **f)** Perpetrators or their families were supported as necessary?	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	
1.3.6 Did the internal investigation report: **a)** Cover the correct period? **b)** Provide a list of witnesses and other evidence? **c)** Neglect to interview any witnesses that you think should have been seen? If yes, please specify: **d)** Provide a chronology of events leading up to the incident? **e)** Provide findings based on evidence?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	

f) Include recommendations that were… a. relevant to the findings b. clear c. actionable d. comprehensive/sufficient	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
1.3.7 Is there an action plan outlining the recommendations? If no: please go straight to 1.3.8 If yes: Are there people identified to take forward the recommendations? Does it have a clearly identified timescale for implementation? If so, is the timescale proportional?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
1.3.8 Have senior management accepted the investigation report? If no: please go straight to 1.3.9 If yes: Has there been a board discussion? Has the senior management reviewed the implementation of the action plan?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
1.3.9 Does the internal investigation report demonstrate significant/systemic service failure? If no: please go straight to 1.3.10 If yes, do any of the documents supplied indicate that action is being taken to address these?	☐ ☐	☐ ☐	☐ ☐	

1.3.10 Do you think that the report is of a good standard?	☐	☐	☐	
Part 4. Any other relevant information to take into consideration	**Yes**	**No**	**Don't know**	**Comments**
1.4.1 Is there any evidence that an independent investigation or review was commissioned by anybody OTHER than the SHA (for example HCC, CSCI, chapter 8 review, probation or local authority)? If yes, please specify	☐	☐	☐	
1.4.2 Is there any indication in the documentation made available to you (the assessor) that the family of the victim think the trust or other agencies have failed? If no: please go straight to 1.4.3 If yes: **a)** What do the family think the failure is? **b)** How do you (the assessor) know this?	☐	☐	☐	
1.4.3 Is there any indication in the documentation made available to you (the assessor) that the perpetrators or their family feel that the trust or other agencies have failed?	☐	☐	☐	

If no: please go straight to 1.4.4 If yes: **a)** What do the family think the failure is? **b)** How do you (the assessor) know this?				
1.4.4 Are the families requesting an independent investigation?	☐	☐	☐	
1.4.5 How much media coverage has there been?				
1.4.6 Have the Department of Health, any other NHS body or other government departments expressed a view or offered advice about the case?	☐	☐	☐	

Part 5. Main themes, findings and recommendations outlined in the internal report

1.5.1 Narrative comment on main themes, findings and recommendations in internal report

1.5.2 Were any of the following themes identified in the internal report?		
A Inadequate risk assessment and management	☐	
B Poor communication between professionals	☐	
C Inadequate application of CPA	☐	
D Lack of or inappropriate use of MHA	☐	
E Failing to listen to carers	☐	
F Insufficient response to the patient's non-engagement	☐	
G Non-compliance with medication	☐	

Part 6. Independent investigation	Yes	No	Comments
1.6.1 Are any of the criteria from HSG (94)27 outlined below met in this case?			
a) A homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event	☐	☐	
b) It is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death or life threatening injury, there is an obligation on the State to carry out an effective investigation	☐	☐	
c) The SHA determines that an adverse event warrants independent investigation, for example is there concern that an event may represent significant systemic service failure, such as cluster of suicides?	☐	☐	
1.6.2 If "yes" to any of the above, please continue to **STAGE TWO**.			

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

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

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

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

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

1: Thematic review ☐
(For example covers CPA, risk assessment, team working, clusters of SUIs, medication reviews)

2: Individual investigation ☐
(For example supplements gaps in the internal inquiry such as reviewing additional documentation, additional limited interviews)

3: Group investigation ☐
(For example involves undertaking a wide ranging investigation into the perpetrators care and contacts with all agencies involved)

2.3.2 Comments

Assessor _____ Date_____ Peer reviewer _____ Date _____

STAGE THREE

Legal assessment

3.1 What are the legal issues arising from this case?

Lawyer _____ Date _____

STAGE FOUR

Outcome of group discussion

4.1 Comments

4.2 What further action on this case was agreed at the group discussion of all cases? (for detailed description of each, please see 2.3.1)

1: Thematic review ☐

2: Individual investigation ☐

3: Group investigation ☐

Verita _____ Date _____ Capsticks _____ Date _____

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Appendix B

Detailed methodology

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

Stage 1

1. The draft assessment toolkit was developed by Verita and Capsticks and shared with NHS London. It was finalised after discussion (see appendix B for final version).
2. A team of seven was assembled to act as assessors and peer reviewers for all cases together with two solicitors from Capsticks.
3. A confidential log was compiled and maintained of all the documents we received.

Stage 2

1. Team members received a comprehensive briefing about the work, the timescales, the use of the assessment toolkit and the peer review process.
2. Each case was individually assessed and the relevant sections of the assessment toolkit completed.
3. Each case was peer reviewed and a summary of the critique of the assessment completed in the assessment toolkit.
4. A consensus was reached between the assessor and the peer reviewer about their initial recommendations for further work.
5. A meeting of the whole team considered the process up to that point, including reviewing the consistency of further action recommended and any themes that had arisen from the individual assessments.
6. Each case was reviewed by a lawyer and the assessor and a legal comment was added to each assessment toolkit.
7. A meeting took place to check the consistency, proportionality and the reasonableness of the draft recommendations and to ensure that no potential themes had been missed. The team then agreed on both the broad types of

further work that were to be recommended and which cases fell into which type of investigation. This meeting also discussed three cases that had been identified by assessors as needing immediate attention.

8. Each assessor completed the assessment toolkits for their cases to include the agreed recommendations from the joint discussion.

9. The "fast-track" cases were referred to NHS London in advance of the drafting of the report.