Review of homicides by people with recent contact with NHSScotland mental health and learning disability services

A consultation on the Mental Welfare Commission for Scotland's proposal

August 2017

Scottish Government
Riaghaltas na h-Alba
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Introduction

1. During the Parliamentary passage of the Bill for the Mental Health (Scotland) Act 2015, concerns were expressed 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 Mental Welfare Commission for Scotland ("the Commission") and Healthcare Improvement Scotland were discussing how best to streamline the current system for reviewing these homicides.

2. Subsequently, the Commission developed more detailed proposals, in consultation with Healthcare Improvement Scotland, and following discussions with the Crown Office and Procurator Fiscal Service. The report on these proposals is provided at Annex A and includes a review of the current process for investigating such homicides as well as a proposal for a revised process.

3. The term 'homicide' is used in this consultation to refer to the crimes of murder and culpable homicide, in Scots law.

4. The purpose of this consultation paper is to present the Commission's report and to seek views on the process proposed in the report. Following consideration of responses to this consultation the Scottish Government will work with the Commission to establish what changes might need to be made to the process at Annex A and how any improved system of homicide reviews will be put in place.

Background

5. Homicide is a crime that has a devastating effect on the family and friends of the victim. Those who are bereaved have to contend with their grief at the loss of a loved one as well as dealing with their feelings about how the victim died.

6. Whilst coping with these feelings of grief, loss and confusion, family members may be involved in any police investigation and subsequent proceedings taken against those accused of committing the homicide. This can have a lasting impact.

7. In some cases, a person who is accused of homicide may have had recent contact with mental health or learning disability services. They may be identified as having a mental disorder, and may have had a mental disorder at the time of the offence.

8. When a person is incapable of participating effectively in the trial because of their mental disorder, there is no trial. The court may instead proceed with an 'examination of facts'. The purpose of this procedure is to determine if the accused committed the acts or made the omissions relevant to the homicide charge. If the accused person is able to stand trial but was affected by mental disorder at the time of the offence to the extent that the court considers that the person was not at that time criminally responsible for their actions, the court may acquit them of the offence on those grounds.

9. In cases where the charge is murder, a person's mental condition may be such that although they cannot be acquitted on account of lack of criminal responsibility, they may be found to be of diminished responsibility. A finding of diminished responsibility does not result in acquittal, but in conviction for the lesser offence of culpable homicide. Where a person's mental condition at the time of the offence was not such that they would be acquitted or found guilty of culpable homicide then, if guilty, they would be convicted of murder as charged.

10. Where an accused or convicted person requires treatment for their mental disorder, the court can decide to send the person to hospital for treatment instead of prison. An order for hospital detention can happen where the person is tried and then convicted or acquitted on grounds of lack of criminal responsibility; or where the person is found to have committed the acts or omissions constituting the offence at an examination of facts (whether or not acquitted on grounds of lack of criminal responsibility).

11. Court proceedings may not give families the answers they are looking for. The criminal courts do not consider whether anything done or not done by health and care organisations might have made a difference. Understandably, this can be a source of frustration for families and may make it more difficult for them to come to terms with what has happened.

12. Homicide reviews will serve a different purpose to the criminal justice process outlined above. Firstly, it is intended that these reviews will identify any connection between the care and treatment given to the perpetrator and the homicide, and any improvements that could be made to prevent similar violence in the future. Such a review would normally include recommendations for individual practitioners, organisations and multi-agency systems. Secondly, a review based in improvement and learning has the opportunity to include bereaved families and provide them with information about what may have happened, and what can be done to improve.

13. There are a number of investigative processes which are relevant to homicides by people with mental disorder, including serious adverse event reviews (SAERs), Commission investigations, and fatal accident inquiries. The

Commission's proposal aims to consolidate and streamline these existing processes.

14. Along with other devolved governments and health services in the UK, the Scottish Government participates in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. In other parts of the UK there are different approaches to investigations into homicide by people with mental disorder. In England, NHS England is responsible for commissioning an independent investigation of any mental healthcare-related homicide where the person was under the care of specialist mental health services in the 6 months before the homicide.

15. The Scottish Government is committed to ensuring that health boards are supported to learn and improve. Healthcare Improvement Scotland (HIS) currently works with health boards to improve adverse events management across NHSScotland. An adverse event is any event that could have caused, or did result in, harm to people or groups of people. HIS has published a framework to support NHS boards to standardise processes[1]. It includes a national definition of an adverse event, guidance on reporting, accountability, responsibilities and learning, and principles for an open, just and positive safety culture.

16. The Commission's report sets out some statistics on the prevalence of this type of homicide in Scotland. In the past ten years there have been two Commission investigations into mental health-related homicides.

17. The proposal set out in the report consists of a six stage process. The process has been summarised in a flowchart (see page 6). The flowchart and questions which follow should be read together with the full paper provided at Annex A.

[1] Learning from adverse events through reporting and review, Healthcare Improvement Scotland (2015), available at: http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx

Summary of Revised Process Proposed by the Commission

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.

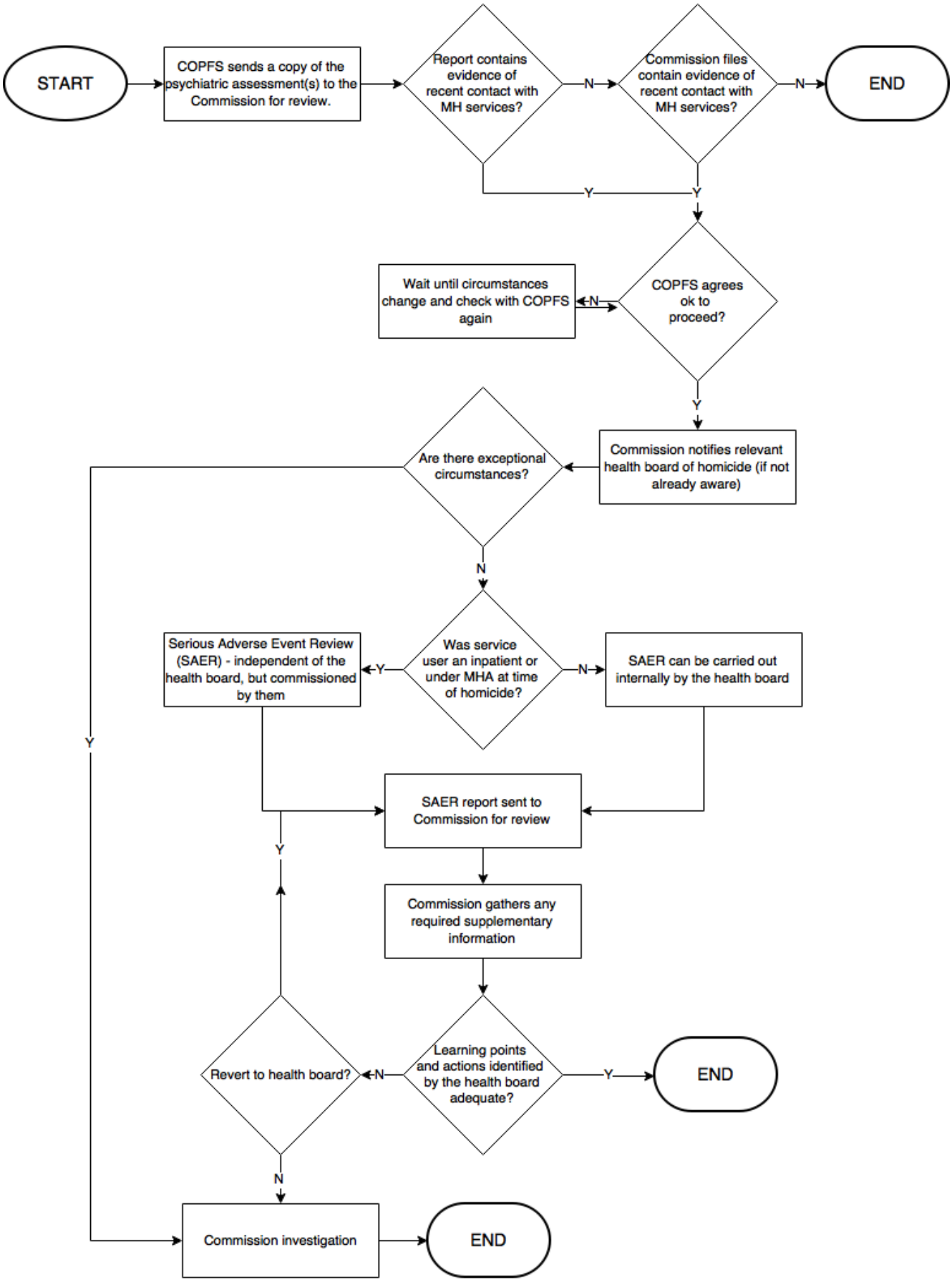
STAGE 5

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.

Flowchart Summarising the Revised Process Proposed by the Commission



Questions on the Proposal for a Revised Process

18. The Commission's proposal outlines the process of review of homicides by people who have had recent contact with mental health and learning disability services. It proposes using the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) criteria to determine recent contact. The proposal aims to use expertise and processes that are already in place and supplement those with additional processes to meet the aims of the new system.

QUESTIONS

(1) The proposal defines recent contact as those who have had contact with mental health or learning disability services within the last 12 months. Do you think that this definition of recent contact is satisfactory for the purposes of this process? [YES/NO]

(1A) Do you foresee any difficulties with using this definition?

(1B) How could such difficulties be addressed?

(2) Do you think that the proposed process adequately involves the family of the victim? [YES/NO]

(2A) If not, how could it be improved?

(3) Do you think that the proposal will help to provide families with meaningful information on the case? [YES/NO]

(3A) What sort of information should be provided to families?

(4) Does the proposal go far enough in ensuring that the rights of the family of the victim to information are balanced with the right to privacy of the perpetrator? [YES/NO]

(4A) What safeguards will there need to be to ensure that confidential health information is protected?

(5) Do you think that the proposal adequately provides for independent investigation to be carried out where necessary? [YES/NO]

(5A) If not, how could this be improved?

(6) The scope of the proposal is confined to looking at the care provided to the accused person by relevant NHS boards. Do you think this is the right focus? If not, which other services should be covered by these reviews?

Other Matters for Consideration

19. The impacts of any revised homicide review process will be fully considered. The proposed process will have an impact on the following:

    - Families of victims
    - The perpetrator
    - NHS boards
    - Healthcare Improvement Scotland
    - The Mental Welfare Commission for Scotland
    - The Crown Office and Procurator Fiscal Service

20. The revised process will have an impact in a number of different ways including:

    - Equalities (impact on those with protected characteristics)
    - Privacy (information to be shared during the course of reviews)
    - Administrative (impact on organisations of any additional administrative or procedural burden)
    - Children and young people
    - Human rights

21. The revised process will be subject to an Equalities Impact Assessment (EQIA) which will help to determine what the potential impact the process would have on those with protected characteristics and how such an impact could be properly mitigated. The protected characteristics are: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

22. Communications with the families of victims would need to properly take account of any special requirements which members of the family may have. The Commission already has policies in place to ensure that its communications are accessible. Additionally, the process will need to be considered for any impact on children and young people.

23. Carrying out homicide reviews would require an exchange of personal information between different organisations. For example, the sharing of psychiatric assessment reports, commissioned by COPFS, with the Commission; and providing the victim's family with information on the progress of the review, or a summary of key learning points resulting from the NHS board's own review. Such exchanges are necessary to make the system work but as with any

exchange of personal information it is desirable to keep the amount of personal information to a minimum. The process will have to be developed to ensure that it does not interfere with the right to private life under Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms ('ECHR')(as set out in schedule 1 of the Human Rights Act 1998). An effective system of inquiry is necessary to ensure that Scotland is compliant with Article 2 of the ECHR (Right to Life).

QUESTIONS

(7) Do you have any views on the proposal's potential impact on those persons with protected characteristics? Please include in your response what you think could be done to minimise any negative impacts.

(8) In addition to any issues you may have highlighted in response to questions 4 and 4A, do you think there are any impacts on personal privacy as a result of information being shared during the proposed homicide review process? Again, please include your views on how these impacts could be minimised.

(9) Do you have any concerns about any financial or administrative burden as a result of this process? For example, costs that may be incurred by NHS boards or justice organisations.

(10) Do you have any comments on the impact of the process on children and young people? Please include in your response what you think could be done to minimise any negative impacts.

(11) Do you have any comments on how the proposed process will impact on the human rights of the family of the victim and of the perpetrator, particularly with regard to Articles 8 of the ECHR?

Responding to this Consultation

We are inviting responses to this consultation by 17 November 2017

Please respond to this consultation using the Scottish Government's consultation platform, Citizen Space. You view and respond to this consultation online at https://consult.scotland.gov.uk/mental-health-law/recent-contact-with-mental-health-services. You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of 17 November 2017.

If you are unable to respond online, please complete the Respondent Information Form (see "Handling your Response" below) to:

Mental Health Law Team
3ER, St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form attached included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them mentalhealthlaw@gov.scot

Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot)

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

ANNEX A

Mental Welfare Commission review of the process for investigation of homicides by individuals with recent contact with mental health services and proposal for revised process.

1. Introduction

The Mental Welfare Commission (the Commission) is proposing a clearer, improved process for the investigation of all homicides committed by individuals with recent contact with mental health services. Our review has shown that not all such incidents are currently being investigated. The proposed new system would ensure that all cases were appropriately investigated by Health Boards and independently reviewed, result in lessons being learned and shared across the system, and provide for the involvement of service users, and victims' families in the process.

The Commission is proposing to make use of existing processes to create a cost efficient mechanism for investigating such incidents. The approach we are proposing will cost over £400,000 less than adopting an English style system.

We have consulted with Healthcare Improvement Scotland, Crown Office and '100 Families' in producing this proposal.

2. Background

During the review of the Mental Health Act, Jamie Hepburn, Minister for Sport, Health Improvement and Mental Health, asked the Commission to review how homicides involving people who are users of mental health or learning disability services are investigated. The Commission has undertaken this work to establish a more robust cross-agency system for these investigations.

The number of homicides in Scotland is decreasing. Over the ten year period from 2005-06 to 2014-15, the annual number of homicide cases in Scotland fell by 36 (or 38%) from 95 to 59. However, the number of homicides by people who use mental health services in that time has remained roughly stable, with on average of 13 per year.

The Commission aims to establish a system in Scotland for the investigation of such incidents, which ensures that lessons are learned and shared across the system, and which provides reassurance to families in these cases.

The current system of investigation is fragmented and confusing, and it needs reform. However, we can build on existing systems for investigating adverse events.

The Commission has engaged with Healthcare Improvement Scotland (HIS) to put together a proposal which builds on our existing powers, and ensures that all cases are reviewed appropriately. In doing this, we have looked at the approach taken to such cases by the NHS in England to learn lessons from that process.

3. Review of existing process

Local adverse event review

The HIS framework on 'Learning from adverse events through reporting and review' (the framework) defines an 'adverse event' as an event that could have caused or did result in harm to people or groups of people.

The framework defines 'people' as:

- service users
- patients
- members of staff
- carers
- family members, and
- visitors.

Harm is defined as 'an outcome with a negative effect'**.** The framework states that harm to a person or groups of people may result from unexpected worsening of a medical condition, the inherent risk of an investigation or treatment, violence and aggression, system failure, provider performance issues, service disruption, financial loss or adverse publicity.

The framework is intended to cover all adverse events but does not provide a core list of events that must be reported. As such, the framework doesn't specifically include homicides committed by patients; particularly it does not cover events where the victim is an unknown person or someone outwith the groups listed in the definition of 'people' given above.

We consider that the framework is not explicit enough to prompt a formal investigation in every instance where a mental health service user has caused the death of another person.

The framework does say that a homicide by an individual who is receiving care from mental health or learning disability services must be reported to the Commission. This does imply an expectation that such events will be reported and reviewed in line with the framework and the local adverse event review policies and processes.

Adverse event review processes aim to examine the processes of care delivery to identify if any system failures occurred which contributed to the adverse event and outcome, and if improvements can be made for future care provision. The scope is

restricted to people in contact with the health and social care system, and therefore is not intended to cover harm to people outwith this system. Therefore, an adverse event review would not cover the harm caused to a victim of homicide and their relatives. It would, however, cover the care provided to the individual who had committed the homicide and if there were any learning points from the case.

The framework says that the response to each adverse event should be proportionate to its scale, scope, complexity and opportunity for learning. All events are subject to review, and the basic process of adverse event review and analysis should be essentially the same. However, some events, due to the complexity or the potential for learning, require a more formal, extensive review making full use of associated techniques to comprehensively examine the chronology, care delivery problems and contributory factors. It is most likely that homicides by mental health service users will be reviewed as a significant adverse event review. A full review team is commissioned by a senior manager to review significant adverse events. The review team should be sufficiently removed from the event, and have no conflict of interest, to be able to provide any objective view.

The framework contains a number of stages where the Board is encouraged to engage and share findings with service users and their families. There is no mention of engaging with the families of victims. This is something which victims organisations feel strongly should be happening. This was not included within the scope of the framework, as it covers harm to people in contact with the health and care system. However, families of victims could be informed of the progress of the review and the learning points and recommended actions. However, it is recognised that there will be confidentiality considerations when it comes to sharing information in this way.

An FOI request in 2014 revealed that of the 40 homicides reported by the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (NCISH) over the previous 3 years, only 10 had been the subject of a significant adverse event review (SAER) or similar investigation (100 families report).

During informal discussions with a number of NHS Boards, we were told that there is no formal mechanism for them to be informed of homicides by their patients. Boards reported often finding out through informal word of mouth and through stories in the press. Given this situation, it is inevitable that a number of homicides may never come to the Boards' attention and are, therefore, never subject to a SAER.

<u>Reporting to the Commission</u>

Boards are required to notify the Commission of all cases where an individual who is receiving care from mental health or learning disability services is accused of or convicted of a homicide. We ask that they send us:

- A brief account of the circumstances of the incident or situation, its antecedents and any other relevant information;
- Information on the diagnosis, treatment and mental state of the person;
- Information on any other person involved;
- What further action is being taken or considered;
- An indication of any further investigation, enquiry or review that is being carried out or considered, and a copy of the outcome of these when available.

The Commission's system does not currently enable us to specifically search for/ retrieve such notifications. However, of the 19 relevant homicides we were able to identify, we had only been properly notified of 9. We had become aware of a number of others through other routes. The Commission carried out full investigations in two of these cases and paper investigations in five of them.

Although we have only been able to identify a small sample of cases, we have also spoken to Commission casework teams, and it is clear that the Commission is not receiving anywhere close to the number of notifications we should be. This is probably largely due to Boards not being aware of incidents, as described previously, or being unaware of our guidance.

Conclusion

The information available shows that the majority of homicides by mental health service users are not being investigated by Boards and are not being reported to the Commission. This is partly due to the lack of any formal mechanism for Boards to be made aware of such events but also because of the lack of formal guidance about how they should be handled. The existing system needs to be strengthened in order to make sure that learning points can be identified and improvements made.

4. Proposal for new process

The Commission considers that the new process should apply to homicides committed by people who have had contact with mental health or learning disability services within the last 12 months. This is the criterion applied by NCISH so will ensure a consistent approach.

The Commission has significant experience of this type of case and we do not consider that all cases need a full independent investigation. We are proposing a system utilising expertise and existing processes that takes a proportionate approach and is cheaper than the system in place in England.

Stage 1

Each person accused of homicide has one psychiatric assessment which is arranged by COPFS. If the first psychiatric assessment identifies a mental health issue, then a second assessment will be arranged. COPFS have proposed entering into an Information Sharing Agreement with the Commission in order that it can discuss with the Commission the information which it needs in order to determine whether a person accused of homicide has had recent contact with services. This agreement will include the stage in proceedings that the information will be provided by COPFS and will also include what be done with the information and when. In 2014 – 15 the number of homicides in Scotland was 59.

The Commission will review the information provided by COPFS to determine whether there is any evidence of recent contact with services. This information may be contained in the information provided by COPFS but we are also able to check our own database to find out whether the perpetrator is known to the Commission.

We propose that homicides by service users who have had contact with drug and alcohol services will not qualify under this process unless the individual has a co-morbid mental health condition.

Where a relevant homicide is identified, the Commission will liaise with COPFS to ensure that it is appropriate for the Board to proceed with an adverse event review. COPFS are clear that in the majority of cases, there will be no issue with the Board or MWC proceeding with an adverse event review or investigation. However, there will be cases where it would not be appropriate for an investigation or local adverse event review to take place until after criminal proceedings have concluded, for example where the presence of a mental health issue and its impact upon the commission of the offence are contentious matters that will be debated at trial.

The Commission will notify the relevant Health Board of any homicide committed by someone who has accessed their mental health service during the year prior to the offence being committed.

If the Health Board becomes aware of a relevant homicide before the Commission, they will be required to notify the Commission.

Stage 2

The Commission will generally require the Health Board to report to it with the same information that is required under the current process (see 'reporting to the Commission' section above). However, in exceptional circumstances, the Commission will move straight to an independent investigation of the events (stage 5).

Stage 3

The Health Board adverse event review

The Commission will work with HIS to produce some guidance specific to SAERs in these circumstances. This will promote a consistent approach and reduce variance. We propose two tiered approach to serious adverse event reviews involving homicides:

- If service user is an inpatient, is detained in hospital or in the community at the time of the homicide, review should be independent of the Health Board (but commissioned by the Board). [HIS category 1]
- For any other service user, the review can be internal but Board can appoint independent person if they feel it is appropriate. [HIS category 2]

The Board should have the discretion to take a proportionate response to each incident – we envisage most reviews being in category 2.

The Board should make early contact with the victim's family and contact with the perpetrator. The requirement and appropriateness of this will vary depending on the circumstances of the case and on the preferences of the individuals involved.

The aim of the SAER is to review internal processes and systems and to identify any learning points. It is not to determine the services user's guilt or innocence.

When complete, the Board will be required to send the SAER to the Commission. The Commission and the Board will liaise with COPFS at this stage to discuss whether there is any reason why a summary of key findings and learning points cannot be shared with the family of the victim. Subject to this discussion, the Board will share a summary of key findings and learning points to the family of the victim.

Stage 4

The Commission will review the SAER and liaise with the Board to obtain any further information they consider is necessary to reach a view on the case.

The aim of this stage is to determine whether the SAER adequately identifies any learning points in the care and treatment and puts in place appropriate actions to address these. It will generally be necessary to request the service user's medical records as a minimum; however, there will be cases when this is not necessary. There may also be value in interviewing some members of the treatment team at this stage.

The Commission will make contact with the victim's family and will consider whether to make contact with the perpetrator / their family.

Stage 5

Following consideration of the case by the Commission's Senior Management Team, the Commission will decide whether to take the case to investigation, revert it back to the Board for further work or to close it. All relevant parties will be notified of the decision and the reasons for it.

The Commission will open an investigation:

- Where the Board adverse event review does not sufficiently address issues and that is deemed inappropriate to ask them to investigate further;
- Where the issue is a matter which is deemed to require independent investigation because of direction from Scottish Ministers, because of the level of public interest, or because of concerns about the Board's actions which have not been resolved by the SAER;
- Where the Commission deems that there are wider lessons to be learned.

Stage 6

Commission appoints a team to investigate. The team will be headed by the lead investigation practitioner, who will decide what other staff are required for the investigation. These may be internal or external depending on the specialism required. Investigations will follow the Commission's existing process and reports will be made publicly available. The Commission will engage with victims' families, and the service user and their family as appropriate.

Monitoring

The Commission will work with HIS to make use of existing networks and to share learning from the homicide cases.

This publication is available at **www.gov.scot**

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