Information for Families of an Alleged Perpetrator of a Mental Health-Related Homicide

Introduction

We know that this can be a very difficult and distressing time and hope this information will help you understand what you can expect from your local NHS services and where you might find further advice, support and information.

Looking after yourself and your family

In the weeks and months after a mental health-related homicide, you will experience some reactions to this traumatic and life-changing event. Considering the enormity of what has happened to you, these reactions are normal, healthy and understandable.

Some families have found that counselling or having someone else to talk to can be very beneficial. You may want to discuss this with your GP and your local NHS Mental Health Provider who can refer you to local support.

Alternatively, there are other local or voluntary organisations that provide counselling support, that you would prefer to access. Details of some of the organisations that offer help are detailed in this booklet.

Advocacy

You may find it helpful to get independent advice and support.

Please see details of independent organisations that may be able to help, later in this booklet.

NHS Investigations

When someone is killed by a person with a mental health condition, who was being cared for by the NHS it is called a “mental health-related homicide”. The person who has done the killing is referred to here as the alleged perpetrator.

Following a mental health-related homicide, it is necessary to find out as much as possible about how the alleged perpetrator was cared for and treated in order to try to prevent similar incidents happening again. Sometimes more than one investigation is necessary to fully understand what has happened and what improvements might be helpful. This is separate from the criminal proceedings.

Initially the Mental Health NHS Provider (‘provider’ is the name given to the organisation which runs the facility, hospital, clinic or treatment centre providing services) that primarily provided care for the alleged perpetrator, investigate the care and treatment of the alleged perpetrator.

This is an “internal investigation” which commences within days of the incident.

In some cases it may be necessary to undertake and additional “independent investigation” which may be commissioned by the NHS England and which usually takes place after any criminal proceedings are complete.

NHS investigations are conducted for the purposes of learning to prevent recurrence, they are not inquiries into how a person died as this is a matter for Coroners. Neither are they conducted to hold any individual or organisation to account as other processes exist for that purpose including: criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as those overseen by the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

Management of all health-related incidents, including homicides should be in line with the Serious Incident Framework and the Duty of Candour.[1] Duty of Candour is a statutory duty to be open and honest with patients (or ‘service users’), or their families, when something goes wrong that appears to have caused, or could lead in the future, to significant harm.

[1]Serious Incident Framework: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf
Duty of Candour: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

The Mental Health Provider's contact with you

The Mental Health Provider where the alleged perpetrator was being cared for will get in touch with you as soon as possible after the incident. There might be a delay if the Police advise the Mental Health Provider that contact would not be appropriate at this point in time.

Your involvement in the investigation process

You will be offered a meeting with a member of the Mental Health Provider. This can be in person at a location of your choosing or a telephone call, if this is your preference. The Mental Health Provider will explain the investigation process to you and this will be inclusive of the following:-

- the extent of the investigations, such as; what will be reviewed/looked into and the reason for it
- your comments in relation to the extent of the investigation
- your questions in relation to the incident
- name(s) and contact details of those investigating the incident
- how would you like to be kept informed on the progress of the investigation (i.e by e-mail/telephone and frequency of contact)
- commenting on draft reports before they become final
- future meeting(s) to discuss the findings of the investigation and what will happen next
- advice on where to get support, such as counselling if appropriate, or independent advice.

"I wanted help for my son. I needed someone I could talk to, somewhere I could go, a number I could call."

Family of alleged perpetrator

Staying in contact with the mental health provider

The Mental Health Provider will offer you a dedicated contact person to support you throughout this investigation process. This dedicated contact person will provide you with updates on the progress of the investigation and other relevant information. They will also be able to provide links to support for emotional, physical and practical needs.

It is important to note that the dedicated contact person works for the organisation where the alleged perpetrator was treated, but in a separate department. They have extensive knowledge and experience of health-related incidents, supporting families and the way the system and their organisation works. They will also be able to direct you towards independent advocacy should you prefer it.

Duty of Candour

A statutory requirement has been introduced to ensure health care providers operate in a more open and transparent way. The regulation for Duty of Candour applied to health service bodies from 27 November 2014.

The Duty of Candour is a statutory duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused, or could lead in the future, to significant harm.

Families should be told what happened as fully as possible, and in a sensitive way, in person. This should be done as soon as possible after the incident is known about, and it should include an apology.

The trust should then write confirming the agreed plans for an investigation and the agreed method and timescales for communication. The results of further enquiries and investigations must also be provided in writing to the relevant person, if they wish to receive them.

Trusts should tell families where they can get support, such as counselling if appropriate, or independent advice.

> *"I was the only person who really knew how he had been changing over the few weeks before."*
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> **Family of alleged perpetrator**

Coroner

Some deaths are referred to the coroner, for example where the cause of death is unknown, or the death occurred in violent or unnatural circumstances. When a death is referred to the coroner they may request a post mortem examination. The coroner will decide whether an inquest is required, to establish the cause of the death. An inquest is a 'fact finding' exercise which normally aims to determine the circumstances of someone's death.

If you are involved in an inquest, you may wish to find further independent information, advice or support. There are details of organisations that can advise on the process, including how you can obtain legal representation, at the end of this booklet.

Providing feedback/ raising concerns, making a complaint

Receiving feedback from families helps Mental Health Providers to understand the things they are doing right and need to continue and the things they need to improve.

It is very important that you feel able to ask any questions or raise any concerns regarding the investigation process. Mental Health Providers will do their best to respond to any questions or concerns that you have.

Additionally, you can raise concerns as a complaint, at any point. Please note you do not have to wait until an investigation is complete before you complain – both processes can be carried out at the same time

If you are not happy with the response to a complaint, you have the right to refer the case to the Parliamentary and Health Service Ombudsman. Information about what you should expect from the complaints process is available here: www.ombudsman.org.uk/publications/my-expectations-raising-concerns-and-complaints.

Useful information, help and support

The list below does not include every organisation but the ones listed should either be able to help you themselves, or refer you to other specialist organisations best suited to addressing your needs. Some of the organisations listed below may be able to find you an advocate if you need support when attending meetings.

They may also direct you to other advocacy organisations that have more experience of working with certain groups of people, such as people with learning disabilities, mental health issues, or other specialist needs.

Advocacy after Fatal Domestic Abuse
Specialises in guiding families through Inquiries including domestic homicide reviews and mental health reviews, and assists with and represent on inquests, Independent Office for Police Conduct (IOPC) inquiries and other reviews. Help and support with impartial media advice and advocacy to support with media enquiries.
www.aafda.org.uk
Telephone: 07768 386 922

AFFECT
(Action For Families Enduring Criminal Trauma) are a group of people who currently have, or have had, a family member in prison. Founded in 2001 they aim to help others by offering confidential and non-judgemental support, regardless of length of sentence or type of offence. They do not discriminate, and are supportive of those who choose to support their loved one and those who choose not to support their loved one.
www.affect.org.uk
Telephone: 0300 365 3651

Hundred Families
Offers support, information and practical advice for families bereaved by people with mental health problems, including information on health service investigations.
www.hundredfamilies.org

INQUEST
Provides free and independent advice to bereaved families on investigations, inquests and other legal processes following a death in custody and detention. This includes deaths in mental health settings. Further information is available on its website including a link to 'The INQUEST Handbook: A Guide For Bereaved Families, Friends and Advisors'. www.inquest.org.uk
Telephone: 020 726 3111

Metropolitan Police Bereavement Information Phone Line and Advice
Telephone: 0800 0329 996/met.police.uk look under "B."

National Survivor User Network
Is developing a network of mental health service user and survivors to strengthen user voice and campaign for improvements. Also has a useful page of links to user groups and organisations that offer counselling and support.
www.nsun.org.uk

Patients Association
Provides advice, support and guidance to family members with a national helpline providing specialist information, advice and signposting. This does not include medical or legal advice. It can also help you make a complaint to the CQC.
www.patients-association.org.uk
Telephone: 020 8423 8999

Respond
Supports people with learning disabilities and their families and supporters to lessen the effect of trauma and abuse, through psychotherapy, advocacy and campaigning.
www.respond.org.uk

Samaritans
Provide emotional support to anyone who is struggling to cope and needs someone to listen 24 hours a day
www.samaritans.org
Telephone: 116 123

Thank you

This information has been prepared with the support of families, Mental Health Providers and other stakeholders.

The NHS is very grateful to everyone who has contributed to the development of this information. In particular, they would like to thank all of the families who very kindly shared their experiences, expertise and feedback to help develop this resource.

This information has been produced in parallel with materials and podcasts for mental health providers, available here:

www.england.nhs.uk/london/our-work/mhsupport/

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Note: Due to the current NHS England and NHS Improvement alignment and Serious Incident Framework review some terms within this document might be subject to change, however the ethos of this document should remain