Learning from inquiries and investigations

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Former social worker (20 years)
3 years working in the legal department of MIND
Co-director of the Institute of Mental Health Law (1992 - 2012)
Panel member / chair of 4 inquiries following homicide
Undertaken reviews for trusts and social services
Independent trainer and consultant since 1992
New findings show suicides under home treatment in England are almost double ward cases, National Confidential Inquiry into Homicide and Suicide, July 2012

- Deaths by suicide among mental health patients treated at home have reached 150 to 200 a year.
- Sustained fall in in-patient suicides across all countries.
- A decrease in the number of patient suicides by overdose of tricyclic antidepressants in England, Wales and Scotland.
- A decrease in in-patient suicides following absconding in England.
- A recent decrease in the number of mental health patients convicted of homicide although it is too early to draw definitive conclusions.

Annual Report
http://tinyurl.com/bnuctss
"If the current rash of inquiry reports are not widely read and do not influence practice, then they risk being as nationally relevant as a private stamp collection ... if the are dismissed before they are read and fail to engender a debate of the issues, then a valuable opportunity for improving national practice will be lost"

Dr John Crichton and Dave Sheppard

_Inquiries after homicide_ (1996)

I now have 330 Inquiry reports published since Inquiry into the Care and Treatment of Christopher Clunis (1994)

Also have additional number of reports where victim was a child / young person
In June 2005 the Department of Health published new guidelines removing the necessity for an independent inquiry after all cases of homicide, with new criteria specifying that independent investigations should be conducted:

▫ “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, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.”

“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.” (Department of Health, 2005).
Independent investigations after homicide by people receiving mental health care (2010)

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http://tinyurl.com/c8sawof
The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness report identified:
- 28 reports (with one covering two separate homicide cases) and 1 serious case review published in 2006
- 7 independent investigation reports and 1 serious case review published in 2007
- 15 independent investigation reports (with one covering two separate homicide cases) and 1 serious case review published in 2008
- 14 independent investigation reports published in 2009 (one of which was also subject to a serious case review).

**Total: 64 published in 4 years**

**Recommendations**

1. In uncomplicated cases, independent investigation reports should be available within six months of conviction. Extensions to this time in complex cases should be agreed with SHAs. ....
“The NCI proposes to continue analysing the independent investigation reports as they are published, monitoring themes and implementation of recommendations.”

49 inquiries following homicide published in 2010;
36 inquiries published in 2011;
23 inquiries following homicide published so far in 2012
**Total: 108 published in 30 months**

Last 18 months, (59 inquiries) – date of publication was, on average, 4 years and 4 months after date of homicide
“There may be homicides which can be prevented but their number is likely to be obscured by a greater number for whom the quality of mental healthcare is largely irrelevant. Rather than highlighting homicide reduction, it would be better to demonstrate that services are open, accountable and reflective.”

9.0 Recommendations for Improving Safety

The main causes of the incident are determined as being:

(i) The view that ___________

(ii) The ___________

(iii) The failure to proactively follow up ___________

(iv) It was clear that ___________ when he was __________.

Against this background there was a failure to include __________.