Mental Health-Related Homicide

Information for Mental Health Providers

April 2019

Contents

Foreword	5
Introduction	7
Guiding Principles	9
Existing Frameworks	10
1. Communicate	11
2. Provide Support	12
3. Involve Families & Staff	13
4. Commit to Learning	14
Key Actions	15
The first days and weeks following an incident	17
Meeting the family	19
Staff Support	22
Independent Investigation Following a Mental Health-Related Homicide	23
Engaging families to support continuous learning	25
Help and Support	26
Language	28

Foreword

The impact on families, friends and staff following a mental health related homicide is traumatic and life changing.

We have developed a set of principles and activities to help Mental Health Providers support families and staff following a mental health-related homicide. These materials should be shared with relevant teams within your organisation and we hope they will support existing processes and structures to continue providing meaningful support to those affected by incidents of this kind.

It is important that there are robust systems in place to ensure learning is shared across the healthcare system and with other agencies, such as the Police and social services to reduce the likelihood of such tragic incidents.

Whilst it is essential to learn from these incidents this can, on occasion, be difficult, especially if the alleged perpetrator has had minimal contact with health and social care services. However, if there has been contact with services then this contact should be reviewed to identify learning, which could be both service improvements and sharing of good practice. As responsible bodies, there should be clear platforms to take this learning forward locally, regionally and nationally.

Families often ask investigating teams if the incident could have been prevented. Health and social care is complex and a service user may come into contact with multiple agencies and multiple services. Whilst it is often difficult to say for certain that an incident was preventable, an independent investigation will often identify gaps and omissions in care pathways and recommend actions that could improve systems. These actions are put in place to strengthen the systems that staff work in, improve care for service users and reduce the risk of reoccurrence of such incidents.

Public services must ensure that those families affected by a mental health homicide are treated in a respectful, sensitive and professional manner without discrimination. Families should be offered appropriate, compassionate support and be provided with information on how they can access available help to begin to cope and recover.

We appreciate that all situations and organisations are different, and that one size does not fit all. To help achieve a consistent approach, we have worked with families and staff to develop a set of principles and activities to support them in the aftermath of a mental health-related homicide and some information for families about what to expect. These written materials are entitled *Information for Families of Victims Following a Mental Health-Related Homicide* and *Information for Families of an Alleged Perpetrator of a Mental Health-Related Homicide.* They are accompanied by podcasts that reflect the experience of a mental health-related homicide from a range of perspectives and are are available on the NHS England website.

NHS England London has developed these materials in collaboration with the families of victims of mental health-related homicide, the families of alleged perpetrators, voluntary/charity and advocacy organisations, NHS Resolution, NHS organisations, Metropolitan Police Service and Independent Investigators.

Families and staff have been incredibly generous by sharing insights at workshops, in interviews and by contributing content. We would like to thank them for the time they have taken to help us to create these materials.

We hope the materials will help us to provide meaningful support to those affected by incidents of this kind.

NHS England

NHS Resolution

METROPOLITAN POLICE

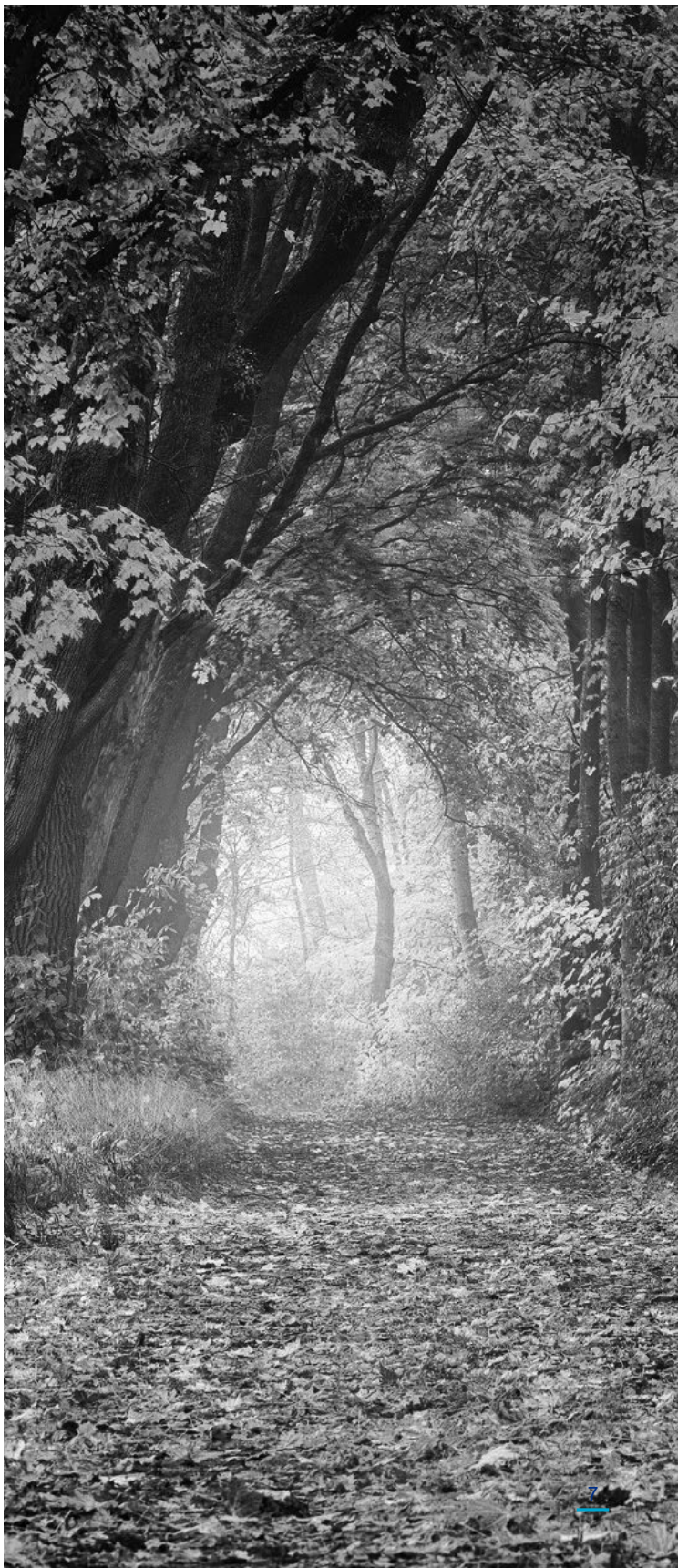
Introduction

There is no escaping the intensity of emotion for all involved in the weeks and months following a mental health-related homicide and every individual has their own way of expressing and dealing with the situation.

For those families bereaved by mental health-related homicide the devastation is unique and made worse by the suddenness of the event and knowledge of the circumstances. This emotional trauma will have a long-lasting impact on the immediate family, which can include children, and those around them including wider family and friends.

In addition to coping with pain and grief, research has shown that bereaved families often experience problems with physical health, housing, employment and the breakdown of relationships. In the case of domestic homicide, the family may be coping with additional complexities, multiple deaths and sometimes suicide.

As well as having to contend with their loss, families must deal with the immediate aftermath: the media, the Police investigation and the criminal justice process which can take years. There are long lasting consequences for families' mental and physical health and often they need support from the very system that they may perceive has failed them. They come to the NHS looking for information and answers and services need to be prepared to respond with openness,honesty and support tailored to their needs.



The family of the alleged perpetrator also suffer greatly and may experience social isolation. In addition, they will want to get information, answers and may want to contribute and be involved.

It is important to be aware that each family or individual will respond differently and, as such, the approach to supporting them will vary depending on the circumstances and how the family would like to be involved.

It is clear from the people who have helped to develop these materials that families value personal support through advocacy (often provided by the voluntary sector), together with a nominated individual within the Mental Health Provider who understands the case and can help families understand what is involved and their role in it.

Mental Health Provider staff will also need support following an incident of this kind. People who cared for the alleged perpetrator may feel anxious and be concerned about their own part in the events that led to the incident. The impact on staff can be profound and they need care and compassion throughout the process.

The aim of the NHS internal reviews and independent investigations is to learn from these events and preventfuture ones. Over time, many families want to be given a chance to help services to change by being included in internal reviews, investigations, sharing learning and supporting development. They need to see positive changes and be confident that our system is able to learn and that their involvement can make a difference for others.

Experience has shown that there are behaviours that, if adopted by the Mental Health Providers and related agencies, can ease the process and prevent making the situation harder for those involved. It is recognised that staff are already working hard to support patients and families following an incident. These materials have been designed to support that work and to continue to help everyone provide appropriate support for families of victims, families of alleged perpetrators and staff.

Guiding Principles

We have identified Four Principles when supporting people during this time:

Communicate, Support, Involve and Learn

1. Communicate regularly and with sensitivity and clarity.
2. Provide support for both families and staff.
3. Involve families and staff in reviews, investigations and in sharing learning.
4. Commit to learning.

We have identified a number of Key Actions that underpin the principles:

- Supporting families in the first days and weeks following an incident.
- Staff support.
- Independent investigation.
- Engaging families to support continuous learning.

Existing Frameworks

NHS England, Mental Health Providers and commissioners of mental health services have a number of responsibilities and reporting obligations following a serious incident:

- NHS England Serious Incident Framework 2015[1]
- Duty of Candour[2]

In addition the NHS England and National Quality Board Learning From Deaths Guidance sets out guiding principles and ways for NHS organisations to improve how we engage with families and how we learn when things go wrong.[3]

These Mental Health-Related Homicide materials are intended to accompany and complement official frameworks, by describing some of the experiences that people have shared, practical things that have been found to help and suggestions for further resources and support.

1 https://improvement.nhs.uk/resources/serious-incident-framework/
The Serious Incident Framework is currently under review. The updated version will be published in 2019
2 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
3 https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/ Note: An updated version will be available in March 2019

1. Communicate

Initial actions

When an incident occurs, it is important to immediately assign responsibility for effective communication.

Join up

Depending on the nature of the incident, it may be necessary for several organisations to make contact with those families affected. This should be clearly explained to the families and where possible, agree one point of contact/an identified person.

Say Sorry

Families have told us that organisations do not always say sorry or they do it in a way that does not resonate or seem well-intended at the time. It is important to continue to acknowledge our empathy throughout the often long process. For additional guidance on saying sorry see NHS Resolution (resolution.nhs.uk).

Adopt the right style

Families affected by a mental health-related homicide must be treated in a respectful, sensitive and professional manner, without discrimination.

Enable Choice

The quality and accuracy of the internal review and independent investigation is likely to be significantly enhanced by the involvement of family and friends. Some families will decline/defer communication from the Mental Health Provider when it is offered, and this is their right. Record this choice but try re-establishing communication at a later date when the family may be ready to engage.

Ensure Timeliness

It is important to identify and open communication channels with families as
early possible, to maintain communication throughout and to commit and keep to the next communication each time contact is made. Stay in contact as planned, even if you do not have any new information to share. Always keep families informed on progress including reasons that may result in delays to the agreed schedule.

"We were assigned a person. There was a diary reminder every month. This makes a difference to the family: a process, something to hold them account to, a structure."

Victim Family Member

2. Provide Support

Commit for the long-term

The sudden loss and trauma that families experience following a mental health-related homicide cannot be underestimated. Families have to re-live the painful memories, with court attendances and organisations investigating their own service's contacts. The process can take years and this impacts on everyone involved: families of the victim and those of the alleged perpetrator who are both facing new challenges every day.

Signpost with support

The incident can impact on the family in many ways (eg: finances, housing and childcare). There are information, support and advocacy services available. Let people know what they can access and support them to do so.

Offer Psychological/Counselling Support

Families should be offered appropriate, compassionate support and be provided with information on how they can access available help to begin to cope and recover. The families may not wish to receive this support from where the alleged perpetrator had received care and treatment. You may need to organise a reciprocal support system with a neighbouring/their local trust.

Keep the door open for support

Families may change their mind about the support they need or want. This experience will impact everyone differently and they might find that they need support at different times. This support should be available for the wider family also. Consider how the local processes (including waiting times) might impact and how they can be avoided.

Communicate regularly with staff

Staff need to know what the process will involve, their role and the need for the organisation to learn. An early de-brief as a group, with opportunities for other informal and individual de-briefs is important.

Support Staff

These incidents are rare and so it is unlikely that staff will have experienced this before. They will need support to understand the impact on them both professionally and personally.

Support those providing the family with support

In addition, those assigned to supporting the families will need on-going support, supervision and opportunities to de-brief.

3. Involve Families & Staff

Involve families at the earliest opportunity

The quality and accuracy of any internal review/ independent investigation is likely to be significantly enhanced by the involvement of family and friends. Families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation. If families do wish to be involved, agree on and abide by their preferred timelines and points of contact.

Appreciate that all families are different

It is important to be mindful of the family dynamic and that different family members might want to meet separately with the internal review and independent investigation teams. The internal review/investigation team might also need to meet with friends and other members of the public affected by the incident.

Involve Staff

Mental Health Provider staff may wish to engage in different ways and need a choice of support – as a team or individually. Even though it is often a significant period of time afterwards, it is important to make sure that there is a reflective session around the time of the final report, in addition to the sharing learning sessions.

Work in partnership

It is good practice to work in partnership with the other agencies involved and the other investigations taking place. Activities outside of the Mental Health Provider do sometimes take priority, such as the criminal investigation.

> ***"Ask the family. They're the ones that know the patient."***
>
> **Mother of perpetrator**

4. Commit to Learning

Organisational culture

Consider how the learning from this event will interact with on-going quality improvement programmes and be meaningful to teams. Find ways to share the learning early and often and evidence the changes and improvements that are made as a result.

Work in partnership

It is important that there are robust networks and systems in place to ensure learning across the health system and other agencies, such as Police, social services and the wider social economy to reduce the likelihood of such tragic incidents.

Build family and staff experience into learning

For organisational culture to change and improve it is vital that the experience of care, from all perspectives is fully understood.
It is important to share the findings of the investigation with those involved.

Engage Leadership

It is imperative that the leadership within the Mental Health Provider, commissioners and relevant stakeholders understand and own the changes that are needed at wider system and organisational level. Patient Safety teams need to work with the leadership within the Mental Health Provider and commissioners, during and following a mental health-related homicide investigation, to support them to fully understand and own the changes that are needed at wider system and organisational level.

Engage staff

The investigation process, reporting and action planning can sanitise the information to a certain extent and it is therefore important to find ways to gather and share family and patient stories in a way that engages people in the required improvements at all levels – team, executive, board and wider system.

> *"We are here to help illuminate the past, to make the future safer."*
>
> **Frank Mullane, AAFDA**

Key Actions

In order to support families and staff an awareness of the whole process is required. The family and staff experience the mental health service reviews and investigations in the context of everything else that they are involved in: the Coroner's inquest, funeral, Police investigation and criminal proceedings.

There is a need for flexibility and responsiveness, the ability to enable access to a variety of support methods, an understanding of the complex nature of the grieving process and a close working relationship with investigators.

Families may not necessarily be familiar with either the NHS or other services and how they operate. It is highly unlikely that they are familiar with mental health-related homicide and any of the processes and procedures that will follow.

Every stage will need to be clearly described and explained.

> *"You are left shunned and isolated, as if you are in your own prison cell."*
>
> **Family of perpetrator**

Following a mental health-related homicide the family of the victim have a range of agencies who get in contact and a number of activities that take place that they are required to be involved in. We have listed some of the activities here. This can take place over a number of months and years.

General

- Victim(s) identified (by the family)
- Media interest
- Coroner's Inquest
- Post Mortem
- Funeral arrangements
- Dealing with the estate and will
- Welfare/Bereavement Benefit payments

Police

- Some personal possessions may be held by Police as evidence
- The home may be a crime scene
- Police Family Liaison Officer allocated to victim family
- There may be a criminal trial
- There may be an appeals process
- In some situations, no charges are brought

NHS Internal Investigations

- Early family contact should be made in agreement with the Police Senior Investigating Officers' strategy
- Provide information on internal review process and possible independent investigation.
- Flexible support needed as family timeframe unpredictable
- MH Provider Internal Investigation is conducted alongside the criminal proceedings
- Family involved in terms of reference, mid-point review and final report

Learning

- Should be agreed system/channels for using learning within the MH Provider
- Board ownership of learning
- Action plans will be developed and the Providers held to account for implementing
- Family involved in monitoring of change
- Sharing – nationally – not just local –families appreciate seeing change
- Continued support for the family

NHS England Independent Investigation

- Following internal review, Independent Investigation may be commissioned by NHS England London
- Family involved.
- Final report and sharing findings

Investigations and reviews

- A number of organisations may carry out investigations, depending on the circumstances (Police, NHS, Domestic Homicide Review)
- A range of agencies may be involved. Such as: Healthcare Service Ombudsman, Health & Safety Executive, Independent Office for Police Conduct, Nursing Midwifery Council, General Medical Council, Crown Prosecution Service, Prison Ombudsman

The first days and weeks following an incident

Co-ordinate with other agencies

- Work in partnership with the other agencies involved (other health providers, Coroner, Police, voluntary sector) and ensure that communication is joined up.
- Initial contact with both victim's family and alleged perpetrator's family must be agreed beforehand by the Police Senior Investigating Officer.
- Nominate a single point of contact within the Mental Health Provider to liaise with the Police Family Liaison Officer (FLO) and the families.
- Where an alleged perpetrator was cared for by more than one organisation a Lead Mental Health Provider will be identified.

Offer support to access advocacy services

- There are sources of support and advocacy available, including media advice, but families will need help to access them.
- Families should have access to the help of specialist advocate homicide support agencies and independent advocates experienced in bereavement and sudden loss.
- Check with the Police FLO what agencies/ support has been provided to the family to prevent saturation of information.
- Please see Help and Support section for further information.

First communication

After a mental health related homicide, families often describe being in a state of shock, bewilderment and a sense of disbelief. They need and want information from Mental Health Providers and have reported that, in the past, this has been very difficult to access.

It is important to acknowledge that, on occasion, providing support and information can be difficult if the alleged perpetrator has had minimal contact with health and social care services.

The first communication with the families of both the victim and the alleged perpetrator is important to demonstrate a commitment to openness, honesty and support:

- The Mental Health Provider(s) should send condolences to the family within seven days of becoming aware of the death.
- Say sorry. Saying sorry is not an admission of legal liability; it is the right thing to do.[5]
- Treat families with empathy and respect.
- Communication should be sensitive, clear, inclusive, in plain English, free of jargon and any technical terms should be explained.
- Be sensitive to any cultural needs.

5 https://resolution.nhs.uk/saying-sorry-leaflet/

- Offer interpreters and information in other languages if required.
- Ensure that any contact is sensitive to specific dates, for example birthdays, anniversaries, funeral etc.
- Identify one point of contact within the Mental Health Provider. This person should have the skills and experience to support the family throughout the process and will be independent of the teams that cared for the alleged perpetrator.
- Ideally, use generic contact details in the event that the nominated staff member leaves or is on a period of absence.

We have developed some booklets for families that describe what they can expect from the NHS. These are entitled *Information for Families of Victims Following a Mental Health-Related Homicide* and I*nformation for Families of an Alleged Perpetrator of a Mental Health-Related Homicide.* This information is intended to support your conversations with families.

Meeting the family

- Ensure that the Mental Health Provider's nominated point of contact is available to meet with the families.
- If multiple agencies are involved, consider having one multi-agency meeting with the family to prevent duplication of information.
- Enable the family to decide on the location and timing of meetings.
- Consider who should join this meeting –should the family liaison (NHS and Police) services be present?
- Help staff to prepare, including how to start and end the meeting.
- These meetings will be difficult for all, it is therefore advisable that those assigned to managing such a meeting are appropriately senior and knowledgeable, as to confidently be able to support and answer any queries raised by the family.
- Manage expectations of first meeting:
  - Establishing how much involvement family want in the process.
  - Establishing one point of contact within the family.
  - Explanation of internal review and investigation process.
  - Offer additional meetings at key points during the process.

Offering Psychological and Counselling Support

- The meeting is an opportunity to identify the psychological support/counselling needs of family, including any children.
- Waiting times and processes, such as referral criteria, can be a major barrier – consider how this might be flexed due to exceptional circumstances.
- Grief and the ways that people express their feelings is individual and everyone reacts in their own way. Responses can also change over time.
- A review of the research into the impact of homicide[6] found that bereaved families following a homicide reported repetitive thoughts, being on-guard, detachment, depression and sleep disturbance. Some also reported alcohol and drug dependence. The studies also indicate that these kinds of symptoms can continue for long periods.
- Be mindful of stigma about mental health, some families may be reluctant to access services.

6 Louise Casey CB, Review into the Needs of Families Bereaved by Homicide 2011 – https://www.justice.gov.uk/downloads/news/press-releases/victims-com/review-needs-of-families-bereaved-by-homicide.pdf

Explain the need for a review/ internal investigation

- Ensure families are provided with an explanation as to why the Mental Health Provider organisation is conducting a review and investigation, the purpose of the investigation and the format of the report findings.
- Be clear with families that the purpose of the report is for the organisation to learn, implement change and to minimise any reoccurrence and not to apportion blame.

Family involvement in reviews and investigations

- Families have told us that they want the NHS to be honest with them and to know what happened, why it happened, how it happened and if there is anything that can be done to prevent reoccurrence.
- Offer families the opportunity to assist with the scope of the internal investigation by contributing to the Terms of Reference and listen to any comments they may have.
- Families can also be a vital source of information and insights about a person's care and treatment.
- Allow families the opportunity to read any interim report findings and provide them with sufficient time to comment on the report content and any potential recommendations.
- All information and reports should be preceded with a phone call or meeting with the family.
- No unplanned or new information should be sent without warning.
- Ensure families are asked how they want their loved one to be referred to in the report
- Ask families how they want to receive the report and offer a meeting at your offices, or a location of their choice. If the report is to be sent to their home address, always ask if they will have support at home when they receive it or whether they want a member of the investigation panel/identified point of contact to take it to them.
- Ensure both the interim and final reports are written in plain English[7]
- The Mental Health Provider should remain in contact with the families following the final report to update them on progress with the recommendations.
- Openness and transparency with families on how long recommendations will take to put in place is essential including explanations of any known delays and what may be causing them.

Delays

- If families have chosen to be updated at regular intervals, the agreed single point of contact will need to ensure they update them of any delays in the investigation and the reasons for these.

7 https://www.gov.uk/government/publications/making-written-information-easier-to-understand-for-people-with-learning-disabilities-guidance-for-people-who-commission-or-produce-easy-read-information-revised-edition-2010

- Sometimes the Police investigation and criminal proceedings can impact on the timings of the internal investigation. However, it is preferable for all concerned for this internal investigation process to proceed as planned and the Mental Health Provider should have good communication links with the Police investigation and be able to run both in parallel.

The role of the Mental Health Provider nominated point of contact/family liaison lead

- It helps families enormously to have one point of contact within the Mental Health Provider.
- Some Mental Health Providers have created a dedicated Family Liaison role within their trust.
- This family liaison/point of contact person needs a detailed and wide-ranging understanding of the complexities of sudden and traumatic death and to be well-connected to support services, including:
  - HM Coroners post mortems and inquests
  - Police Family Liaison
  - Coping with the media
  - Advocacy and counseling support
  - Benefits
  - What the court process involves
  - Statutory investigations
  - NHS Investigation

Publication of reports

Mental Health Providers and Independent Investigators should draft reports in the knowledge that disclosure is highly likely to be requested.

Other investigations

- Wherever possible investigations should continue alongside criminal proceedings but this should be considered in discussion with the Police.
- In exceptional cases (i.e. following a formal request by Police, Coroner or judge) and in accordance with the Police Senior Investigation Officer strategy, the Mental Health Provider investigation may be put on hold and this should be discussed with the Police FLO on how best to advise and support the family during this period.
- There could be opportunities for joint working with other organisations including the Police and potentially the Local Authority with other types of investigation such as Domestic Homicide Reviews (DHRs) and/or Serious Case Reviews (SCRs). NHS England's Patient Safety Team can advise on collaboration with other agencies.
- Central to this process is the involvement of all relevant parties, which includes the service user, victim(s), perpetrator(s) and their families and carers and mechanisms to support openness and transparency throughout. There should be an agreed single point of contact and this should ideally be the Police Family Liaison Officer once formalised via the Senior Investigation Officer strategy.

Staff Support

The impact of a mental health-related homicide on the staff involved can be far-reaching.

Soon after the incident, it is helpful to hold a debrief session with the teams who cared for the alleged perpetrator. This is an opportunity to share experiences in a safe environment. This meeting is separate from the internal investigation and is an opportunity for staff to talk through the incident.

Ensure that staff involved are offered appropriate support via individual and team debriefs, followed by further referrals to other support as necessary. Support will also be required for those staff whom may also know the victim.

This mix of informal and formal support should then continue at team and individual supervision. It is important that line managers are aware and supported to create time to listen and help staff to reflect on their practice.

Mental Health Provider Trusts will also have Occupational Health services and counselling services available for staff. People react in different ways and it is important to keep track of delayed or repressed responses.

In the days and weeks following the incident encourage staff to record accurately their contact with the alleged perpetrator. This can help ensure they have a prepared record for any forthcoming or future investigations.

The process of investigating a mental health-related homicide is long and can take years to complete. There are often high expectations around the evidence within the report and sharing the learning needs to be planned and executed with care and attention.

Regular communication and updates can help staff during this difficult time. Often this is as simple as describing the investigation process as they might be unfamiliar with it, or need a reminder, and allaying their fears. Knowing where they are in the process and what the next steps are can be helpful.

Senior leaders in the organisation can set the tone with compassionate leadership, a commitment to personal and professional development, a safe environment to listen and give feedback and mutual trust and respect in teams and across the organisations.

It will be important to reach out to all staff groups involved, including students, agency staff and recently qualified staff and those who might be experiencing a situation of this kind for the first time.

> *"This needs to be talked about as a possibility, at induction, in training. We need to understand the potential for serious incidents, the process and systems in place, the emotional impact."*
>
> **Serious Incident Team Member**

Independent Investigation Following a Mental Health-Related Homicide

Following the initial internal investigation report and subsequent criminal proceedings, in the case of mental health-related homicide, an independent investigation may be commissioned.

In London, the mental health independent investigations are coordinated and commissioned by NHS England (London).

There are a number of independent investigation agencies. These agencies are invited to tender, in a process that is fully compliant with the Public Contracts Regulations 2015.

The decision on whether an independent investigation is required is made by the Independent Investigation Review Group (IIRG). This is a multi-agency group in London which includes members from the Metropolitan Police Service, health services, and commissioning groups in-line with the Serious Incident Framework (April 2015) and the investigation of serious incidents in mental health services (Department of Health, 2015).

In addition to the above legislation requirements, the decision to commission a full independent investigation into the care and treatment of the alleged perpetrator provided by the Mental Health Provider, will also depend on the quality of the internal report, the level of involvement of families of the victim(s) and alleged perpetrator(s) and any other relevant stakeholders.

Following the decision made by the Independent Investigation Review Group to commission an Independent Mental Health Investigation, and once the tendering (appointment of an independent investigation team) process has been completed, NHS England will inform the families and other relevant stakeholders of their decision, share and contribute to the proposed Terms of Reference and offer to meet to introduce the investigators and describe the process that they will follow, including opportunities for families to contribute.

NHS England, in collaboration with all relevant stakeholders, will:

- Agree to a single point of contact for each stakeholder
- Support the activity of the independent investigators and help them as much as possible to meet with the relevant staff and family members in as timely a manner as possible.

The independent investigators will want to:

- Meet with the victim's family to listen to their concerns and to ask them if they would like to contribute to the investigation
- Meet with the alleged perpetrator's family to listen to their concerns and to ask them if they would like to contribute to the investigation
- Meet with the alleged perpetrator if they are prepared to take part.

- Meet with Mental Health Provider senior staff and staff involved in the care of the alleged perpetrator.

It is important the independent investigators listen to the concerns of those involved and that the investigation answers the questions they may have. The independent investigators need to share their findings and discuss the proposed recommendations with all involved.

> *"We are not there to blame, or find fault, we are looking for improvements that reduce likelihood of reoccurrence and improve the quality of care. This is not about individuals."*
>
> **Independent Investigator**

Engaging families to support continuous learning

Mental Health Providers should offer families the opportunity to take part in evaluating the recommendations and actions that result from investigation findings.

It is important that the learning identified can be evidenced and updates on actions taken provided to those involved in the process within the agreed timescales. Families should also be updated at regular intervals until the actions are completed.

Sometimes, when people have been through this process, they might wish to volunteer to help the organisation to improve and develop. Not everyone will want to get involved in this activity, but those who do have reported that it can be fulfilling.

The experience of a family can help staff to understand the impact of incidents of this kind and help the organisation to learn. For organisational culture to change and service quality to improve it is vital that the experience of care, from all perspectives is fully understood.

"Waiting for answers can take a long time, it can seem never ending."

Victim Family Member

When involving families all standard principles of engaging and involving members of the public in health quality improvement activities apply:

- Approach involvement from the perspective of families – what will the experience of working with your organisation be like, what do they need from you?
- Reward participants for their contribution – always reimburse out of pocket expenses and wherever possible offer other incentives such as payment.
- Ensure there is clarity of purpose to the participation – this is not a "box filling exercise," be absolutely clear about what families can contribute and how you will build their insights into improvement activities.
- Consider carefully how to communicate.
- Create a space for equal partnerships between professionals and families.
- Think beyond the meeting and find a range of ways for people to participate.

Help and Support

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.

Child Bereavement UK

Supports families and educates professionals when a baby or child of any age dies or is dying, or when a child or young person (up to age 25) is facing bereavement. This includes supporting adults to support a bereaved child or young person. All support is free, confidential, has no time limit, and includes face to face sessions and booked telephone support.
www.childbereavementuk.org
Telephone: 0800 028 8840.

Child Death Helpline

Provides a freephone helpline for anyone affected by a child's death, from pre-birth to the death of an adult child, however recently or long ago and whatever the circumstances
of the death and uses a translation service to support those for whom English is not a first language. Volunteers who staff the helpline are all bereaved parents, although supported and trained by professionals.
www.childdeathhelpline.org.uk
Telephone: 0800 282 986/0808 800 6017

Cruse Bereavement Care

Offers free confidential support for adults and children when someone dies, by telephone, email or face-to-face.
www.cruse.org.uk.
Telephone: 0808 808 1677

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

National Survivor User Network

Is developing a network of mental health service user and survivors to strengthen user voice and campaign for improvements. It 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 t cope and needs someone to listen 24 hours a day.
www.samaritans.org
Telephone: 116 123.

For any queries or concerns, Mental Health Providers are asked to contact NHS England London:
england.londoninvestigations@nhs.net

Language

A number of terms and expressions, such as mental health-related homicide have been used in the document that have been chosen because they appear to be the most readily accepted at time of writing.

We have referred to the person who has died as the victim and their family are described as the family of the victim. We acknowledge that this term is exclusive and that families are all different and can be complex.

The person with a mental health condition who it is alleged to have killed the victim is referred to throughout as alleged perpetrator and their family as family of the alleged perpetrator.

We recognise that people have their own preferred language and acknowledge that some of the terms may sound impersonal, it is not our intention to offend.

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

April 2019

NHS England (London) Investigations
england.londoninvestigations@nhs.net