Victims' Commissioner

Positive change for victims

Entitlements and experiences of victims of mentally disordered offenders.

June 2018

Foreword by the Victims' Commissioner

One relatively small but important group of victims are those who have suffered at the hands of mentally disordered offenders. Indeed, as the case studies attached to this report show, these victims have been subjected to some of the most horrific violent crimes.

The law rightly makes a distinction between offenders who are of sound mind when committing their crimes and those whose judgement was impaired by mental illness. Nevertheless, the impact of these crimes upon the victim remains the same.

Despite this, victims of mentally disordered offenders do not have the same entitlements under the Victim Code. Neither do they receive the same level of support and assistance. This seeming inequality in treatment prompted me to investigate this further and to assess the impact this had on the victims concerned.

I am grateful to the nine bereaved victims of homicide, whose crimes were committed by mentally disordered offenders, for agreeing to allow their cases to be referred to as part of this report. Their case studies can be found at Annex A, although their voices can be heard throughout the report.

I am also indebted to Hundredfamilies, a charity which supports victims of homicide committed by mentally disordered offenders. It has hugely assisted us by sharing the experiences of its membership and enabling us to contact victims.

The general message I take from these victims is that they feel isolated and unsupported in a system that can appear to pay little regard to their needs or support. Whilst there has been real progress in recent years in involving victims in the parole process, this progress has not been extended to victims of mentally disordered offenders.

Instead, they have been overlooked and left behind.

Victims of mentally disordered offenders are not entitled to submit a victim personal statement (VPS) when the offender's case is reviewed by the Mental Health Tribunal. Neither do they have an entitlement to attend the Tribunal hearing and present their statement in person.

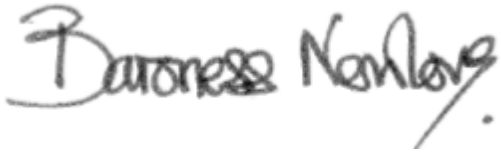
They are entitled to join the Victim Contact Scheme and be allocated a Victim Liaison Officer, but if their offender is an "unrestricted patient" they must deal directly with clinical teams and hospital managers, which can be a traumatic and frustrating experience.

These victims are allowed to make representations in respect of discharge conditions, but if they are refused, they are not entitled to an explanation.

Victim Liaison Officers who are required to assist victims and keep them informed, sometimes appear to struggle with the mental health review process, probably because they are required to engage with it in so few cases. This can exacerbate the victim's sense of frustration.

In April 2018 the Government announced its findings following its review into parole processes and the victim contact scheme. The outcome of this review is that victims whose offenders are serving a prison sentence are to become more involved in parole, the parole process will be made more open and transparent and Parole Board decisions will be open to challenge by victims. These are all welcome developments but once again, none of them will apply to victims of mentally disordered offenders. Instead, they will fall even further behind.

This cannot be fair or right. The time has come to close this gap and offer victims of mentally disordered offenders the same level of support offered to other victims. They deserve nothing less.



Baroness Newlove of Warrington, Victims' Commissioner for England and Wales

Acknowledgements

The Victims' Commissioner would like to thank Hundredfamilies for their support in recruiting victims of mentally disordered offenders to take part in research interviews for this report. Hundredfamilies provide support, information and advocacy to families after their loved ones have been killed by people with mental illness. Most importantly we would like to thank the victims of mentally disordered offenders who shared their experiences in the case studies presented in this report. The Victims' Commissioner is also grateful to Stephen Wooler CB, for peer reviewing this report.

Contents

Recommendations

This report makes the following recommendations:

1. Amend the Victims' Code to afford the same entitlements to victims of both restricted and unrestricted patients as those given to victims of serving prisoners. This should include the right to submit a Victim Personal Statement at the point at which an MDO's continued detention is being reviewed and the right to attend a hearing of the panel to read the statement.

   (Ministry of Justice)

2. Extend the remit of the Victim Contact Scheme to provide the ongoing support of a victim liaison officer (VLO) to victims of unrestricted patients, so that they receive a comparable level of support as that afforded to any other victims of serious sexual and violent offences.

   (National Probation Service)

3. Victim liaison officers to be offered refresher training on the review processes for MDOs.

   (National Probation Service)

4. Review the support and assistance provided to victims of MDOs who wish to submit representations on conditions of discharge.

   (National Probation Service)

5. Guarantee that when such representations are rejected either in part or in whole, full reasons are given to the victim.

   (Ministry of Justice)

6. The remit of the Code of Practice for Victims of Crime (Victims' Code) should be extended to include the National Health Service as providers of victims' services, including the services to inform victims of mentally disordered offenders and cooperate with the Victim Contact Scheme.

   (Ministry of Justice and Department of Health)

7. The Crown Prosecution Service to provide guidance to Crown Prosecutors regarding implications of an indefinite detention order under the Mental Health Act. Crown Prosecutors / VLOs ensure that the implications of an indefinite order are fully explained to victims.

   (Crown Prosecution Service, VLOs)

Introduction

'They should take away the secrecy that shrouds [the perpetrator], it's threatening. We are allowed to know so little. I'm always asking 'what' and 'why' but why can't we know? [The perpetrator] is protected but we are not. We're left to get on with it. I am now a single parent, left to bring up the children. The horror, the trauma, yet I am not allowed to know if he has a new name. we have no safety, no security, it's like bashing your head against a brick wall.'

Case study 4

An average of 122 homicides are committed by mentally disordered offenders (MDOs) in the UK each year.[1] National Statistics are not collated regarding the number of victims of MDOs who have been convicted of other violent or sexual crime.

The trauma and distress experienced by victims of serious sexual and violent crime, including homicide, are the same irrespective of the status of their offender. As such, it would seem only right that victims of all such crimes should receive the same level of support and the same entitlements. Entitlements under the Code are intended to provide support for victims throughout their criminal justice journey and in turn, help them to cope and recover.

The current position does not offer equal treatment to these victims. Instead, it makes a distinction between victims whose offenders are serving prison sentences and those who are patients detained in mental health hospitals. There is a yet further distinction made between the victims of "restricted" and "unrestricted" patients.[2]

Whilst these distinctions are based upon the status of the offender, the result is a disparity of treatment for the victim.

Megan feels that by being a victim of a mentally disordered offender, she had been made to feel victimised all over again as a 'victim of the system.'

Case study 1

In April 2018, the Government announced further progressive steps in assisting victims to contribute to the parole process, including the right to request a summary of reasons for a Parole Board decision and the right to challenge without seeking

[1] Source: The National Confidential Inquiry into Suicide & Homicide by People with Mental Illness 2013 Annual Report p129

[2] Restricted patients are subject to Section 41 of the Mental Health Act and their progress and eventual release are monitored by the Ministry of Justice. Unrestricted patients are mentally disordered offenders who are not subject to Section 41, and whose progress and release are not subject to Ministry of Justice overview.

judicial review. These are welcome developments but they will not apply to victims of MDOs. As a result, the difference in treatment is about to become greater than ever.

The perpetrator's final Tribunal was held in October 2017. The family were not informed about this Tribunal until 21 days after it took place. At this point they were informed that the Tribunal had decided to give the perpetrator conditional discharge. Mark's family asked how the decision was made by the Tribunal, but they were told they were not allowed to know.

Case study 5

Entitlements of victims of mentally disordered offenders

The Victim's Code of Practice

"The man killed my husband. You would think I do have a few rights, but no, no rights at all. I don't feel free, it's a horrible feeling… I feel very vulnerable. I have lost my trust in people. How can a man so ill walk the street? … If we could know more and be listened to, but we are utterly side lined. It is all about [the perpetrator's] care and rehabilitation."

Case study 4

This report focuses solely on the victims' journey following sentencing, as experienced by victims of MDOs. It compares their treatment with that of victims whose offenders are serving a custodial sentence.

The report draws on the experience of 9 families, all of whom have suffered bereavement, following the death by homicide of a loved one and where the perpetrator is an MDO. These accounts are specific to the families that took part in interviews with the Office of the Victims Commissioner. Whilst they cannot be said to be a nationally representative sample of victims of MDOs, they do illustrate some of the issues these families face. The families identified similar difficulties in being kept informed about the MDO and the effects of having no involvement in Mental Health Tribunal[3] processes.

The Victims Code of Practice 2015 (Victims Code) sets out to:

> *"…transform the criminal justice system by putting victims first, making the system more responsive and easier to navigate. Victims of crime should be treated in a respectful, sensitive, tailored and professional manner without discrimination of any kind. They should receive appropriate support to help them, as far as possible, to cope and recover and be protected from re-victimisation. It is important that victims of crime know what information and support is available to them from reporting a crime onwards and who to request help from if they are not getting it."*

It sets out victims' entitlements to support and assistance throughout their criminal justice journey. Paragraph 6.14 of the Victims' Code states that victims:

> *"… of an offender who committed a specified violent or sexual offence but has been detained in a hospital for treatment because he or she has a mental disorder, you will still be entitled to participate in the VCS [Victim Contact Scheme]. If the offender's detention was made subject to 'restrictions by the court (a 'restricted patient'), you will be provided with information by your VLO*

[3] 'Mental Health Tribunal' refers to both the First Tier Tribunal (Mental Health) for England and the Mental Health Review Tribunal for Wales.

> *[Victim Liaison Officer]. If no restrictions are imposed (a 'non-restricted patient'), hospital managers will provide you with information."*

The Code goes on to say:

> *"In these circumstances, as the offender has been diverted away from the criminal justice system and is being treated in hospital as a patient, some of the decisions about the offender's management will be related directly to his or her medical treatment, and as such will be confidential medical information."*

The Code also states that this group of victims are entitled to make representations about the MDO's conditions of discharge, such as conditions that prevent the offender making contact with the victim or entering the area in which they live.

This Section of the Victims' Code gives victims of MDOs whose offender's detention was made subject to "restrictions of the court" the same entitlement for support as equivalent victims whose offenders have been given a custodial sentence.

Victims whose offenders have no restrictions imposed by the courts do not receive the support of a VLO. The expectation is that hospital staff will provide information. This is an important distinction.

Ben has been assigned a series of mental health medical contacts in relation to trying to gain information about the perpetrator. The first was a Mental Health Act Administrator who did not respond to Ben's attempts of contact. The second was a Senior Forensic Social Worker. After not hearing from her for some time Ben attempted to make contact and was told that the individual had moved on from their role and that he would have a new contact, though he had not previously been informed of this change. The third contact was a Mental Health Team Leader. Ben was given an incorrect email address for this individual and had to find out their correct details himself on the internet.

Case study 8 (victim of an unrestricted MDO)

Another important distinction can be found in paragraph 6.26 of the Victims' Code. It states that where victims have opted into the VCS and the Parole Board is going to consider the offender's release or a move to open conditions, the victim is entitled to:

- *be informed by the National Probation Service if a Parole Board hearing is to take place;*
- *make representations about licence conditions (see glossary) to the Parole Board;*
- *be provided with an explanation if a licence condition you have requested is not included on the offender's release licence;*
- *have the Victim Personal Statement (VPS) explained to you by your VLO, including how it will be used by the Parole Board;*
- *make a VPS which will be sent to the Parole Board;*

• apply to attend an oral Parole Board hearing to present your VPS in cases where the Parole Board decides that it is appropriate to hold an oral hearing.

Paragraph 6.14 does not include the right to make a Victim Personal Statement or to attend the Tribunal to present the VPS, both of which are entitlements set out in paragraph 6.26 of the Victims Code in respect of victims and the Parole Board.

Craig's family wrote a letter to the Mental Health Tribunal. They wanted to attend the tribunal and read out their letter in person, but were told this would not be allowed. They were never told why this request was not granted.

Case study 2

There is no explanation for the differential treatment.

Victim Personal Statement (VPS)

Victims, whose offenders are serving a prison sentence and are in the Victim Contact Scheme (VCS), are entitled to submit a VPS to the Parole Board as a part of the parole review process. These victims can also apply to attend a Parole Board hearing for the purpose of reading out their statement. The VPS is the only time that a victim can express in their own words the impact a crime has had on them. It is a powerful voice for victims at the point of sentencing, but it also greatly valued by victims at the point in the sentence where the offender is subject to a parole review.

It is widely accepted that the VPS cannot and should not determine the outcome of a parole review. But, by hearing first-hand the pain and devastation caused by the offence, it gives context to the very serious decisions Parole Board members are required to make. Where the offender is known to the victim, it can, on occasions, assist the Board's understanding of the events that led to the offence being committed.

More importantly, the opportunity for a victim to express the ongoing impact of the crime can be beneficial to them. The victim's sense of empowerment and the resulting catharsis can play a key role in their recovery. The Victims' Commissioner's review into the VPS: 'The Silenced Victim: A Review of the Victim Personal Statement' (published in November 2015) included the views of victims who submitted a VPS to the Parole Board. Many reported that the VPS helped them gain closure and praised its therapeutic value.

The Victims' Code does not extend the entitlement to submit a VPS to victims of MDOs whose cases are reviewed at a Mental Health Tribunal, despite a widespread consensus that the opportunity to submit a VPS is beneficial to victims. Families bereaved by homicide, for example, are not any less affected or traumatised if the homicide was committed by an MDO; nor is there any evidence to suggest that the cathartic benefits of submitting a VPS does not apply to victims of an MDO.

Kate would have liked to have had more of an input into the Mental Health Tribunal. All that she could submit were a couple of sentences from the Victim Personal Statement (VPS) that she prepared for the original sentencing hearing. Kate would have liked to submit a new VPS to fully inform the tribunal of the devastating, on-going impact of the perpetrator's actions. Kate would not have felt able to face the perpetrator herself by attending the tribunal, but would have wanted a family member or her VLO to attend on her behalf to read out a new VPS. This representation of Jonathon's family at the tribunal was denied to Kate. This adds to Kate's feelings of being left out of processes and having no voice in the tribunal. "We have a life sentence without Jonathon. As the wife of the man he killed, I am irrelevant. Even a couple of updated sentences [of a VPS] would give part of the impact on my life. [This would] show more respect."

Case study 4

The Deputy Chamber President, on behalf of the English Mental Health Tribunal, responded to a request for clarification regarding why victims whose offenders were reviewed by the MHRT were not entitled to submit a VPS. He explained the statutory criteria that his members were required to apply and concluded that such criteria were not "…*affected by the impact of the crime on the victim*". The Deputy Chamber President went on to explain that to take such matters into account would be "*unlawful*". To invite a VPS would be "*unfair*" to both victims and patients and would "…*fail to manage expectations*".

When asked about victims attending hearings to read out their VPS, as happens in parole hearings, The Deputy President advised that encounters between victims and patients at tribunal hearings would be "*unhelpful*" and "*inappropriate*" to a hospital's *"therapeutic environment*". [4]

The Deputy President in his letter states that there is no authority for the Tribunal to take into account the impact of the crime on victims. Annex B sets out the statutory tests for the Mental Health Tribunals for England and Wales and the test for Scotland. It also includes the statutory test for release for the Parole Board for England and Wales. It is worthy of note that there is no reference to victims in any of these tests and yet the Parole Board and the Mental Health Tribunal for Scotland are willing to meet victims and listen to their representations. This might imply that the

[4] Correspondence from the Deputy Chamber President of the English Mental Health Tribunal to the Victims' Commissioner dated 27th February 2017.

decision whether to meet with victims is based more upon policy and practice as opposed to statute.

Ayo's sister would like to attend the tribunal hearings… Each time there is a tribunal or appeal hearing, Ayo's sister is sent a form asking her if she would like to attend. She ticks the box to say she does want to, but has never had a response.

Case study 7

Yet a VPS is not intended to influence an outcome. Victims are specifically asked not to offer a view on the outcome. Staff working in the Victim Contact Scheme take great pains to set out the remit of the VPS and manage expectations accordingly. Most victims understand that they are not being offered a chance to influence the parole decision and respect the reasons why.

Megan feels as though the tribunal does not care about her and that she is simply a nuisance for them to deal with: "they are really cold people. It feels like they don't care, we're a nuisance to them. They sit on their tribunals and think they have the power and they do, there's no justification for the way they're treating people."

Case study 1

This was evidenced by the Victims' Commissioner's national victim engagement exercise launched in February 2018, a summary of which was attached to the Government response to the Review into Parole Processes in April 2018. Around half of the respondents that answered questions about making a VPS in the VC's survey on parole processes agreed that the VPS allowed them to express the impact of the crime effectively. For the victims who took part in the in-depth interviews about parole processes, there was a sense that they found it difficult and emotionally laden to write their VPS, but nevertheless, they found it important to express their views as it was their only opportunity to input into the parole process. There were mixed responses from victims interviewed about whether they thought that their VPS was taken into account. Most felt that the VPS was heard but that it did not affect the parole outcome.

The statutory criteria applied to Parole Board release decisions also makes no specific reference to the impact on the victim. The test is that:

> *The Parole Board is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined.*

However, the Parole Board has included the VPS as part of the parole dossier for over 10 years and facilitated the attendance of victims at many oral hearings. There

has been no successful challenge against the inclusion of a VPS in the Parole Board consideration.

… any attempts to communicate with the tribunal were refused and the family felt that it was like 'hitting a wall.' They don't know how the tribunal makes their decision, they asked lots of questions and feel they only got short answers without proper explanation.

Case study 2

In Scotland, Mental Health Tribunals allow representations from victims. The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a statutory right for any party that has an interest to make representations to the tribunal either orally or in writing.

"[Claire's family]… did feel given a voice, and one of the few occasions in the whole process [we] felt [we] had a voice and able to articulate our position… [We] don't think that by putting forward our views… it in anyway inhibited the tribunal from making a decision. [We] thought it only fair and reasonable for the tribunal to hear our side of the story. They needed to know what happened."

Case study 6: Experience of appearing before the Scottish Tribunal

The victim makes representations to the Tribunal panel considering the case. It takes place at a separate oral hearing, where the patient is not present (although it would be attended by their legal representative). The Scottish Tribunal says that *"this has not proved to be in any way problematic. Having heard the victim's representations, the Tribunal has been able to have regard to them in deciding, for example, whether to attach any condition to a patient's conditional discharge."*[5]

Claire's family felt they got a fair hearing from the Tribunal and described the psychiatrist in the Tribunal as being "extremely sympathetic." The panel asked questions and "seemed to take on board what [the family] had to say."

Case study 6: Experience of appearing before the Scottish Tribunal

The experience of the Parole Board and this evidence from Scotland might suggest that a victim submitting a VPS either in writing or in person to an MHRT can be undertaken both lawfully and logistically.

[5] Mental Health Tribunal for Scotland Response to Scottish Government Consultation on Draft Proposals for a Mental Health (Scotland) Bill, April 2014, Scottish Government.

Support given to the victims of unrestricted patients

> *When Ben finally managed to get in touch with his third assigned contact, he received an email reply, the first line of which said: "just to let you know, I'm a very busy person and I'm trying to find you a new contact as I don't have time to deal with you."*
>
> Case study 8 (Victim of an unrestricted MDO)

There are instances when the courts decline to impose a restriction order on an MDO, even when a serious sexual or violent offence has been committed.

Restriction orders are imposed on MDOs where it appears to the court, having regard to all the evidence, it is necessary to do so for the protection of public from serious harm. As a result, their temporary leave, transfer or discharge requires approval from officials at the Ministry of Justice operating on behalf of Ministers.

Unrestricted patients, on the other hand, can obtain leave transfer, or discharge without the approval of the MoJ. There are MDOs who have committed homicide and yet have not been subject to restrictions. Case study 8 relates to a victim's experience where the MDO is unrestricted.

In theory victims of "unrestricted patients" are entitled to join the VCS, but in practice they do not receive the support and assistance given to other victims.

> *Ben has requested to be kept informed about the perpetrator's progress and any possible escorted or unescorted leave, transfer or eventual discharge which may affect his family's safety. Ben's requests have not been met and the health trust that Ben has been in contact with have refused to give Ben any information about the perpetrator.*
>
> Case study 8 (Victim of an unrestricted MDO)

The Mental Health Act 1983: Code of Practice (paragraph 40.16) states that victims of unrestricted patients should be offered the opportunity to engage with the VCS if the patient has been made subject to a hospital order without a restriction order. However, it then goes on to say that those victims who want to engage with the VCS will then have their details passed to the relevant hospital. The hospital manager or responsible clinician then becomes responsible for providing information to the victim.[6]

[6] An independent review of the Mental Health act is currently being led by Professor Sir Simon Wessely and is due to produce a report with recommendations for change in autumn 2018. https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act

Paragraph 40.18 goes on to state:

> *"The Victim Liaison Officer has no further role so clinical teams and hospital managers should be fully aware of their obligations with respect to the victims of unrestricted patients."*

In other words, the only service the victim receives from the VCS is a referral to the hospital authorities. They are not allocated a victim liaison officer (as do all other victims of serious sexual and violent crimes). Instead, the victim is dependent upon the hospital authorities keeping them up-to-date with developments. Evidence from the case studies in this report suggests that different Trusts deal with victims in different ways. Some are forth coming with information while others regard any request by victims for information to be a breach of patient confidentiality.

Inevitably, the onus is placed on the victim to chase and search out information if this is not forthcoming, whereas in the case of victims of restricted patients, any chasing and seeking of information is undertaken by a victim liaison officer.

Ben's constant battles with the medical authorities and Local Authority have contributed hugely to his levels of anxiety and to his concerns for his family's safety… Ben does everything he can to reassure his family, but can't give them any truthful answers because he is not provided with the necessary information. "I know nothing and the perpetrator is in control. There is no reassurance for the family."

Case study 8 (Victim of an unrestricted MDO)

The charity, Hundredfamilies, report that victims who fall into this category can often struggle to establish contact with hospital managers. Understandably, this can be a distressing experience. According to the charity, it can appear to victims that hospital managers (and Mental Health Trusts) do not always fully appreciate or understand their responsibilities towards victims of unrestricted patients. These victims and their families have to work hard to receive the necessary information under the current guidance. Case study 8 demonstrates the struggles that victims of unrestricted MDOs face in accessing any information and the effect that this has had on the family involved.

Hundredfamilies are aware of cases where victims of very serious offences have been informed that no information regarding the MDO would be divulged to them due to 'patient confidentiality'. It might appear that "patient confidentiality" is, on occasions, being used as a pretext to withholding information that victims have a right to be told.

Currently, all Megan knows about the perpetrator is that he is still being detained in hospital and that he is still alive. Megan has been told by the tribunal that she is not allowed to know any more due to patient confidentiality. Yet it is important to Megan to be able to meaningfully communicate with the individuals overseeing the perpetrator's treatment. Megan wants to know that the perpetrator is in a secure place and that he can't hurt anyone else, but this is being denied to her and her family because the perpetrator is a patient.

Case study 1

On the premise that victims need to be treated equally, based on their needs, the exclusion of victims of unrestricted patients from being allocated a victim liaison officer under the VCS cannot be justified. Many will be suffering the same trauma and anxiety as any other victim of a serious sexual or violent offence and yet it seems they are being left to fend for themselves.

Representations for discharge conditions

We are aware of victims who have submitted representations for discharge conditions to be included in their MDO's discharge order. In some cases, these have been considered by the MHRT and in others by the Ministry of Justice's Mental Health Casework Section. Victims are not always sure who the decision maker is.

When victims in the Victims' Contact Scheme make a representation to the Parole Board for specific conditions to be included in the offender's release licence, inevitably, there is confusion about what can reasonably be requested by the victim. In these cases, HMPPS staff will often proactively engage with the victim to try and ensure that requests submitted to the Board are both proportionate and reasonable. This early engagement can be helpful to all concerned and results in most requests submitted by victims being approved by the Parole Board.

Arthur's family were sent some pre-determined exclusion zones. They asked if they could change the exclusion zones to cover the area where the family lived. They are not sure whether these wider exclusion zones were accepted.

Case Study 9

Yet there would appear to be more passive engagement with victims of MDOs. Those who have a victim liaison officer may receive some direction within the understanding that the officer can offer, but not to the same extent as those cases that are being referred to the Parole Board. In some cases, victims simply submit

their representations and await an outcome. The requests will be accepted, amended or rejected; and often there is little or no explanation of the reasons behind the decision and no suggestion about how the request might be amended. Case studies 2, 4 and 9 give examples of victims being given no reasons as to why request for exclusion zones have been turned down or modified.

The victim in Case study 4 contacted the Victims' Commissioner, exasperated that her request for an exclusion zone had been severely amended and that no explanation was provided. Her palpable frustration is reflected in her response and is shared by other victims in similar circumstances:

> *"The response to my dismay by my VLO is also very troubling. Far from being my advocate, my VLO, though perhaps well-intentioned, expresses only a fatalistic acceptance of a bureaucratic inevitability; a dull, resigned shrug. The fact that the much-reduced and wholly inadequate zone is itself manifestly incorrect is treated as a minor administrative slip-up."*
>
> Case study 4

Again, it appears that there is inequitable treatment for victims of MDOs. They need support and assistance in making their representations so that they have a better understanding of what can be deemed as reasonable and proportionate. Helping victims to understand the limitations of what can be imposed will reduce the sense of anger and frustration as well as giving a more positive impression of the criminal justice system.

> *A non-contact order will be put in place but they have been told that the exclusion zones the family requested would not be granted. Instead the exclusion zones originally put to the family would be applied. The family were not given any reasons as to why their request was rejected.*
>
> Case study 2

One likely consequence of the parole process review, the findings of which were published on 26 April 2018, is that victims who request licence conditions from the Parole Board will be offered reasons where their requests are amended or rejected.

Where representations are either rejected or varied, either by the Mental Health Tribunal or Mental Health Casework Section, natural justice must surely require that the victim be offered full and comprehensive reasons for the decision. Instead, victim liaison officers are caught in the crossfire, trying to explain a decision that is not of their making, with frustrated victims struggling to understand why their request was refused.

Providing victims with full explanations for all decisions will make the decisions more comprehensible and therefore more palatable.

Sentencing guidance for victims of MDOs

Feedback in some of the case studies demonstrates uncertainty about what an indefinite detention order might mean in practice. Some of the victims were under the impression that it would be years before the MDO was considered for discharge, whereas in reality, the first review of detention might take place within a year of the trial, and can be initiated just six months after the conviction. When this happens, it can be a shock for the victims. Some felt as if they had been misinformed.

> *When the case went to court, the barrister talked to Arthur's family… and told them that the perpetrator would be sent to hospital, saying that this would be harsher than a prison sentence because the perpetrator was restricted and would need Government permission to be discharged from hospital… The perpetrator was discharged from hospital after three years.*
>
> Case study 9

It is important that prosecutors understand how a detention order under the Mental Health Act works in practice and that they are able to inform the victims accurately and with clarity. Although it may be upsetting for the victims to hear about how soon a case might be reviewed, it would set reasonable expectations and avoid the distress and shock that has been reflected in the case studies.

> *[Ayo's family] were shocked when two years after the original hearing (three years after Ayo and her unborn baby were killed), they were contacted out of the blue by email to say that the perpetrator was going to Mental Health Tribunal and he could be discharged. Ayo's sister received the email on her way to work and was shaking and crying. She had never been informed about what a Mental Health Tribunal is or that this could happen at some point.*
>
> Case study 7

> *David's family feel they would benefit from further explanation about tribunal processes and find it difficult to come to terms with the perpetrator's entitlement to an annual tribunal hearing so soon after the crime. "Why is it automatically put up? He's killed our brother then he's been in hospital for two years and – oh he must be better now?"*
>
> Case study 3

Victim Liaison Officers

Victims of mentally disordered offenders make up a very small proportion of the victim contact scheme. It is likely that there are VLOs who have never been responsible for a victim of an MDO. The processes and entitlements for this group of victims is very different and we sense that some VLOs might struggle to give them the information and advice they need.

Where victims have a good relationship with their VLO and feels confident that they are being properly informed, the Victim Contact Scheme can offer enormous value. This was evidenced by our case studies.

The National Probation Service has recognised that it would be timely to provide all victim liaison officers with refresher training on mental health reviews. This training is scheduled to take place later in 2018. This is something the Victims' Commissioner has called and she very much welcomes this commitment. Hopefully it will assist the officers in supporting this group of victims. It is important that managers in the VCS seek feedback from victims of MDOs in order to be satisfied they are getting the support they need.

Kate valued the initial face to face meeting with the VLO and felt this helped them to build up a good rapport. Kate also appreciated her VLO's considerate methods of communication such as putting a warning in the header of an email when the email content might be distressing or upsetting for Kate. Kate described her current VLO as sympathetic, "knowing how to deal with real life people, real traumas."

Case study 4

Given the variation in practices between the parole process and mental health process, and given the complexities in securing information from NHS Trusts and hospitals, there might be a case for victim liaison officers who specialise in supporting victims of MDOs. This specialism might provide victims of MDOs with a more tailored service. This would be welcomed by victims.

Conclusion

This short report highlights the inequality of treatment and entitlements between bereaved victims of MDOs and those bereaved by offenders serving a sentence under the criminal justice system. These inequalities are about to be exacerbated as a result of the Government's recent parole process review.

The report highlights how some victims are struggling to extract information. It suggests that some officials may struggle to provide accurate information about a mental health review system that is unfamiliar to them.

The recommendations at the top of this report do not require primary legislation. The numbers of victims affected by our recommended changes are sufficiently small to mean that the resource implications for providing equitable treatment will be minimal.

There are opportunities to address these shortcomings, either as part of the Government's National Victim Strategy, or its Mental Health Act Review.

The time has come to act.

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Annex A: Case Studies: experiences of victims of mentally disordered offenders

Case Study 1: Nicholas

Megan became a victim of a mentally disordered offender overnight. Her son, Nicholas, was severely beaten in an unprovoked attack by someone known to him. Nicholas later died as a result of the injuries he sustained. The perpetrator had known mental health issues and a history of offending. At the time of the attack, the perpetrator had been excessively drinking alcohol despite being repeatedly warned that he should not be drinking alongside the medication he had been taking.

Megan lives abroad, and after Nicholas' death was flying back and forth to arrange her son's funeral and to attend the trial of the perpetrator. Megan was not allowed to bury her son for 9 months as the defence would not release his body to his family. The defence conducted 3 post mortems on his body before he could be buried. This was extremely distressing for Megan and her family.

When the attack on her son went to trial, on the first day, the perpetrator admitted manslaughter by reason of diminished responsibility, which was accepted by the CPS. This meant that Megan didn't get to have her say during the court process about what had happened to her son, and the impact it had left on herself and her family. During the hearing the court determined the perpetrator to be mentally disordered and he was detained under the Mental Health Act 1983 Section 37/41 as a restricted patient. This means that the perpetrator was to be held in a secure hospital without limit of time; only the Secretary of State for Justice would be able to approve his release.

The perpetrator received treatment as part of his detention at the secure hospital. Seven years after the perpetrator had been detained, he applied for the first time to the Mental Health Tribunal to request a move to a lower security hospital. This new hospital would have the option of day release. Megan's understanding is that such a move would be part of the process to rehabilitate the perpetrator back into society and prepare him for discharge into the community.

Megan is concerned about the possibility of the perpetrator being allowed out on day release. Megan is particularly worried that the perpetrator might attempt to visit her son's grave, as well as the possibility that her grandson may come face to face with the perpetrator. Megan wanted to be able to express this, and her concerns about the perpetrator's eventual discharge directly to the Mental Health Tribunal. Megan wanted her concerns to be considered when the decision about moving the perpetrator was made.

Megan was given two months' notice that the tribunal would be meeting to discuss moving the perpetrator to a lower security hospital. Megan put a letter together setting out her representations, including the conditions that her family requested the

perpetrator follow if he was to be allowed on day release, and eventually discharged. Megan asked to be able to attend the tribunal hearing so that she could discuss her concerns in person, but was told that this wasn't allowed. In an administrative error, the name and contact details of the judge on the tribunal, and the hospital at which the perpetrator was being treated, were included in this correspondence. Using these details, Megan wrote directly to the judge, explaining her position with supporting documents, and requesting permission to attend the tribunal hearing so that she could have her voice directly heard before a decision was made. Megan had booked tickets to fly over to participate in the hearing and had made the tribunal aware of this, but she still did not get a response to her email. It was not until Megan was boarding a plane to England, three days before the tribunal hearing was due to take place, that Megan received an email from her VLO saying that the perpetrator's application had been removed and the tribunal hearing would not be going ahead.

Megan found the delay in communication received about the hearing extremely cold. In her experience so far, there has been a real lack of recognition or understanding that Megan and her family live abroad. Megan feels strongly that the system should not treat every case the same but should show consideration and compassion for families who will find it difficult to participate, such as families who live further afield and abroad.

Since this first tribunal attempt, the perpetrator has submitted a second application to move to a lower security hospital. Again, Megan was told that she would not be allowed to attend. The perpetrator's application to be transferred was again rejected. Megan feels that if the application comes before the Mental Health Tribunal again then she would want to have her say. In the meantime, Megan has had no reassurance that the conditions she requested that the perpetrator adhere to if he is moved or discharged, will be accepted by the tribunal. Megan feels as though the tribunal does not care about her and that she is simply a nuisance for them to deal with: *"they are really cold people. It feels like they don't care, we're a nuisance to them. They sit on their tribunals and think they have the power and they do, there's no justification for the way they're treating people."*

Megan's main source of information has been her VLO. Megan has had the same VLO since the perpetrator was detained in hospital and describes her as *"absolutely marvellous"*. They are in contact a couple of times a year and Megan finds her as informative as she believes a VLO can be.

Despite her positive relationship with her VLO, Megan feels that there is not enough information out there to help victims who have to go through these experiences. All Megan had been given about the process itself was a government paper which she found uninformative, unhelpful and lacking in compassion.

Currently, all Megan knows about the perpetrator is that he is still being detained in hospital and that he is still alive. Megan has been told by the tribunal that she is not allowed to know any more due to patient confidentiality. Yet it is important to Megan to be able to meaningfully communicate with the individuals overseeing the perpetrator's treatment. Megan wants to know that the perpetrator is in a secure place and that he can't hurt anyone else, but this is being denied to her and her family because the perpetrator is a patient. Megan described her family's situation *as*

"being treated as if [the perpetrator] has nothing to do with us". Megan feels that by being a victim of a mentally disordered offender, she had been made to feel victimised all over again as *"a victim of the system".*

Case Study 2: Craig

Craig was killed in 2004 by his long-term friend who was diagnosed with paranoid schizophrenia. The perpetrator was given an order for indefinite detention. Craig's family were told by police and the sentencing judge, that this meant the perpetrator would be held indefinitely. They were told that only the Secretary of State could allow his release. The family thought that this would never be agreed. They were also told at the time that if the perpetrator's mental health recovered he would then have to go to trial again. Craig's family were relieved that the perpetrator would face trial again if he ever improved. This incorrect information[7] has added to their subsequent distress when they have found out that this is not the case.

Craig's sisters were assigned a Victim Liaison Officer (VLO), but they felt that this VLO didn't listen to them and was not able to deal with the emotional vulnerability of Craig's bereaved family members. They thought the VLO '*wasn't equipped for dealing with families of victims of this kind of offence.'*

The family received a letter once a year saying there has been no change in circumstances for the perpetrator and he remains in the same secure hospital unit. They were then '*dumb founded and shocked'* to receive an email from the National Probation Service (NPS) informing them: '*as you are aware… [the perpetrator] has been having unescorted day release.*' The family had not previously been made aware of this and replied to the NPS to tell them so. This was one amongst many events throughout the process that the family found confusing and ill-prepared for.

The family met with a representative of the NPS who discussed the perpetrator's potential move to a less secure hospital unit. They were later relieved to hear that this move did not happen, only to be informed shortly after that the perpetrator will be discharged in May 2018. Craig's family feel they were given misleading and conflicting information.

After receiving little communication from the original VLO, Craig's family received a letter of introduction from who was to be their new VLO, even though they had not been informed that the previous one had left the NPS some time before. Craig's sister felt that this VLO was more helpful and sympathetic, but they felt that the service is dealing with such large numbers of victims of different types of crime and that dealing with victims of homicide should be a specialist role. All the information the family have received about the perpetrator has been from their VLO. They have had no direct contact with the hospital themselves. Craig's family feel the new VLO can only tell them what she knows, but they are told they can't get the information they really want because it is confidential.

[7] The authors are not aware of any incidence of an offender facing trial once their mental health has improved.

Craig's family wrote a letter to the Mental Health Tribunal. They wanted to attend the tribunal and read out their letter in person, but were told this would not be allowed. They were never told why this request was not granted. They wanted to ask the tribunal why the perpetrator is going to be released from hospital. They were told that the tribunal panel consists of psychiatrists and mental health nurses, but they were not sure if the tribunal knew the exact circumstances of their brother's death, they question whether the panel had all the information they needed to make their decision, but any attempts to communicate with the tribunal were refused and the family felt that it was like '*hitting a wall*.' They don't know how the tribunal makes their decision, they asked lots of questions and feel they only get short answers without any proper explanation.

Craig's sisters were told that they can request conditions to be put on the perpetrator if he is to be discharged. They asked for three conditions: that the offender is tagged, that he is required to have regular blood tests to make sure that he is taking his medication and that he is required not to enter their specified exclusion zones. When the offence occurred, the perpetrator had stopped taking his medication and so Craig's family think it is vital that this is monitored if the perpetrator is to be discharged. The sisters want to do what they can to prevent what happened to their brother happening to anyone else. They have been told that information about the offender's medication cannot be shared due to confidentiality and that the perpetrator will not be tagged upon release. A non-contact order will be put in place but they have been told that the exclusion zones the family requested would not be granted. Instead the exclusion zones originally put to the family would be applied. The family were not given any reasons as to why their request was rejected and found the letter informing them of discharge conditions confusing and hard to understand. They want to know whether the perpetrator feels remorse for killing their brother but have not been given this information.

Craig's sisters have recently been told that the perpetrator has been considered for release and that the tribunal was then deferred. They were told that everything needs to be put into place such as the perpetrator's new accommodation and his treatment team. They want to know what will happen to the perpetrator if he reoffends. None of this has been explained clearly to the family and they find it very confusing.

Craig's sisters' main frustration is the lack of communication. They don't know who is on the tribunal panel, they can't express their concerns directly to the panel and so they don't feel as though they are being heard or included in the process. Fourteen years ago, when they attended the original court hearing, they thought that they had been heard. They now think that they were not heard at all and they report having lost trust in the system. The lack of information and communication leaves them with no reassurance that the perpetrator has changed or that what happened to their brother will not happen to someone else when the perpetrator is discharged. They are concerned about the future, about what happens in five to ten years' time when the tribunal members have moved on. The family have received no reassurances about how the perpetrator will be monitored in the future.

Craig's sisters report that the lack of information and the confusing communication has had a severe emotional impact on them. When they hear some new or conflicting information '*it stirs it all up and causes loads of stress… [they] wish those involved would get what it's like for families.*' Craig's sisters describe how they '…*get some kind of closure then it all gets back. It's really hard*!' They report that what would make the whole process better for them would be to be kept informed about whether the perpetrator's mental health is improving, to be informed about safeguarding procedures on the perpetrators release, and to know who is accountable if things go wrong.

Case Study 3: David

David was killed by his landlord in the home they shared. The perpetrator had a history of mental health problems and had not been taking his medication when he killed David. The perpetrator's mother had taken him to hospital twice that day for help but the perpetrator went missing before he could be seen by doctors. That evening, after going missing from the hospital and his mother, the perpetrator went home. He then brutally and fatally attacked David.

The perpetrator was sentenced to an indefinite hospital order. The judge reported that he was suffering from schizoaffective disorder and he was sent straight to a secure hospital from court.

David's family's main source of information about the perpetrator is their VLO. The person in this role has changed a number of times. They have not met their current VLO in person, all contact has been by email or telephone. The family often chase the VLO for information, contacting them to find out if the perpetrator is still in hospital.

When the perpetrator went to the Mental Health Tribunal, David's family received some advice about making representations for discharge conditions from police officers and their Victim Liaison Officer (VLO). Most of the exclusion zones were granted but their request to exclude the perpetrator from the local city centre was not granted, it was said to unrealistic. David's family said they '*tried to be balanced [in their request], but [we] just don't want to bump into him.'*

The perpetrator was released and within approximately three months he was recalled to the secure hospital. David's family asked for details about why the perpetrator was recalled to hospital but were told they could not be given this information due to patient confidentiality. David's family think that the perpetrator must have done something serious or hurt somebody to get recalled. The family feel that they should be able to access this information for peace of mind but they say: '*it's a wall you can't get over whoever you are.'*

More recently, David's family were told that the perpetrator was moved to a less secure hospital. They would like to know where the hospital is for their own peace of mind, but again they were told they are not allowed to know where he has moved to

due to patient confidentiality. They have been given no explanation about the implications of moving to a less secure hospital or what that entails for the perpetrator.

David's family say that the level and timeliness of information received from VLOs has been variable. The family think that some VLOs may have told them more than they should have while others have to be chased to provide any information. "*VLOs vary, it depends how much you bug them. I'd rather go direct to people but they filter communication. Some are proactive, some we won't hear from. The second one gave more communication, was more personable, more understanding of our situation. The first one was like a computer – you can't do this, can't say that. I've heard nothing, the VLOs don't say I'll try and find out, you have to ask.*"

Victims' of mentally disordered offenders are not entitled to make a Victim Personal Statement, but the family aim to write a letter expressing their views for each of the tribunals. They fear they may have missed some tribunals due to a lack of information. David's family feel strongly that they should have the right to express their feelings about the discharge of the perpetrator and whether the tribunal members would be sufficiently confident in their decision to discharge the perpetrator that he would be of no danger to the public. They ask that their letter is distributed to all members of the Tribunal to ensure their views are heard.

The family have been told by their VLO that they should not include anything in the letter that would offend the perpetrator and they feel strongly that they do not want the perpetrator to see this letter. They have not had any feedback about whether the perpetrator has seen their letter. David's family hopes that the panel will take into account what they have written. They have not received any information about how their letter will be used in the tribunal process, or how it has been used by previous tribunals.

David's family feel they have little insight into what criteria are used to judge whether the perpetrator is released. They would like to know more about the experience of the people in the tribunal and what qualifies them to make their judgement. The family want further information to be reassured that the best quality decision is made in the interests of public safety, rather than purely in the interests of the perpetrator.

For the first tribunal David's family wanted to ensure that the panel saw photographic evidence from the scene of the crime. They pursued the police themselves in order to ensure that the photographs were sent to the tribunal. "*We know so little about the process, it could be a balanced process, we don't know. We want to make sure that evidence is seen. The police were helpful in doing that. Maybe photos are part of the tribunal, but we want to make sure.*"

David's family would like the opportunity to attend the tribunal. David's brother would like to face the tribunal and ask them '*Are you so convinced that he won't hurt anyone that you would have him live next door to you or your children? Look at what he did after the arguments of the experts who persuaded a previous tribunal to release him. Is he really safe enough that he won't hurt anyone again… It is important to me they understand the strength of my conviction. Representatives of*

[the perpetrator] can do this, they don't just submit charts, they can advocate on his behalf. People can be influenced strongly. This seems unbalanced to me. '

David's family feel they would benefit from further explanation about tribunal processes and find it difficult to come to terms with the perpetrator's entitlement to an annual tribunal hearing so soon after the crime. "*Why is it automatically put up? He's killed our brother then he's been in hospital for two years and – oh he must be better now?"*

David's family feel that the whole process is focused on the needs of the perpetrator and they have to battle to get any of their needs met. The family are determined to get as much information as they can, they aim to learn about the system and to vocalise their concerns, but worry for other victims in their situation who are perhaps not as vocal. "*I worry for some people. You have to be pushy, persistent to get the result. What about people who are not as confident, who looks after them?"*

David's family say they are concerned for the safety of the general public if the perpetrator is discharged. They want to know that the tribunal would be sufficiently confident in their decision that they would think he would never carry out such an atrocity again. They see the mental health tribunal process as very much in favour of the perpetrator due to issues around patient confidentiality. They feel that the victims' family should have a greater insight and say in what happens in the tribunal process and when considering release, priority must be the safety of the general public.

Case Study 4: Jonathon

Kate's husband Jonathon was killed in a vicious attack by a stranger in 2014. Jonathon was in a café when the perpetrator came in arguing with his friend. The perpetrator was highly agitated and called out to Jonathon who in turn asked the perpetrator if he knew him. The perpetrator told Jonathon that he was going to kill him and unprovoked, proceeded to stab Jonathon repeatedly in the upper back and then the heart.

The perpetrator had a history of mental illness and had stopped taking his medication at the time of the attack. The sentencing hearing took place one year after the attack and the court heard that the perpetrator was suffering from schizoaffective disorder at the time. The perpetrator was sentenced to an indeterminate hospital sentence. Kate and her family were told that the perpetrator would spend at least five years in a named high security psychiatric hospital.

In 2017 the perpetrator applied for a Mental Health Tribunal which he cancelled at the last minute. Kate was relieved but felt like the perpetrator was calling all the shots. A new tribunal date was set for early 2018. Kate's VLO informed her that this was then moved to take place two months later. Neither the VLO or Kate had been told that the perpetrator had already been moved to a lower security unit at this point. The Mental Health Tribunal granted the perpetrator a Conditional Discharge and he was released on the day of the Tribunal Hearing. This was only three years and

eleven months after killing Jonathon. She was not told the reasons behind the decision to discharge the perpetrator and would like to know whether he has undertaken any courses in hospital and how he has responded to treatment. She feels that the short time he was in hospital cannot be long enough to rehabilitate the perpetrator and Kate has no idea whether the perpetrator has shown any remorse for killing her husband. "*They should take away the secrecy that shrouds [the perpetrator], it's threatening. We are allowed to know so little. I'm always asking 'what' and 'why' but why can't we know? [The perpetrator] is protected but we are not. We're left to get on with it. I am now a single parent, left to bring up the children. The horror, the trauma, yet I am not allowed to know if he has a new name. We have no safety, no security, it's like bashing your head against a brick wall."*

Kate has had three VLOs in the Victim Contact Scheme. Kate finds her current VLO the most helpful and understanding. Kate valued the initial face to face meeting with the VLO and felt that this helped them to build up a good rapport. Kate also appreciates her VLO's considerate methods of communication such as putting a warning in the header of an email when the email content might be distressing or upsetting for Kate. Kate describes her current VLO as sympathetic, '*knowing how to deal with real life people, real traumas.'* But Kate feels that the VLO is limited in how much information she has access to that she can share with Kate.

Kate and her VLO did not know that the perpetrator had previously been moved to a lower security unit when the tribunal was held in March 2018, and the VLO didn't think it would be possible that the perpetrator could be released on the day of the tribunal. This meant that Kate was totally unprepared for the news that the perpetrator was released which increased her feelings of anxiety about her and her family's safety. Kate and the VLO are under the impression that the decision to discharge the perpetrator had been made in January and the tribunal were preparing the papers to discharge the perpetrator between January and March, but this cannot be corroborated.

Kate would like to have more information about the perpetrators discharge condition relating to his medication. "*I just see him as a big threat. I want to know that he can't come off his med's. I know that he was previously ill and he came off his meds when he killed Jonathon."*

Kate would have liked to have had more of an input into the Mental Health Tribunal. All that she could submit was a couple of sentences from the Victim Personal Statement (VPS) that she prepared for the original sentencing hearing. Kate would have liked to submit a new VPS to fully inform the tribunal of the devastating, on-going impact of the perpetrator's actions. Kate would not have felt able to face the perpetrator herself by attending the tribunal, but would have wanted a family member or her VLO to attend on her behalf to read out a new VPS. This representation of Jonathon's family at the tribunal was denied to Kate. This adds to Kate's feelings of being left out of the process and having no voice in the tribunal. *"We have a life sentence without Jonathon. As the wife of the man he killed, I am irrelevant. Even a couple of updated sentences [of a VPS] would give part of the impact on my life. [This would] show more respect."*

Conditions of the perpetrator's discharge include a non-contact order preventing him from contacting Kate and her family and a small exclusion zone where Kate lives and the perpetrator is not allowed to go.

After the first sentencing hearing Kate's VLO helped her to apply for exclusion zones should he ever be released. The VLO said this would send a clear message to the perpetrator that he could not go near Kate and her family. Kate requested an exclusion zone of two counties. Five months later the perpetrator challenged the exclusion zones and won, resulting in the current small exclusion zone of one segment of a county which Kate feels makes her family's home area easily identifiable to the perpetrator. Kate was told that the requested exclusion zones were not proportionate for the perpetrator, but feels that "*what he did to us was not proportionate*!"

Kate has asked to be informed of the approximate area that the perpetrator is living in so that she can avoid going to that area. She has been told that she is not allowed to know this information. This lack of knowledge about the perpetrator's whereabouts leaves Kate feeling even more anxious for the safety of herself and her family and this affects the way that Kate lives her life on a daily basis. *"It's the hardest thing. I want to make sure that I don't go to that part of the country but I don't know where he is living. It affects my behaviour. I'm vigilant most of the time, constantly looking over my shoulder. I haven't travelled. I have no idea where he is. If I did, I would just avoid it. I am always wondering… what if I see him? I have become paranoid. He took Jonathon for no reason. He's done it once he could do it again. It's the not knowing that's the worst thing!"*

Kate feels that all the rights and entitlements are biased towards the perpetrator. "*The man killed my husband. You would think I do have a few rights, but no, no rights at all. I don't feel free, it's a horrible feeling… I feel very vulnerable. I have lost my trust in people. How can a man so ill, walk the street?... If we could know more and be listened to, but we are utterly side lined. It is all about [the perpetrator's] care and rehabilitation.'*

Case Study 5: Mark

Mark was killed by his lodger in 1997. The perpetrator received an indefinite hospital order and was sent straight to a high security psychiatric hospital as a restricted patient. Mark's family were told by the crown prosecutor that this was the best the family could hope for, but they were warned that the perpetrator might be released at some time in the future.

Mark's family were not allocated a Victim Liaison Officer (VLO). They did not hear anything further about the perpetrator until 2011 /12 when a family friend bumped into the perpetrator by chance in a local hospital. The perpetrator was on his way out of the hospital on an escorted fishing trip. This hospital was far from the high security unit that the perpetrator had been sent to and the family had never been told that the perpetrator had been moved, much less that the hospital he had been moved to was less secure.

Mark's family were distressed to find out this news from their family friend. They didn't know where to turn to get up to date information. They contacted the police force that was involved in the case at the time. The police suggested that there was little they could do because of the hospital setting and suggested that Mark's family contact a VLO. They sought advice from their local MP who also suggested they contact a VLO and that was how Mark's family managed to make contact with the Victim Contact Scheme in 2012.

Mark's family have had three different VLOs and describe the contact with them as '*sporadic'*. Problems in communication have occurred, particularly when the case has been handed over to a new VLO. At times the Mental Health Tribunal had been and gone by the time the new VLO has contacted Mark's family to let them know.

The perpetrator's final Tribunal was held in October 2017. The family were not informed about this Tribunal until 21 days after it took place. At this point they were informed that the Tribunal had decided to give the perpetrator conditional discharge. Mark's family asked how the decision was made by the Tribunal, but were told they were not allowed to know that.

The perpetrator was discharged on conditions earlier this year, though the family were told about this after his release. They have not been allowed to know the perpetrator's whereabouts or anything about him. The family had initially asked that if the perpetrator was ever released he should not be allowed to return to the area where he killed Mark. The family have been told that this condition was included on the perpetrator's conditional discharge order. The family was also asked if they would like to set out some exclusion zones so that the perpetrator couldn't go into areas where the family live when he was released. Mark's family wanted to request exclusion zones, but chose not to in the end because they felt that the ones which would be granted would highlight where the family live to the perpetrator and they didn't want him to know that.

Mark's family say they have '*lost faith in the system'* and that the rights of the perpetrator have been more important than the rights of Mark and his family. They feel that without the chance encounter of their family friend with the perpetrator in a hospital, they would not have got in touch with the Victim Contact Scheme themselves or received any information at all. They think there should be greater sharing of information, giving people more choice about the information they receive. As '*lay people in the system'*, Marks family had to struggle and carry out research to find out how the system works for themselves. More information about processes and about the movements of the perpetrator would have helped Mark's family to cope with the situation, though ultimately their main hope was that the perpetrator would never be released and if he was, that their friends and family members would not have to come face to face with Mark's killer in the street.

Case Study 6: Claire

Claire was in her early twenties when she was killed by her boyfriend in what the Judge described as a '*most distressing*' case. The perpetrator had been suffering from schizophrenia, but Claire had not previously been informed of his condition. On the day that he killed Claire, the perpetrator had been to his local medical practice where he was assessed and deemed not to meet the criteria for detention under mental health legislation.

The incident and subsequent criminal and medical processes occurred in Scotland which has significantly different procedures than those followed in England.

In the immediate aftermath of the incident, the perpetrator displayed signs of total alienation of reason and could not appear before the Sheriff. He was transferred from a local mental health hospital to a state hospital within a few days of Claire's death. The Crown accepted a plea of insanity, there was an examination of the facts of the case and at the end of the presentation the jury was instructed to acquit the perpetrator on the grounds of insanity. The judge imposed a compulsion order and a restriction order. The Scottish Cabinet Secretary for Justice had ultimate responsibility for the perpetrator's eventual discharge or any change in circumstances.

There had been some confusion about the Crown's acceptance of the perpetrator's plea of insanity at the time. There was a point when the perpetrator was deemed fit to proceed and understand the court proceedings and he would be charged with murder. Claire's immediate family were not allowed to attend the preliminary hearing because they were considered as prosecution witnesses. Other family members attended and said that the Crown then accepted a plea of insanity despite the family being told that he would be prosecuted for murder.

Claire's family were allocated a Victim Liaison Officer (VLO). They got on well with the VLO, who showed great sympathy with the family's situation. However, the VLO felt that the family were not being supplied with adequate information. She disagreed with the person dealing with the case at the Crown Office and Procurator Fiscal Service and was subsequently taken off the case. From this point on, Claire's family did not have a VLO and received any information directly from the Crown Office.

After the examination of the facts, Claire's family were told that the perpetrator was not convicted of a crime and would be treated as a patient. They were told that the perpetrator would never get any better, that he was a very dangerous individual who could only be controlled through drugs and on-going treatment. Claire's family received no further information about where the perpetrator was being held, and no information about changes in circumstance or treatment programmes.

Five years after the examination of the facts hearing, Claire's family received a letter from the Mental Health Tribunal for Scotland to say they had received an application for the offender to be discharged into the community.

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a statutory right for any party that has an interest to make representations to the tribunal either orally or in writing. The letter also advised Claire's parents to seek independent legal advice on the matter which they did.

Their solicitor advised Claire's family on making representations for conditions to be applied upon the perpetrator's release. They asked that a condition be set which would prevent the perpetrator from contacting them either directly, indirectly or through social media. Claire's family asked for exclusion zones which included areas where family members lived, where Claire was buried and where Claire had gone to university at the time of her death. Family members did not want to bump into the perpetrator when going about their daily lives. Initially, the family were advised that exclusion zones of only a few streets would be likely to be granted. The family were asked for further reasons as to why they had chosen the specific areas which they provided to the tribunal.

In Scotland, victims or interested parties can attend the Mental Health Tribunal, and Claire's family took the opportunity to present their point of view to the tribunal. The Tribunal was concerned that Claire's family should not have to come face to face with the perpetrator and convened a separate hearing which Claire's father and brother attended. This meeting was also attended by the perpetrator's legal representative and mental health representatives from the Scottish Government. Claire's father presented her family's statement to the Tribunal. The panel consisted of the Sheriff (Scottish County Court Judge), an independent psychiatrist and a lay member. In his statement, Claire's father expressed the reasons why their family thought the perpetrator should not be discharged. The Tribunal was held just five years after being told that the perpetrator was a threat to the public and his condition would deteriorate unless he is controlled by drugs. They asked how the perpetrator could go from being a threat to the public with a lifetime restriction order imposed on him to now being ready to be discharged into the community in such a short space of time. Claire's father expressed the dreadful impact of Claire's horrific death on their family.

Claire's family felt they got a fair hearing from the Tribunal and described the psychiatrist in the Tribunal as being '*extremely sympathetic'.* The panel asked questions and '*seemed to take on board what [the family] had to say.'* When an opportunity was given to the perpetrator's legal representative to ask questions of the family, she declined to do so.

The Tribunal held a separate hearing with the perpetrator in attendance. Two months later, Claire's family were informed that the perpetrator would be granted a conditional discharge. They were not informed of the reasons for the decision to discharge the perpetrator but were told all the conditions attached.

Claire's family feel that it would have been helpful to see representations made to the Tribunal by the perpetrator's psychiatrist, even if some of the more confidential aspects were redacted. They feel it would have helped them to understand how the perpetrator has gone from someone described as being very dangerous, to someone who is allowed back into the community within five years. *'[We] understand there is confidentiality to some extent, but for someone who has committed an appalling act,*

which had immeasurable consequences, for our daughter and for family and friends, some of whom are still deeply traumatised by what happened. [We] do feel at times, far too much emphasis on protecting the rights of the patient and not telling us what was going on. Can they not see having committed the act he did, a lot of people feel vulnerable now he's out in the community?'

The perpetrator is required not to contact Claire's family. The exclusion zones requested by Claire's family have been put in place. The authorities were not able to tell Claire's family where the perpetrator would be living when he was discharged. They later found that the perpetrator was living just 3 miles from Claire's family, when the press released pictures of him in the local area and reprinted pictures and sensationalist details of Claire's death which the family found to be extremely distressing.

Claire's family have been told discharge conditions related to the perpetrators continuing medical treatment and supervision. They were told that the police in the area he is living will be made aware of his presence and are advised to take immediate action should the perpetrator commit even a minor offence.

Although ultimately, Claire's family did not agree with the decision to discharge the perpetrator, they did feel that it was helpful for them to attend the Tribunal and put their views. *'[Claire's family] … did feel given a voice, and one of the few occasions in the whole process [we] felt [we] had a voice and able to articulate our position… [We] don't think that by putting forward our views…it in anyway inhibited the tribunal from making a decision. [We] thought it only fair and reasonable for the Tribunal to hear our side of the story. They needed to know what happened.'*

Case Study 7: Ayo

Ayo and her unborn child were stabbed multiple times and killed by her partner, an illegal immigrant to the UK. Ayo's family had not been aware that the perpetrator ever had a history of mental illness, though they later found out that he had been to visit his GP at least once about mental health issues.

Upon being arrested the perpetrator was taken to hospital due to his self-inflicted wounds. He was then arrested and was determined to be mentally disordered. The court hearing took place a year later and the Judge told Ayo's family that the perpetrator would be held indefinitely as a restricted patient in a secure hospital. They were also told that because he was an illegal immigrant, the perpetrator would be deported if he should ever be discharged from hospital.

Ayo's family were allocated a Victim Liaison Officer (VLO). Their VLO visited the family and explained how the Victim Contact Scheme works. Ayo's family decided to join the Victim Contact Scheme so that they would be notified about any changes in circumstances for the perpetrator and to be sure that the perpetrator would be deported if ever he was discharged from hospital.

Ayo's family found communication with the VLO to be very one-sided with them having to contact the VLO and ask for updates about the perpetrator. The normal response from the VLO would be '*don't worry, the perpetrator is still under lock and key'*. Ayo's family expected that if there were any significant changes, they would be contacted by telephone or in person and then this would be followed up with an official letter. They were shocked when two years after the original hearing (three years after Ayo and her unborn baby were killed), they were contacted out of the blue by email to say that the perpetrator was going to Mental Health Tribunal and he could be discharged. Ayo's sister received the email on her way to work and was shaking and crying. She had never been informed about what a Mental Health Tribunal is or that this could happen at some point.

Ayo's sister telephoned her VLO and arranged to meet her in person who then explained how Mental Health Tribunals work and how they are different from the prison system. The VLO told Ayo's sister that '*indefinitely didn't mean much under mental health law*.' The family were shocked that the perpetrator could be considered for discharge following such a brief time in hospital after killing Ayo.

Ayo's family contacted their local MP to seek support in communicating with the mental health authorities. Their MP wrote to the perpetrator's mental health case worker who informed her that the perpetrator had been going out of the hospital on escorted visits for the past two years. Ayo's sister had opted into the Victim Contact Scheme to gain updates on this sort of information about the perpetrator and despite knowing about the escorted visits, the VLO had not told the family. The VLO later told the family this omission was because '*she was overburdened with numerous cases*.'

With their MP's help, Ayo's family secured a thorough investigation by the Ministry of Justice into what information the family had not been kept up to date with about the perpetrator. This investigation detailed how the perpetrator had been on escorted leave for the previous two years. This included attending classes at a local Further Education College which was close to where Ayo's mother lived and the house in which Ayo and her unborn baby were killed by the perpetrator. Other escorted visits were to the local town centre where most of Ayo's family live. The family also found out that the perpetrator was being held in a local hospital in which one of Ayo's sisters frequently works. Ayo's family had never been invited to make a request for exclusion zones.

Since that first tribunal, the perpetrator has taken up his right to request an annual tribunal. Ayo's family have normally been notified of the tribunal two months in advance. They have been told that they can make an '*impact statement',* but at the same time have also been told that under the mental health law this statement would not be taken into account. Ayo's family always make a statement, but feel that it '*probably just sits in a file somewhere and is not considered.'*

As well as taking up his right to an annual tribunal, the perpetrator also takes up his right to appeal the decision of the tribunal each year. He has occasionally decided to withdraw his appeal at the last minute. Ayo's family also prepare a statement for the appeal. Ayo's sisters describe this as '*double trauma… re-living the nightmare of the offence.'* She says going through this process twice a year is '*torment'* going on to

say that '*I haven't even had time to grieve and now we [Ayo's family] are caught up in a nightmare scenario in the mental health system.'*

Ayo's sister would like to attend the tribunal hearings. She wants to understand more about how the tribunal works and she wants the tribunal members to meet her family and to see their grief. Each time there is a tribunal or appeal hearing, Ayo's sister is sent a form asking her if she would like to attend. She ticks the box to say she does want to, but has never had a response. She normally receives notification about the results of the tribunal within four weeks.

Since finding out about the perpetrator's escorted leave, Ayo's family have been able to make representations for exclusion zones. The perpetrator has not been discharged and Ayo's family have been informed that he has now been moved to a secure hospital far from the family's home. They receive an annual assurance that the perpetrator is still being securely detained.

Ayo's sister writes to the Home Office every time there is a change of minister to check that the perpetrator will be deported upon his eventual discharge from hospital. Their VLO has told the family that mental health services are likely to support the perpetrator against his deportation upon discharge so that his treatment could be continued in the UK. The VLO informs them that this is because the perpetrator's country of origin does not have the appropriate facilities to cater for the perpetrator's mental health needs and as a result, the authorities would rather monitor the perpetrator in the UK.

Ayo's sister feels that the perpetrator being moved to another secure hospital and the family now being given more information is due to her determination in chasing up information, meeting with politicians and ministers and raising the family's concerns and experience in the media. She fears for victims of mentally disordered offenders who do not have the capacity to do this and '…*who might still be short-changed by the system*.'

Case Study 8: Danny

Five-year-old Danny was killed by a close family member. The perpetrator was sentenced for manslaughter with diminished responsibility, given an indefinite hospital order and detained as an unrestricted patient. In unrestricted cases, it is down to the discretion of the doctors in the hospital as to what information they share with the victim.

Danny's father, Ben is concerned for the safeguarding of the rest of his family. He has requested to be kept informed about the perpetrator's progress and any possible escorted or unescorted leave, transfer or eventual discharge which may affect his family's safety. Ben's requests have not been met and the health trusts that Ben has been in contact with have refused to give Ben any information about the perpetrator, indicating that to do so would breach the perpetrator's patient confidentiality.

As a victim of an unrestricted patient, Ben is not supported by a National Probation Service Victim Liaison Officer, but must deal directly with hospital contacts to find out information for himself. The hospital contacts that he has been given are from the NHS trust in his home area. They refuse to tell Ben the name of the hospital trust responsible for the perpetrator's care, the names of any clinicians relating to medical treatment or anything about the perpetrator's progress due to patient confidentiality.

While in hospital, the perpetrator attempted to contact a family member by writing letters via Ben. With these attempts by the perpetrator to make contact and a lack of information about the perpetrator's whereabouts, Ben was so concerned that he paid legal fees to take out a Prohibited Steps Order through the Civil Courts to ensure that the perpetrator cannot contact the family member directly or through third parties. The clinicians responsible for the perpetrators care sought to challenge the Prohibited Steps Order, but this challenge was not accepted by the Judge.

Ben has been assigned a series of mental health medical contacts in relation to trying to gain information about the perpetrator. The first was a Mental Health Act Administrator who did not respond to Ben's attempts of contact. The second was a Senior Forensic Social Worker. After not hearing from her for some time Ben attempted to make contact and was told that the individual had moved on from their role and that he would have a new contact, though he had not previously been informed of this change. The third contact was a Mental Health Team Leader. Ben was given an incorrect email address for this individual and had to find out their correct details himself on the internet. When Ben finally managed to get in touch with his third assigned contact, he received an email reply, the first line of which said: '*just to let you know, I'm a very busy person and I'm trying to find you a new contact as I don't have time to deal with you*.' Subsequent correspondence came primarily from the contact's secretary who frequently called him by the wrong name in the emails. Ben was concerned about sharing such private information with other individuals and was not comfortable with corresponding with the secretary. Ben has now been given a fourth contact who is a Forensic Psychiatrist. This latest contact visited the family at home, which Ben thought was an encouraging sign of a better potential relationship, but this contact has also not been able to give Ben any of the information he requires and Ben has now been informed that his requests are a '*grey area'* and have been passed on to the NHS Trust's legal representatives.

Ben has been able to glean some information from the perpetrator's family. When Ben asked his hospital contact to confirm the accuracy of the information, he was told that they didn't inform him due to patient confidentiality and despite the fact that the lack of information was causing him and his family great anxiety, they did not need to know.

A serious case review was undertaken to investigate the circumstances leading up to the incident when the perpetrator killed Danny. The review has not been published due to reporting restrictions imposed by the court. Ben has been allowed to read the review on Local Authority premises in the company of Local Authority officials, but he has not been sent a copy and was not permitted to keep a copy of the review that he read. Ben was not allowed to read the report until a year after the review was completed. Ben feels the case review has identified some serious safeguarding mistakes which led up to the incident. Ben found the letters from the Local Authority

regarding the decision not to publish the review to be lacking in empathy. Ben also put in a subject access request to social services to view the files held about himself. It took five and a half months for Ben to gain access to his files. The lack of transparency from the Local Authority adds to Ben's feeling that he is being shut out of receiving any information about the perpetrator at all.

Ben's constant battles with the medical authorities and Local Authority have contributed hugely to his levels of anxiety and to his concerns for his family's safety. His family ask Ben questions about the whereabouts of the perpetrator. Ben does everything he can to reassure them, but can't give them any truthful answers because he is not provided with the necessary information. '*I know nothing and the perpetrator is in control. There is no reassurance for my family.'*

Case Study 9: Arthur

Arthur was brutally attacked in his sleep by a male perpetrator who was known to him and his former girlfriend. He died from his injuries 36 hours after the attack.

When the case went to court, the barrister talked to Arthur's family in the waiting area and told them that the perpetrator would be sent to hospital, saying that this would be harsher than a prison sentence because the perpetrator was restricted and would need Government permission to be discharged from hospital. Arthur's family believed this was an appropriate sentence because it meant that the perpetrator would be in a secure hospital for a very long time and would have to gain approval from the Secretary of State for his discharge. The perpetrator was discharged from hospital after three years.

An independent serious case review found that the perpetrator had a history of mental health problems and had been in and out of institutions for the previous 30 years. A few days prior to the attack, the perpetrator had reported to hospital to seek help for his mental health illness. The hospital did not have a bed available for the perpetrator and he was cared for in the community. The perpetrator had been violent to the staff caring for him in the community a few days before attacking Arthur. Yet, the case review said that what happened to Arthur could not have been avoided by the authorities.

Arthur's family were allocated a Victim Liaison Officer (VLO). Arthur's sister describes contact with the VLO service as '*rubbish'*, and '*painstaking'*. The family's VLO was changed, but they were not informed about this. The family met the first VLO face to face and found this useful, but hasn't met some of their VLOs at all. One of the VLOs regularly emailed Arthur's sister at her personal email address when she had asked to be emailed at her work address. The family were not informed of their rights to claim criminal injures compensation and by the time they found out about it themselves it was too late for the family to apply.

The VLO liaised with the hospital on the family's behalf, but when the family was not happy with the amount of information they were receiving, they contacted their local

MP. The family describe having to '*scrimp and scrape'* for information, and chasing information '*being like a cat and mouse game, the whole thing.'*

The family were not told which hospital the perpetrator was being detained in or whether he had ever been moved. They were told that the perpetrator had been allowed escorted leave and then unescorted leave around six months after this had started.

The VLO wrote to Arthur's family to inform them of the date of the Mental Health Tribunal. The family made a statement and submitted it to the Tribunal, but they are not sure whether it was read out or how it might have been considered.

Arthur's family were sent some pre-determined exclusion zones. They asked if they could change the exclusion zones to cover the area where the family lived. They are not sure whether these wider exclusion zones were accepted. The family wanted to know if there were any conditions for the perpetrator's discharge regarding his use of drugs and alcohol, but they were told they were not allowed to know this information.

Arthur's sister has found that her own health has suffered greatly since her brother's death. She has found it difficult to access services, waiting three months for bereavement counselling. She feels that the whole process has treated the perpetrator more as a victim, but there has been little consideration for the needs of Arthur's family as victims of such a horrendous crime.

Annex B: Powers of the Tribunals and Parole Board

Powers of the Tribunal (England and Wales)

The test is set out in s.72(1)(b) MHA 1983 for England and Wales (here: http://www.legislation.gov.uk/ukpga/1983/20/contents). This applies to all patients (whether restricted or unrestricted).

Unrestricted hospital orders (s37)

In the case of detained restricted patients subject to a hospital order under s37 MHA, the role of the Tribunal is limited to determining whether it is satisfied:

(i) That the patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to be detained in hospital for medical treatment; or
(ii) That is it necessary for the health or safety of the patient or the protection of others that they should receive that treatment; or
(iii) That appropriate medical treatment is available.

If any one of these statutory criteria is not met, then the Tribunal must order that the patient should be discharged.

Restricted hospital orders (ss37/41)

The same test applies, but the Tribunal must decide whether the discharge should be absolute or conditional.

If the Tribunal is not satisfied that these criteria are met *and* it is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment, then it must direct the patient's absolute discharge.

Powers of the Tribunal (Scotland)[8]

The following guidance is issued to practitioners when considering the legal tests for conditional discharge:

1. [Patient's name] does/does not have mental disorder.

[If yes specify the nature of mental disorder(s)] When was the diagnosis made? What were the symptoms? What are the current symptoms?

2. As a result of [patient's name] mental disorder, it is/is not necessary, in order to protect any other person from serious harm for

[8] The Office of the Victims Commissioner has contacted the Scottish Mental Health Tribunal to confirm the wording of the Scottish statutory test and has not received confirmation at the date of publication.

- **the patient to be detained in hospital for medical treatment or**
- **the patient to be detained in hospital whether or not for medical treatment.**

[Please specify nature of serious harm, who the potential victim may be and how detention in hospital reduces or minimises the risk of serious harm. Refer to HCR-20/ CPA documentation if relevant.]

Note: If this test is met, CD cannot be considered.

3. Medical treatment is/is not available for [patient's name] which would be likely to:

(i) prevent the mental disorder worsening; or

(ii) alleviate any of the symptoms, or effects, of the disorder.

[Please specify the nature and the effect of the treatment provided (see s329 – medication, psychological intervention, nursing, care, rehabilitation, habilitation) is patient currently receiving?]

Are there other treatments available which the patient is not receiving? If so, why not?

How do each of the treatments which are available alleviate symptoms or prevent the patient's metal disorder worsening?

4. If [patient's name] was not provided with such medical treatment there would/would not be a significant risk -

(i) to the health, safety or welfare of the patient; or

(ii) to the safety of any other person.

What would the potential consequences be were the patient not to be provided with any of these treatments?

Would there be a significant risk to the health, safety or welfare of the patient? If so, what is the nature of that risk?

Would there be a significant risk to the safety of any other person? If so, what is the nature of that risk? Refer to HCR-20/ CPA documents.

5. It does/does not continue to be necessary for [patient's name] to be subject to the compulsion order.

[Specify the reasons why.] Why is the compulsion order necessary at this point? [with reference to insight into illness, need for medication/engagement & risks, potential impact of destabilisers/disinhibitors & any history of non-compliance pre or during CORO

6. It does/does not continue to be necessary for the patient to be subject to a restriction order.

Comment on the relevance of the index offence, patient's antecedents, the risk of serious harm to the public if [patient's name] is at large and on the features of the restriction order which are relevant to [patient's name].* Is there a real risk that, without a compulsion order or restriction order, the factors which were relevant to the index offence/previous convictions would re-occur? [ie with reference to risk assessment formulation]

Should those factors re-occur, would the patient pose a real risk of serious harm to others?

In light of the patient's current circumstances and the current risk assessment, what aspects of the restriction order are necessary, and why?

Patient's views, maximum benefit, least restrictions on the freedoms of the patient as are necessary in the circumstances…

[see Annex E – Purpose and Effect of Restriction Order]

7. It is/is not necessary for [patient's name] to be detained in hospital. why are they now ready for CD?)

Why is it not necessary for the patient to continue to be detained in hospital at the present time? [with reference to treatment, need for a level of monitoring and supervision which can be provided in the community, establishment of structure, gradual management of transition, fully tested out and assessment of risks prior to CD etc]

Powers of the Parole Board for England and Wales

The release test in respect of indeterminate sentence prisoners and which is to be applied by the Parole Board for England and Wales is set out in Section 28 of the Crime (Sentences) Act 1997

Life Sentence Prisoners

> (6) The Parole Board shall not give a direction under subsection (5) above with respect to a life prisoner to whom this section applies unless—
>
> (a) the Secretary of State has referred the prisoner's case to the Board; and
>
> (b) the Board is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined.