The Nottingham Inquiry

Mental Health Related Homicides
The Inquiry Legal Team Review
(ILT Review)

May 2026

Index

Section 1: Introduction

1.1. The function of the ILT Mental Health Related Homicide Review is to:

(i) provide a qualitative review of a cohort of cases available to the ILT; and

(ii) identify recurring themes and patterns across the cohort to assist the Chair when making recommendations.

1.2 On 22 May 2025 the Nottingham Inquiry published a questionnaire inviting family and friends touched by fatal attacks to share their accounts and experiences of mental health related homicides. The aim of the questionnaire was to contribute to the Inquiry's wider understanding of mental health homicides beyond the attacks carried out by VC in June 2023.

1.3 The questionnaire sought information in respect of the following: the circumstances of the mental health related homicide, the perpetrator's history and presentation, their clinical and forensic background, the role of state agencies prior to the incident and the steps taken after the homicide to investigate and prosecute. The questionnaire resulted in 67 responses, touching on 44 different cases. Three additional witness statements were also obtained by the ILT, in circumstances where members of the public had relevant information to provide, but their circumstances did not strictly meet the criteria for inclusion in the questionnaire.

1.4 In addition to the information received via the Inquiry questionnaire, the ILT considered all publicly available independent reviews on mental health homicides since the conclusion of the Ritchie Report in 1994. The combination of questionnaire returns and publicly available reports resulted in a dataset of 540 cases. 528 of the 540 cases were subjected to a structured, qualitative review and analysed using numerical and percentage-based summaries.

1.5 The ILT Review covers a substantial proportion of mental health related homicides over the last 30 years. The Review is not a random sample of such events. Inclusion relies upon a case being subject to a publicly available report and/or being volunteered through the Nottingham Inquiry questionnaire. Therefore, whilst percentage summaries are provided, and the percentages are based upon a large number of cases, the selection of cases means that these percentages cannot be

generalised to the total numbers of relevant events, and will not be a complete analysis or representative sample of all such events. The percentages should be understood as descriptive of the cohort of material reviewed, rather than figures which can be readily generalised to the total population of mental health related homicides.

1.6 The names of victims have not been included in this report. Their names, where known, will be included by the Chair as an appendix to her report.

Section 2: Source material

2.1 The ILT Review draws upon three bodies of material, which are addressed below in descending order of the size of each group.

2.2 First, 516 published, independent reports on mental health homicides in England and Wales. This material is all publicly accessible, largely through the Hundred Families website and the NHS England website. The reports analysed have usually been undertaken after a Trust-level report has been prepared. The independent reports include reviews commissioned by NHS England, domestic homicide reviews, serious case reviews, safeguarding reviews, inquiry reports and learning summaries relating to fatal incidents involving individuals in contact with mental health services. The ILT Review has limited itself to reports that explicitly set out to consider mental health care. Coroner's reports and sentencing remarks have, for example, not been used. The materials reviewed span the period from 1994, following the publication of the *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, to 2023 (there are incidents post-2023 that are still awaiting the preparation of independent reports).

2.3 Second, the Inquiry has considered a group of cases brought to its attention by respondents to the Nottingham Inquiry questionnaire. A total of 44 cases spanning attacks from 2003 to 2024 were identified through this process and were examined in greater detail by the Inquiry. Independent and publicly available reports were available in relation to 20 of the 44 cases. In respect of a further 12 cases, reports (some independent and some at Trust level) were obtained from NHS England pursuant to a request under Rule 9 of the Inquiries Rules 2006. Reports obtained were used to supplement the Inquiry's understanding of the relevant case.

2.4 Reports were not available for 12 of the questionnaire cases. These cases have not been included in the structured review or the numerical and percentage-based summaries derived from it. However, the information provided by all respondents has formed part of the overall ILT Review.

2.5 Third, the ILT received information relating to a small number of incidents that did not fall within the criteria for inclusion within the questionnaire but which nevertheless provided relevant insight into the issues under consideration. In those circumstances, the Inquiry invited the provision of witness statements so that the relevant accounts and experiences could be documented and considered as part of the overall analysis. A total of 3 such statements were received and reviewed. These cases have been considered by the ILT in preparing this Review but again have not

formed part of the structured review or the numerical and percentage-based summaries derived from it.

Section 3: Methodology

3.1 Five hundred and forty-three cases (including the three witness statement cases referred to at paragraph 2.5 above) have been considered within the overall thematic analysis of this Review.

3.2 Reports were available in 528 of the cases and this enabled the ILT to subject those cases to a structured, issue based comparison and analysis. The issues were identified following consideration of the points raised in published reports relating to the care and treatment of VC and from other evidence received by the Inquiry.

3.3 The issues considered as part of the structured analysis included:

(a) the date of the attack and the investigation report;

(b) the attacker's clinical history, including their diagnosis and any previous reported symptoms of psychosis;

(c) clinical intervention, such as engagement with mental health services, admission to/detention in hospital and use of medication;

(d) patient engagement with mental health services and their medication regime;

(e) concerns identified by the investigation report, including issues relating to communication between services, engagement with families and carers, the adequacy of risk assessments, care planning and treatment coordination, the experience levels and supervision of staff, the availability of resources, the effectiveness of organisational systems and processes, as well as discharge planning;

(f) steps taken after the attacks, including the adequacy of Trust internal reviews and criminal justice disposal.

3.4 Most of the issues were framed as yes/no type responses. Some fields, such as diagnosis, required a narrative input.

3.5 The ILT applied ‘yes’ if the available information positively indicated the presence of an issue; ‘no’ if there was no evidence on the point. A negative may not therefore necessarily mean the issue was not present, simply that there was no available evidence of the same. That said, if issues of such importance were completely omitted from reports (and the questionnaire responses where applicable) the relevance of the issue may have been limited or marginal in any event.

3.6 Where an issue was not identified in the body of a report, it has not been recorded as present for the purposes of this analysis. Recommendations have been considered with care; however, where a recommendation appears to address a broader or systemic issue, rather than one arising from the specific facts of the case, a judgement has been made as to whether it properly reflects a shortcoming identified in that case. Only those matters assessed as doing so have been included.

3.7 The reports analysed were prepared to investigate clinical and state agency intervention and failures with a view to identifying good and bad practice and recommendations for improved practice. They were not reports prepared for litigation. The causative link between any identified issue and the death was not generally the core focus of the investigation. Accordingly, a positive return in the structured analysis is evidence that the factor was present in the case and relevant to the investigation but not necessarily causative.

3.8 The investigation reports vary in scope, structure and level of detail. At times the information provided appeared internally contradictory, vague or unclear. Further, some of the issues underpinning the ILT analysis were not clear cut when applied to a range of different case reports of differing quality. It is acknowledged that at times a degree of evaluative judgment was required by the ILT reviewers. As a result, the outcome of the structured analysis on particular issues could be open to a reasonable range of interpretations. Auditing of the structured analysis has identified a high level of alignment between reviewers and auditors, with an overall match rate in excess of 95%. The Inquiry is therefore satisfied that any differences in interpretation are limited in nature and do not materially affect the overall patterns identified in this report.

3.9 It is acknowledged that the material reviewed by the Inquiry is, by its nature, a self-selecting sample. The cases included are those in which a fatal incident has occurred and which, for the overwhelming majority, has been the subject

of an investigation report. In addition, all cases in the structured review involve individuals who had contact with mental health services prior to the incident, as it is this contact which typically gives rise to the commissioning of such reports. As explained further at paragraph 5.10 below, such reports should be prepared in all mental health homicides pursuant to Health Services Guidelines published in 1994 (HSG(94)27). The limitation, therefore, is not principally that reports are only commissioned in some categories of case, but that not all reports are publicly available or otherwise accessible for review. It is accepted that publicly available reports could be skewed to cases that have attracted greater public interest and therefore cases where failures by state agencies may be more prominent. The material reviewed may therefore be described as a dataset of available investigation reports - with additional information from the questionnaire responses and three witness statements - rather than a complete sample of mental health homicides.

3.10 It is also acknowledged that the cases have been analysed by a pre-determined set of issues that were deemed relevant by the ILT.

3.11 As far as the structured analysis of the 528 cases is concerned, 496 relied exclusively on publicly available independent reports. The remaining 32 were cases in which a report was available (independent or Trust level) as well as information provided by family or friends of the deceased via the questionnaire. In those 32 cases, the information provided by the questionnaire respondents was integrated into the structured analysis. In the overwhelming majority of those cases, the reports and the questionnaire responses were entirely consistent. Where there was a potential inconsistency, a case-by-case and issue-by-issue approach was taken. On certain issues, the family and friends of the deceased provided information on matters upon which the report was simply silent. In such circumstances it is presumed, where reasonable to do so, that the family/friends had reliable supplementary information to supplement the structured analysis. On certain other issues, for example where there had been incidents of previous intra-familial violence involving the attacker, the respondents provided further information within their knowledge and likely to be reliable, so this was included. Where there was disagreement in respect of the clinical management of the attacker, this was considered carefully on a case-by-case basis, keeping in mind that the reviewers would have had access to the attacker's clinical records as part of the investigation process.

Section 4: Overview of structured analysis findings

Issue	Cases	Percentage of cohort
Attackers identified as male	460/528	87%
Diagnosis of schizophrenia	285/528	54%
Psychotic symptomology	451/528	85%
Previous physical violence	420/528	80%
Previous contact with the police	454/528	86%
Previous conviction for violence	252/528	48%
History of drug and/or alcohol misuse	379/528	72%
Previous contact with mental health services	524/528	99%
Previously admitted to hospital	437/528	83%
Previously detained under the MHA	324/528	61%
Not subject to a Community Treatment Order at the time of the incident	505/528	96%
Never subject to a Community Treatment Order at any time prior to the incident	484/528	92%
Prescribed medication prior to the attack	475/528	90%
Non-concordance with prescribed medication	384/528	73%

Non-concordance with antipsychotic medication	334/528	63%
Concerns regarding compliance with treatment programme generally	455/528	86%
Risk assessment failures identified	467/528	88%
Recording / record keeping and audit concerns	450/528	85%
Concerns as to communication / information sharing / information gathering	483/528	92%
Concerns as to inter-agency communication	440/528	83%
Concerns regarding communication with carers / family	345/528	65%
Family raised concerns about risk prior to the incident	241/528	46%
General treatment failures identified	466/528	88%
Inadequate care planning and coordination	472/528	89%
Oversight/supervision concerns	349/528	66%
Inexperienced professionals/ training issues / lack of reflective practice	304/528	58%
Bed availability / waiting times / delays	175/528	33%
Resourcing issues	240/528	46%
Concerns as to policies / systems / processes / organisational concerns	464/528	88%
Concerns over capacity / incapacity of perpetrators under the MCA	31/528	6%

Previously discharged from hospital or community services	477/528	90%
Concerns regarding discharge planning	402/528	76%
No or inadequate discharge / treatment plan	345/528	65%
Concerns as regards Trust investigations after the event	267/524	51%

Criminal justice – offence outcome

Murder	121/528	23%
Manslaughter on basis of diminished responsibility	282/528	53%
Unfit to plead	20/528	4%
Other	105/528	20%

Criminal justice – sentence/order

Hospital and restriction order	262/528	50%
Hybrid order	12/528	2%
Prison sentence	149/528	28%
Non-custodial	1/528	<1%
Other	104/528	20%

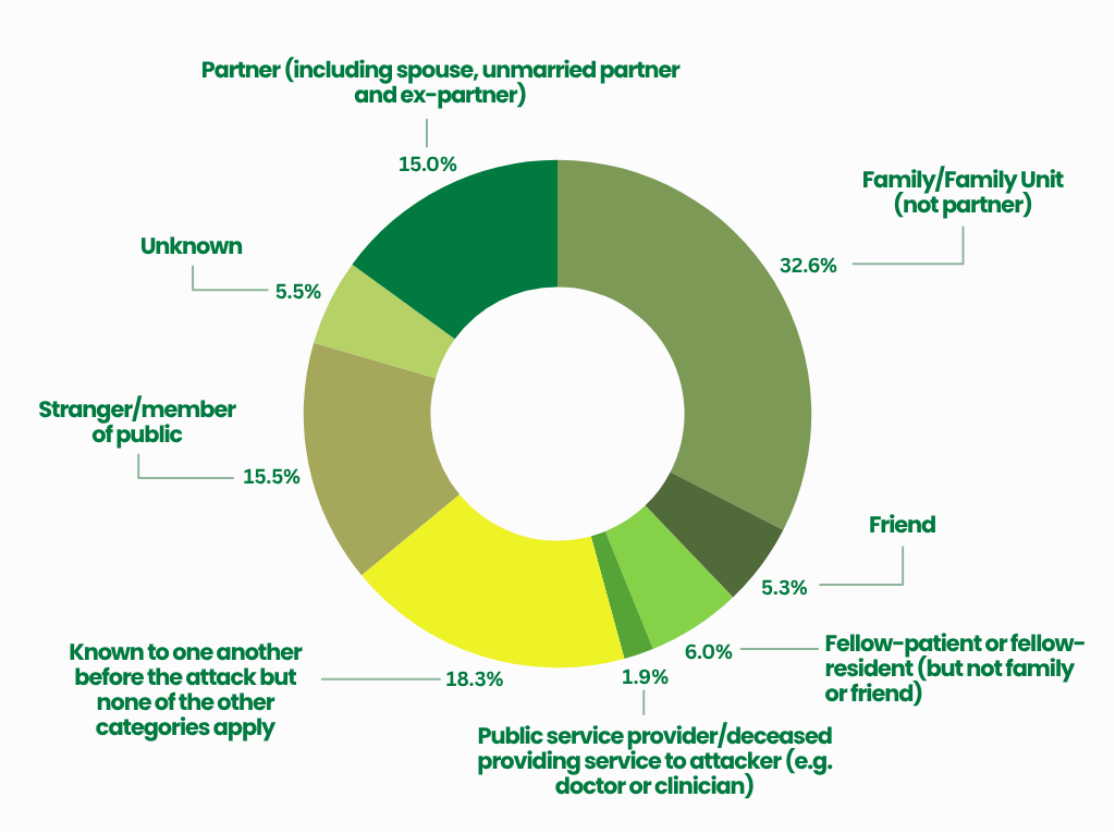
Section 5: The attacks

5.1 The structured analysis considered 528 attacks involving 570 victims.

5.2 87% of the attackers were identified as male. This is comparable to the findings of the *National Confidential Inquiry into Suicide and Safety in Mental Health* for the period 2005 to 2015, which found that 85% of mental health homicide convictions were of men.[1]

5.3 The available source material did not consistently record ages/dates of birth of the attackers, nor their ethnicity. As a result, it has not been possible to undertake a reliable analysis of age and ethnicity.

5.4 The Inquiry also examined the relationship between perpetrators and victims across the cases reviewed. The breakdown is as follows:



[1] Professor Louis Appleby, Director of the National Confidential Inquiry into Suicide and Safety in Mental Health, has provided a statement WITN0069001 and will be giving oral evidence about the work of the National Confidential Inquiry and the data it has obtained

5.5 The approach taken was to record the relationship from the perspective of the perpetrator by reference to the closest relationship at the time of the attack. The category of “partner” includes spouses, unmarried partners and former partners. The category of “family / family unit (not partner)” includes relatives, stepfamily members, in-laws, and others forming part of the same household or wider family environment. The category of “fellow-patient or fellow-resident” includes individuals connected through supported accommodation, medical settings, shelters, care homes or similar welfare-based environments involving placement, referral, support, supervision or other forms of structured oversight. By contrast, flatmates or housemates in ordinary domestic settings, where not otherwise falling within another category, were recorded under the category of persons known to one another before the attack but not falling within the other defined relationship categories. Cases in which the victim was known to the perpetrator but did not fall within the defined categories were recorded separately under its own category. Where the available reports did not identify or clarify the relationship, the case has been recorded as “unknown”.

5.6 In 79% of cases the attacker and the deceased had a pre-existing relationship. Family members (including those within the wider family unit) comprised the largest category (33%). Partners (including current and former partners) accounted for 15% of victims. Smaller proportions included fellow patients or residents (6%), friends (5%), and those providing services to the perpetrator, such as healthcare professionals (2%). In a limited number of cases (6%), the relationship could not be determined from the available material.

5.7 A total of 33 cases involved multiple victims, resulting in the identification of 570 victims across the dataset. For the purposes of this analysis, cases have been treated as involving multiple victims only where there were multiple deceased arising from the same incident, or from incidents expressly considered within the same review report. Cases in which the perpetrator died by suicide following the attack have not been treated as involving multiple victims. In a small number of instances, reports referred to additional victims from separate incidents involving the same perpetrator at different points in time. Where those incidents were not the subject of the review under consideration, they have not been included in the analysis.

5.8 As with other aspects of the dataset, the information available in relation to victim-perpetrator relationships varies in scope and clarity across reports. The figures set out above should therefore be understood as descriptive of the material reviewed, rather than as a complete account of all relevant cases.

5.9 The Inquiry considered information on attacks spanning the period from 1992 to 2023. The number of attacks per year considered in that period ranged from 1 to 31. This is far fewer than the number of incidents per year reported by the *Confidential Inquiry into Suicide and Safety in Mental Health* for the period 2005 to 2015.[2] The difference is likely accounted for by the fact that this review has based its analysis largely upon reports that are available in the public domain.

5.10 Pursuant to *Guidance on Discharge of Mentally Disordered People and Their Continuing Care* in the Community Health Service Guidance 94(27) (HSG(94)27 DOH 1994) reports should be prepared in all mental health homicides since 1994. The policy was modified in 1995 and then significantly changed in 2005. But not all such reports are publicly available at the time of this review. Some of the most recent are yet to be published. For cases from 2013 onwards, NHS England retains reports it has commissioned. Obtaining more historic reports has been greatly assisted by the Hundred Families charity. Although only established in 2015, Hundred Families has a repository of historic case reports but it is by no means a compendious library of all mental health homicides.

[2] WITN0069001_0005 – an average of 58 homicides per year committed by mental health patients

Section 6: Diagnosis and symptomology

Issue	Cases	Percentage of cohort
Diagnosis of schizophrenia	283/528	54%
Psychotic symptomology	451/528	85%

6.1 Where a diagnosis is recorded for a particular case, this is based upon a diagnosis having been reached and identified either by treating clinicians prior to the attack, or, on some occasions, reached by psychiatrists after the event but held to have been extant at the time of the attack. Similarly, psychotic symptomology is marked as 'yes' where this was explicitly identified by (i) treating clinicians before the attack, or (ii) after the attack and identified by psychiatric opinion as being present at or before the time of the attack.

6.2 Schizophrenia features in over half of the cases. Psychosis is a feature of most cases.

6.3 Psychosis was recognised as a significant feature in the following questionnaire cases:

Case #R38

Case R38 concerned a fatal incident in which a man killed his mother and seriously injured his father whilst experiencing an acute psychotic episode.

The investigation report recorded that the perpetrator had presented with paranoid delusions and command hallucinations, including a belief that he was required to kill his mother in order to protect her from a perceived threat. At the time of his first admission, he lacked insight into his condition and did not accept that he required treatment. He was detained under section 2 of the Mental Health Act and later discharged into the community under a Community Treatment Order, following a period of treatment with antipsychotic medication and support from early intervention services.

The fatal incident occurred following a period of apparent stability during which antipsychotic medication had been discontinued. This period coincided with an increase in illicit substance misuse and a number of personal stressors, including the breakdown of a relationship. The investigation concluded that these factors, taken together, were associated with a relapse into a further acute psychotic episode, during which the perpetrator acted on delusional beliefs and hallucinations.

The report identified that, notwithstanding the earlier presentation involving threats towards his mother and the known risks associated with relapse, insufficient consideration had been given to the potential for serious violence within the family setting. In particular, the investigation concluded that the risk arising from the interaction between substance misuse, relapse into psychosis, and the perpetrator's continued residence with the family member he had previously threatened had not been fully explored.

Case #R24

Case R24 concerned a fatal incident in which a woman carried out a series of unprovoked and sustained attacks in a public setting, using a kitchen knife and improvised weapons. The perpetrator initially struck a man in a public setting before entering a public premises, where she stabbed a number of individuals and continued to attack others. One victim, who attempted to intervene, was subjected to repeated blows and later died from blunt force trauma to the head.

The investigation report recorded that the perpetrator was suffering from a severe psychotic illness at the time of the incident, later diagnosed as schizophrenia. She experienced persecutory delusions and auditory hallucinations, including voices telling her that others were going to slit her throat. She had ceased taking her prescribed medication due to its side effects and, in the period leading up to the incident, was described by clinicians as “floridly psychotic” and “tormented by voices”.

In the hours and days preceding the attack, there were clear indicators of acute deterioration. Family members reported that she was in crisis and actively sought assistance from services. Clinical records from a recent admission noted distress, aggression, non-compliance with medication and active psychotic symptoms. Nursing staff considered that detention under the Mental Health Act was warranted. However, this view was not shared by the assessing doctors, who concluded that the criteria for detention were not met. The fatal incident occurred shortly thereafter, during a period in which the perpetrator remained untreated and actively psychotic.

Section 7: Violence and police contact

Issue	Cases	Percentage of cohort
Previous physical violence	420/528	80%
Previous contact with the police	454/528	86%
Previous conviction for violence	252/528	48%

7.1 In the ILT's structured analysis, violence is defined as the application of unlawful physical force upon another person (i.e. a battery at common law). The requirement of the use of physical force provides a definition that could more easily be applied across a wide range of cases in which a variety of behaviours were described with various levels of detail. Cases involving assaults without the application of unlawful physical force are also not included. Violence against property and animals is excluded, as is self-harm. The figures above may therefore be an underrepresentation of the presence of previous violence using other definitions.

7.2 The ILT analysis indicates that previous violence is present in the vast majority of mental health homicides. This data sits consistently with other evidence heard by the Inquiry.[3]

7.3 It is noted that the rate of conviction for violence (48%) is much lower than for previous use of violence (80%). Clearly some acts of violence are not prosecuted because they are not reported to the police in the first place. The smaller dataset of questionnaire cases indicates that events of violence often do not lead to investigation and prosecution even when reported. There were reports to the police of violent incidents prior to the attack in 31/44 (70%) of cases. But only 24 of those 31 cases (77%) involved any police investigation or prosecution.

7.4 The number of attackers in the structured analysis who had previous contact with the police (86%), even if not convicted, supports the importance of considering

[3] See Professor Fazel's evidence: INQT0000055; WITN0401001_0008-9 and the paper referenced therein at WITN0320014

more than convictions when taking a forensic history and for the purposes of risk assessment.

7.5 Another available source of information about previous violence is the patient's family. Many of the questionnaire cases detailed earlier incidents of intra-familial violence that were not known to state agencies.

7.6 The following questionnaire cases illustrate and elaborate on many of the points raised above:

Case #R7

In case R7, the perpetrator was convicted for the manslaughter of her mother on the grounds of diminished responsibility and detained under a hospital and restriction order but later released. Five years post the initial detention, the perpetrator attacked a young woman with a knife but was fought off. She then, moments later, obtained a butcher's knife from a shop and stabbed and killed the Deceased.

The investigation report examined the circumstances in which the perpetrator had presented to hospital shortly before the attack. The investigation panel also considered whether the police should have exercised their powers under section 136 of the Mental Health Act 1983, which permits a police officer to remove a person appearing to be suffering from a mental disorder from a public place to a place of safety for the purpose of enabling a mental health assessment to be carried out. The panel concluded that there had been a point at which the statutory criteria for detention under section 136 were likely to have been met, particularly given the perpetrator's level of agitation and her attempts to leave the hospital environment.

Although the officers involved were deemed to have reached their decision in good faith, the investigation concluded that the circumstances could reasonably have justified the use of section 136 powers in order to ensure that the perpetrator remained in a place of safety for assessment.

Case #R11

The attacker stabbed and killed another resident at the supported housing hostel where they both resided. Both men were under the care of the Trust's Early Intervention Service (EIS) at the time of the incident. A "near-miss" incident involving a knife occurred five days prior to the killing, following a noise dispute.

Case #R30

Case R30 concerned a fatal incident in which a 93-year-old care home resident was assaulted in her bed by another resident and later died from her injuries.

The investigation report recorded that, in the weeks preceding the incident, the perpetrator had exhibited a sustained and significant pattern of violent and aggressive behaviour while admitted to hospital. Between August and September of of the year preceding the attack, there were at least thirty-four recorded incidents involving threats or violence towards staff and other patients. These included the use of objects such as knives, scissors and trays as weapons, repeated threats to kill staff, expressions of paranoid beliefs, and multiple episodes of physical aggression requiring intervention.

Despite the frequency and seriousness of these incidents, none were reported to the police. The report records that this was on the basis that the behaviour was considered to be related to the perpetrator's mental health, and it was assumed that no criminal action would be taken. As a result, the police were not made aware of the incidents and were unable to access or contribute information regarding any prior offending history. The report further notes that this prevented police intervention with the perpetrator, which might have served as a warning that continued threatening or aggressive behaviour could result in arrest. Also, safeguarding referrals were not made, and there was limited restriction of the perpetrator's access to potential weapons despite repeated incidents involving such items.

Section 8: Alcohol and/or drug misuse

Issue	Cases	Percentage of cohort
History of alcohol and/or drug misuse	379/528	72%

8.1 A previous history of drug and/or alcohol misuse is another prevalent feature in the profile of the attackers in the cases analysed. In its annual report for 2017 (covering the period 2005 to 2015), the *National Confidential Inquiry into Suicide and Safety in Mental Health* indicated that 73% of patients convicted for mental health homicides had a history of alcohol misuse. The corresponding figure for drug misuse was 78%.[4] Use of drugs and alcohol can worsen dangerous symptomology. It can also hamper medication concordance and cooperation with treatment programmes. An example of intoxicants both worsening symptomology and compliance can be seen in questionnaire case #R29:

Case #R29

Case R29 concerned a fatal incident in which the perpetrator set fire to the family home during the early hours of the morning, resulting in the death of an elderly relative, who had been left inside the property.

The investigation report recorded that, shortly before the incident, police had been called after the perpetrator's father reported aggressive behaviour and expressed fear of his son. Although the situation was initially considered to have de-escalated, the perpetrator subsequently lit a fire under the stairs and left the property. However, the perpetrator's father was already out of the property but an elderly relative remained inside the property.

The perpetrator had a history of substance-induced psychosis and had previously been under the care of mental health services. At the time of the incident, however,

[4] WITN0069001_0005

he was no longer subject to detention under the Mental Health Act and was therefore not required to comply with treatment. The report noted that he had been advised of the risks associated with drug use, including the potential to trigger further psychotic episodes.

The report recorded that, in this context, the perpetrator did not adhere to his prescribed medication, having left it behind when he moved away from home. It identified the combined effect of ongoing substance misuse, lack of insight into his condition, and the absence of any mechanism to compel treatment as contributing to his non-compliance with the treatment regime and the difficulty in managing risk.

8.2 In the smaller dataset of questionnaire cases, the attacker was understood to be under the influence of illicit drugs or alcohol at the time of the incident in 19/44 (43%) of cases. Some examples of this include:

Case #R4

This concerned a fatal incident in which a man carried out an unprovoked knife attack in a public setting, fatally stabbing one victim outside a shop and subsequently assaulting an elderly man in the street.

The investigation report recorded that the perpetrator had left his home armed with a kitchen knife prior to the attack. The court received evidence that, at the time of the incident, he was acutely intoxicated and psychotic as a result of ingesting a substantial quantity of amphetamines.

Case #R8

This case concerned a fatal incident in which the perpetrator repeatedly stabbed the victim at a residential address. He was arrested shortly afterwards and detained under section 2 of the Mental Health Act 1983, before being admitted to hospital. A drug screen conducted following his arrest was positive for multiple substances, including cocaine, amphetamines, methamphetamine, morphine, cannabis and MDMA (ecstasy).

Case #R18

Case R18 concerned a fatal incident in which the perpetrator attacked his parents at the family home following a period of escalating disturbance on the day of the incident.

The investigation report recorded that, earlier that evening, the perpetrator threw what he described as two guns across the garden, behaviour which was witnessed by neighbours, and smashed a window at his home. He was arrested for the damage and taken by police for assessment at healthcare settings, before being returned to police custody and released the following morning.

The perpetrator later reported that he had taken cocaine on the morning of the incident and described using cocaine on a daily basis for approximately nine months prior. He stated that he had little recollection of events that day due to his drug use. In accounts given after the incident, he described experiencing unusual perceptual disturbances and changes in mood, including visual imagery, altered sensory experiences, and periods of heightened or “high” mood.

Case #R36

The Deceased’s family informed the Inquiry that the attacker could be seen drinking vodka on the CCTV footage that immediately preceded the attack. The attacker also had a history of illegal drug use.

Section 9: Treatment and intervention

Issue	Cases	Percentage of cohort
Previous contact with mental health services	524/528	99%
Previously admitted to hospital	437/528	83%
Previously detained under the MHA	324/528	61%
Not subject to a Community Treatment Order at the time of the incident	505/528	96%
Never subject to a Community Treatment Order at any time prior to the incident	484/528	92%
Prescribed medication prior to the attack	475/528	90%

9.1 It is unsurprising that all/nearly all the attackers had previous contact with mental health services given the source material. It is unlikely that a report would be prepared if a perpetrator had not previously been under mental health care.

9.2 The high proportion of perpetrators that had previously been admitted to hospital is notable. Many of these had been the subject of multiple previous admissions. The vast majority of the cohort therefore had high levels of previous mental health contact. This is far from a hidden group. The attackers had for the most part been the subject of multiple previous assessments of their clinical presentation and, if previously violent, the risk they pose to others should have been professionally considered.

9.3 An example of a case with extensive previous in-patient contact is case #R26:

Case #R26

This case concerned a fatal incident in which the perpetrator fatally assaulted a member of the public. At the time of the incident, he was under the care of the Trust's community mental health team.

The investigation report recorded that the perpetrator had an extensive history of contact with mental health services over a prolonged period. Over a ten-year period, he was admitted to hospital on six occasions, each requiring detention under the Mental Health Act, and was discharged on two occasions subject to a Community Treatment Order.

In the two-year period leading up to the incident, there were further admissions associated with violent behaviour towards members of the public. These admissions were described as brief, with the perpetrator stabilising quickly and demonstrating only superficial engagement with staff. There were also concerns regarding non-compliance with prescribed antipsychotic medication.

The report also recorded continued contact with services shortly before the incident, including an attendance at hospital in the month preceding the attack, where the perpetrator was described as intoxicated and exhibiting disordered thinking. He was later assessed, denied any mental health concerns, and was discharged with a plan for follow-up by the community team.

9.4 A number of the analysed cases concerned failures to exercise powers under the MHA 1983 at or around the time of the attack. For example:

Case #R5

The fatal incident occurred when a mental health service user attacked his grandparents at their home, resulting in the death of his grandfather and life-changing injuries to his grandmother.

The investigation report considered whether the perpetrator should have been assessed under the Mental Health Act prior to the incident. The review concluded that a number of indicators had emerged in the months leading up to the attack which might reasonably have justified a Mental Health Act assessment.

The investigation noted that professionals appeared to be waiting for a further deterioration in the patient's condition before initiating a formal assessment under the Act. The review concluded that there had been a missed opportunity to assess the patient's mental state through the statutory framework before the incident occurred.

Although the investigation could not conclude that an assessment would necessarily have resulted in compulsory detention or treatment, it emphasised that the absence of such an assessment meant that an important opportunity to evaluate the patient's mental state and consider possible interventions had been lost.

The investigation recommended that the Trust provide further practice-based training to community staff regarding the organisation and use of Mental Health Act assessments.

Case #R7

Case R7 was referred to in section 7 above. It concerned a fatal attack that occurred following a series of contacts between the perpetrator and police and mental health services on the day of the incident.

The investigation report examined the circumstances in which the perpetrator had presented to hospital shortly before the attack. At that time she was known to have a significant history of serious mental illness and had previously been convicted of manslaughter.

The investigation panel considered whether the police should have exercised their powers under section 136 of the Mental Health Act 1983, which permits a police officer to remove a person appearing to be suffering from a mental disorder from a public place to a place of safety for the purpose of enabling a mental health assessment to be carried out. The panel concluded that there had been a point at which the statutory criteria for detention under section 136 were likely to have been met, particularly given the perpetrator's level of agitation and her attempts to leave the hospital environment.

Although the officers involved were deemed to have reached their decision in good faith, the investigation concluded that the circumstances could reasonably have justified the use of section 136 powers in order to ensure that the perpetrator remained in a place of safety for assessment.

9.5 Community Treatment Orders ["CTOs"] were not in force at the point of the vast majority of the reported homicides (96%). The general picture is in fact one of limited deployment of CTOs generally. Despite the heavy involvement of most of the attackers with mental health services, the analysis of the numerous reports identified only 28 cases overall where CTOs were positively identified as ever having been used. It is further noted that the recommendations in the reviewed reports made little mention of CTOs as an intervention that could or should have been arranged.

9.6 One case where the use of a CTO was raised by the independent review was case #R16:

Case #R16

The perpetrator had been under the care of multiple mental health providers prior to committing a series of fatal attacks. The individual had previously been admitted to hospital and had a documented history of non-compliance with medication.

The investigation report questioned why the possibility of a Community Treatment Order had not been considered earlier in the patient's treatment pathway despite there being a known history of non-compliance with medication. The report suggested that the existence of a CTO might have provided a framework through which services could have responded more assertively when the patient indicated that he did not wish to continue taking medication.

The report also raised concerns regarding the discontinuation of Section 117 aftercare, which imposes a joint duty on health and social care authorities to provide ongoing support to certain patients following discharge from detention under the Mental Health Act. The investigation noted that the patient appeared to have been discharged from aftercare arrangements despite there being no clear evidence that his mental health needs had sufficiently reduced. The report indicates that there was a pressure to discharge patients.

9.7 In case #R13, the fatal attack occurred when the attacker was the subject of a CTO:

Case #R13

This matter concerned a fatal incident in which the attacker, who had been subject to a Community Treatment Order, killed another following a period of deterioration in his mental state.

The investigation report examined the operation of the Community Treatment Order in practice and identified a number of significant shortcomings. The individual had been discharged into the community on oral antipsychotic medication, but there was no effective system in place to monitor compliance with that medication. As a result, he ceased taking medication without this being identified or acted upon.

The report concluded that the Community Treatment Order had not been implemented in a manner consistent with its intended purpose. In particular, there was a failure to monitor adherence to treatment conditions, a lack of effective care planning, and insufficient response to concerns raised by family members regarding the individual's deterioration.

The investigation also identified delays in recalling the individual to hospital. These delays were attributed in part to operational factors, including the lack of an available inpatient bed and the manner in which recall processes were managed within the community team.

The investigation further observed that the level of engagement with the individual reduced following discharge, with the care coordinator allowing the individual to determine the terms of contact with services. This was inconsistent with the framework of the Community Treatment Order, which is intended to provide structured and, where necessary, assertive supervision in the community.

Section 10: Engagement with treatment

Issue	Cases	Percentage of cohort
Prescribed medication prior to the attack	475/528	90%
Non-concordance with prescribed medication	384/528	73%
Non-concordance with antipsychotic medication	334/528	63%
Concerns regarding compliance with treatment programme generally	455/528	86%

10.1 86% of attackers had a history of non-compliance with the treatment programme generally (this could include medication non-compliance or other matters).

10.2 The figure of 73% of cases that demonstrated non-concordance with medication should be scrutinised alongside the data that 90% of attackers had, at some stage, been prescribed medication. Discounting the 10% of cases in which medication was not prescribed in the first place, non-concordance was a feature in approximately 81% of the remaining cases where medication was part of the clinical history.

10.3 Non-concordance with antipsychotic medication specifically may be underrepresented in the results as many of the cases do not clarify the precise medication that was not taken.

10.4 In its annual report for 2017 (covering the period 2005 to 2015) the *National Confidential Inquiry into Suicide and Safety in Mental Health* indicated that 49% of patients were either non-adherent to prescribed medication or had missed their final contact with services and were therefore not in receipt of planned treatment prior to the homicide; and 59% of patients with schizophrenia were non-adherent

with drug treatment in the month before the homicide or had missed their final appointment.[5]

10.5 The material reviewed by the ILT indicates that difficulties arise not only in relation to medication adherence, but also in relation to the way in which services respond to non-concordance and optimise treatment over time. Investigation reports frequently identify circumstances in which non-concordance with medication was known or could reasonably have been anticipated, but where limited steps were taken to address the underlying causes of disengagement or to adapt the treatment approach.

10.6 Reports also focus on a failure to recognise or respond to patterns of non-concordance; limited use of structured or objective approaches to verify medication adherence; insufficient monitoring following the initiation or adjustment of medication; and a lack of adaptation of treatment regimes where patients experience adverse side effects or express reluctance to continue with or be started on prescribed medication. This is reflected in questionnaire case #R1, in which the respondent described the perpetrator as having been *"culturally resistant"* to medication and in denial of her condition.

10.7 Investigation reports also identify that difficulties in medication management may arise from the interaction between diagnosis and treatment. In some cases, an incomplete or insufficiently reviewed clinical formulation led to a treatment approach that did not adequately address the patient's underlying condition. In those circumstances, opportunities to optimise medication — including the use of alternative pharmacological strategies — were not fully explored.

10.8 In particular, investigation reports frequently identify concerns relating to the management of higher-risk medications, including depot antipsychotic injections. In some cases, there was a lack of clear protocols for responding to missed doses or failures to attend for monitoring. In others, there was limited evidence that alternative treatment options had been explored where patients were unable or unwilling to tolerate depot injections.

10.9 The themes identified in the wider dataset can be observed in a number of the questionnaire cases examined by the Inquiry. A selection of those cases is summarised below by way of illustration:

[5] WITN0069001_0005; WITN0069003

Case #R10

This case concerned a fatal incident in which a child was killed by a young person who was receiving care from Child and Adolescent Mental Health Services.

The investigation report examined the prescribing and monitoring of antidepressant medication initiated shortly before the incident. The treatment plan, which involved a combination of medication and psychological therapy, was broadly consistent with relevant clinical guidelines for moderate to severe depression. However, the report identified concerns regarding the implementation of those guidelines in practice.

In particular, the NICE guidance required close monitoring of the patient following the commencement of antidepressant medication, including weekly contact during the initial stages of treatment in order to identify potential adverse effects. No such monitoring arrangements were put in place and the investigation report questioned the decision to commence the patient on a new medication regime prior to the start of the Christmas holiday period, when there would have been reduced primary and secondary care services available.

The investigation also noted that the general practitioner had not been informed of the new medication until after the incident, limiting the opportunity for primary care to contribute to monitoring or support.

In addition, the report identified that the patient had exhibited potential indicators of psychosis, including auditory hallucinations, prior to the incident. However, there had been no comprehensive reassessment of her presentation, nor any engagement with specialist early intervention services.

The investigation concluded that the absence of structured monitoring following the initiation of medication, coupled with a failure to reassess the underlying clinical presentation, meant that opportunities to identify deterioration or adverse effects were not taken at an early stage.

Case #R22

This case concerned a fatal incident in which a man killed his cousin following a period of deterioration in his mental health.

The investigation report identified a repeated pattern in which the patient would request reductions in, or cessation of, his prescribed medication following discharge from hospital due to the physical side effects of the medication, including weight gain. This was in the context that physical fitness was an important part of the patient's identity. Despite clinical advice, he would stop taking medication without supervision, leading to a deterioration in his mental state and disengagement from services. However, there was no evidence that alternative medication regimes were explored in response to these concerns.

The investigation concluded that the failure to address the patient's concerns regarding side effects and to adapt the treatment approach contributed to repeated cycles of non-concordance and relapse. On the occasion in question, this deterioration was identified as a significant contributing factor in the events leading to the fatal incident.

Case #R26

Case R26, which has previously been referenced in section 9 of this report, is also relevant here. By way of brief reminder, the case concerned a fatal incident in which the attacker assaulted an individual who later died from their injuries.

The investigation report identified a sustained pattern of apparent engagement with medication services which did not, in fact, reflect actual adherence to treatment. Over a prolonged period, the individual attended weekly appointments to collect prescribed medication from the community team base. This increased level of contact had been introduced in part to facilitate closer monitoring following earlier concerns about his presentation and engagement.

However, following the incident, police discovered in excess of 800 tablets at the individual's home address, which he had not taken. This indicated that, notwithstanding regular collection of medication, he had not been taking it as prescribed.

The investigation found that clinicians had relied upon the individual's attendance for medication collection as an indicator of compliance, without implementing objective or structured methods to verify whether medication was being taken. This was of particular significance given the individual's documented history of limited insight into his condition and previous episodes of non-compliance with medication.

The report concluded that there had been no planned interventions to assess or improve adherence, and no systematic approach to monitoring compliance. As a result, opportunities to identify non-concordance and to respond to it through adjustments to treatment or supervision were not taken.

Case #R33

In case R33 the perpetrator violently assaulted a fellow patient while admitted to an acute mental health ward, causing injuries from which the victim later died. The investigation report identified that the patient had stopped taking his prescribed antipsychotic medication, including clozapine and aripiprazole, prior to his admission. This medication had previously been effective in maintaining stability in the community.

However, the investigation found that there was insufficient focus on the likelihood that the patient's relapse was primarily driven by non-concordance with medication. Instead, greater emphasis was placed on procedural aspects of the patient's assessment under the Mental Health Act.

The report concluded that this lack of focus on the medication-related causes of deterioration meant that opportunities to address the underlying drivers of the patient's relapse were not fully explored at an early stage.

Section 11: Risk assessment

Issue	Cases	Percentage of cohort
Risk assessment failures identified	467/528	88%
Recording / record keeping and audit concerns	450/528	85%

11.1 Risk assessment failures were an overwhelming feature of the cases analysed. Such failures have a long history. The Ritchie Inquiry emphasised the importance of obtaining and considering a full history when assessing dangerousness and highlighted the need for professionals to have access to accurate records, to consider patterns of behaviour over time, and to ensure that relevant information is shared between clinicians, agencies and others involved in a patient's care. It also drew attention to the need for those responsible for assessing risk to be properly trained in doing so.[6] The material reviewed by the ILT demonstrates that concerns relating to risk assessment and recording have continued to arise in the years since the Ritchie Inquiry.

11.2 The analysis of the recommendations within the reports reviewed also contain recurring themes relating to risk assessment. Investigation reports frequently recommend strengthening risk assessment processes, including through the use of structured risk assessment tools; the regular updating of assessments when new information emerges; obtaining relevant information from police where appropriate; and improving the quality assurance and auditing of risk assessment processes. Reports also identify concerns regarding inadequate or incomplete risk assessment, including failures to incorporate historical information, family concerns or indicators of relapse, failures to verify or test information obtained from patients or other sources, and failures to update or revisit risk assessments in response to changing circumstances or emerging warning signs.

11.3 The questionnaire cases examined by the Inquiry provide further illustration of how these issues may arise in practice across a range of factual circumstances.

[6] DHSC0000160

The examples below illustrate how issues relating to risk assessment and record keeping have arisen in individual cases:

Case #R9

This case concerned the killing of a woman by her daughter, both of whom were receiving care from the same NHS Trust at the time of the incident. The investigation report identified concerns regarding the extent to which information held by different clinical teams had been brought together in order to assess potential risks.

The perpetrator had been receiving treatment from adult mental health services, while the victim was being supported by an Older People's Community Mental Health Team. The investigation found that although clinicians were aware that the perpetrator was involved in caring for her mother and had been experiencing significant stress in that role, there was limited evidence that this information had been shared between the relevant teams.

The report concluded that this lack of information sharing meant that a more comprehensive risk assessment was not undertaken. In particular, the investigation noted that the risks associated with the perpetrator providing care for her mother were not fully explored, despite the perpetrator's ongoing mental health difficulties and the availability of information across the Trust that could have informed a more holistic assessment of the situation.

Case #R22

This case, which was discussed in section 10 above, concerned a fatal incident in which the perpetrator killed his cousin, who had become a principal source of support following the death of the perpetrator's mother.

The investigation report raised concerns regarding the adequacy of risk assessments undertaken using a structured risk assessment tool (an actuarial tool, namely the Domestic Abuse, Stalking and Honour Based Violence tool). The investigation team concluded that the risk assessments did not adequately reflect either the seriousness of the perpetrator's previous incidents or how recently those

incidents had occurred. It also noted that the risk assessments and management plans appeared to rely largely on the perpetrator's self-reporting, without adequate validation through family members or other agencies.

The advice from the Royal College of Psychiatrists to use a tool such as HCR20v3 was noted by the investigation.

The report further identified wider pressures affecting the service at the time, including high caseloads, difficulties recruiting and retaining suitably qualified staff, reliance on agency workers, and limited senior management capacity to support inexperienced practitioners. These factors were identified as relevant context for understanding how the risk assessment process had operated in practice.

Although the investigation team did not conclude that different risk assessment processes would necessarily have prevented the fatal incident, it identified these shortcomings as important to understanding how the perpetrator's risks had been assessed and managed.

Case #R21

In case R21, the fatal incident occurred when the perpetrator killed his father at the flat they shared.

The relevant investigation report identified concerns regarding the way risk assessments were undertaken over the course of the perpetrator's contact with mental health services. Risk assessments were often completed in response to particular stages of care, such as admission or discharge, but were not consistently updated to reflect developments occurring between those stages.

The report also identified concerns regarding the sources of information used to inform the assessment of risk. Information provided by family members regarding the perpetrator's behaviour — including concerns about substance misuse, medication non-compliance, aggression and the carrying of a knife — were not consistently incorporated into the risk formulation.

As a result, the report concluded that the assessment of risk was largely based on information provided by the perpetrator himself, with limited evidence that clinicians

had sought to verify that information with family members or other agencies. The panel found that this meant the Trust's understanding of the risks posed by the perpetrator was incomplete.

The report also linked these shortcomings to a broader failure to assess and use evidence properly in the management of risk. The report emphasised that it was not sufficient merely to record relevant information. The information gathered needed to be actively assessed and synthesised in order to form a coherent assessment of the risks posed by the perpetrator.

Case #R33

Case R33, previously mentioned in section 10, concerned a fatal incident in which the perpetrator violently assaulted a fellow patient while admitted to an acute mental health ward, causing injuries from which the victim later died. The investigation report identified concerns regarding the extent to which known historical information about the perpetrator's behaviour had been incorporated into risk planning following his admission.

The perpetrator had a documented history of serious violence and had previously committed an assault on a member of NHS staff while an inpatient. He had also recently stopped taking antipsychotic medication, following a period in which his mental health had stabilised while receiving treatment in the community.

Although this information was available within clinical records, the investigation concluded that there was insufficient evidence of a comprehensive plan being developed to mitigate the risks associated with his admission to the ward. In particular, the report noted that limited attention appeared to have been given to the significance of his recent medication non-concordance or to the implications of his previous violent behaviour when assessing risks to other patients and staff.

Case #R38

Case R38, previously mentioned in section 6, concerned a fatal incident in which an individual killed his mother while experiencing an acute psychotic episode. The individual had previously made a serious threat to kill his mother during a previous episode of illness.

The investigation report identified that, although the individual was known to mental health services and had been in contact with clinicians, there had been no recent formal review of risk by trained staff in the period leading up to the incident.

The report noted that, while the individual's risk when well was considered to be low, insufficient attention had been given to the risk of relapse and the factors which might trigger deterioration, including illicit substance misuse and significant personal stressors. In particular, the fact that the individual continued to live with his mother whom he had previously threatened was not fully explored from a safeguarding perspective.

The investigation also identified the absence of a crisis or mitigation plan and shortcomings in the way risk was recorded and managed. It concluded that a formal review of risk may have prompted a reassessment of the balance between the individual's autonomy and the need to protect family members, particularly in light of the known history of threats and relapse.

Case #R41

This case concerned a fatal incident in which the perpetrator, an inpatient on a Psychiatric Intensive Care Unit (PICU), went absent without leave whilst on escorted leave, and during this period, stabbed a member of the public.

The investigation report identified significant deficiencies in the recording and synthesis of risk information. There was no single, accessible source bringing together current and historical risks, with staff instead relying on multiple documents. This created the potential for inconsistent understanding of the patient's risk profile as different staff members could rely on different documentation.

In particular, the patient had a recent history of carrying knives during periods of absence from the ward. However, this information was not consistently recognised across the clinical team and there was no evidence this had been discussed in multidisciplinary risk planning.

The report also found that the patient's psychological formulation was incomplete. At the same time, the clinical team appeared to derive reassurance from specialist input which had not involved a full forensic risk assessment.

Section 12: Information sharing

Issue	Cases	Percentage of cohort
Concerns as to communication / information sharing / information gathering	483/528	92%
Concerns as to inter-agency communication	440/528	83%

12.1 Risk assessment is only as good as the information on which it is based. It is noted that, as with risk assessment, communication and information sharing failures are an overwhelming feature of the cases considered.

12.2 The following questionnaire cases provide examples demonstrating how failures in information sharing have led to unmanaged risk prior to the fatal attack:

Case #R25

This case concerned a fatal incident in which a man was killed following a sustained and violent assault by a family member who had been in recent contact with mental health services.

Prior to the fatal incident, there had been an earlier assault involving the same individuals. The investigation report noted that, although risk assessments were undertaken following that earlier incident, they largely repeated information from previous assessments and did not demonstrate that further enquiries had been made into the circumstances of the assault.

In particular, there was no evidence that clinicians had sought information from the victim, other family members, or the police in order to understand the nature and severity of the earlier incident. The perpetrator was reported to have been apologetic, but had provided limited detail, and this appeared to have been accepted without further verification.

The investigation concluded that the assessment of risk was based on incomplete information and that opportunities had been missed to obtain and incorporate relevant safeguarding and third-party information. As a result, the potential risk of further serious violence, including within a domestic context, was not fully explored or understood.

Case #R30

In case R30, previously mentioned in section 7, a care home resident in their nineties was fatally assaulted by another resident who had previously been admitted to a conventional hospital setting, where he had demonstrated repeated episodes of threatening and violent behaviour towards patients and staff. The investigation report recorded that, during a period of hospital admission, there were at least thirty-four documented incidents in which the perpetrator behaved in a violent or threatening manner.

Despite this pattern of behaviour, the investigation found that these incidents were not formally analysed in order to understand the risks posed by the perpetrator. In particular, the report noted that no structured risk assessment was undertaken to synthesise the information available regarding the perpetrator's behaviour and mental state.

The investigation also identified that some of the incidents involved the use of weapons and that these were not reported to the police or raised as safeguarding concerns with the local authority. Nor were steps taken to establish whether the perpetrator had any previous contact with the criminal justice system. As a result, the investigation concluded that the risks posed by the perpetrator were not fully understood when decisions were later made regarding his placement in a residential care setting.

Section 13: Engagement with families

Issue	Cases	Percentage of cohort
Concerns regarding communication with carers / family	345/528	65%
Family raised concerns about risk prior to the incident	241/528	46%

13.1 One critical source of collateral information – relevant to both clinical care and risk assessment – is the family, carers and/or housemates of patients. Unfortunately, a majority of cases recorded problems with communication in this area.

13.2 In 46% of the cases the perpetrator's family had expressed concern as to risk of violence prior to the attack. An example of this can be seen in questionnaire case #R42, in which the respondent described a pattern of escalating behaviour, including property damage and aggression. Despite repeated police attendance, the perpetrator was assessed as posing no risk to himself or others, and no further action or follow-up was taken. The respondent emphasised the need for authorities to *"take the family pleas for help seriously".*

13.3 A failure to assist a family to obtain a Mental Health Act assessment was a feature of case #R31:

Case #R31

This case concerned a fatal attack on a family member that occurred approximately one year after the perpetrator had been discharged from inpatient and community mental health services.

Prior to the incident, family members had repeatedly contacted services expressing concern regarding the perpetrator's deteriorating presentation. The investigation report identified failures relating to the role of the "Nearest Relative" under the Mental Health Act 1983. This term reflects the statutory framework in force at the time of the events in question. Under the Mental Health Act 2025, the role has been replaced with that of the "Nominated Person", although the investigation reports reviewed by the Inquiry largely use the earlier terminology.

In particular, this report concluded that the nearest relative had not been informed of her statutory rights, including the right to request a Mental Health Act assessment. The report also identified a lack of documentation demonstrating that the nearest relative had been informed of decisions relating to the patient's detention or discharge.

13.4 In a witness statement provided to the Inquiry, a father gives evidence in relation to his daughter, who has a longstanding diagnosis of paranoid schizophrenia with repeated detention under the Mental Health Act over a period of more than twenty years. At all material times, the witness was the individual's "nearest relative" within the meaning of the Act. The statement addresses a recent relapse in which the individual ceased taking prescribed antipsychotic medication, leading to a deterioration in her mental state characterised by delusions and paranoia. Despite a high level of concerning behaviour reported by the father, an ambulance declined to attend. The witness contacted the police, again providing detailed information regarding his daughter's condition, her lack of medication, and the risks posed to herself and others. The police located her but did not detain her or take her to a place of safety. The statement records that a factor in this decision was the absence of an available out-of-hours crisis response. As a result, the individual remained untreated and continued to move between locations for a period of approximately four weeks whilst in a psychotic state.

13.5 The statement records that intervention was ultimately secured only after the witness obtained legal advice and initiated the process for a warrant under section 135 of the Mental Health Act. Following execution of the warrant, the

individual was detained and treated, with a subsequent improvement in her condition following the reintroduction of antipsychotic medication.

13.6 The statement highlights concerns regarding, amongst other things, the failure of emergency and mental health services to respond to information provided by the nearest relative.

13.7 Similar concerns were raised in case #R44. The respondent considered that community mental health services did not have the practical capacity to respond rapidly and effectively to acutely psychotic individuals who require urgent intervention.

13.8 Concerns as regards engagement with the family on the issue of risk assessment was a regular feature of the cases explored above in sections 11 and 12 – see for example *case #R21* and *case #R25. Further:*

Case #R22

Case R22, which was previously referenced in sections 10 and 11, is also relevant here. The case concerned a fatal incident in which a man killed his cousin, who had become a principal source of support following the death of the perpetrator's mother.

The investigation report identified concerns regarding the extent to which family members were involved in the patient's care. Although the Trust's policies emphasised the importance of involving carers in treatment planning, there was no evidence that the patient's family members had been involved in assessments or care planning discussions.

The report emphasised that the involvement of families and carers has long been recognised as an important component of effective mental health care. Family members often possess valuable information regarding a patient's behaviour, adherence to treatment and early signs of relapse. In this case, the absence of family engagement limited the information available to clinicians when assessing the patient's needs and risks.

Section 14: Treatment and care planning failures

Issue	Cases	Percentage of cohort
General treatment failures identified	466/528	88%
Inadequate care planning and coordination	472/528	89%
Oversight / supervision concerns	349/528	66%
Inexperienced professionals / training issues / lack of reflective practice	304/528	58%
Bed availability / waiting times / delays	175/528	33%
Resourcing issues	240/528	46%
Concerns as to policies / systems / processes / organisational concerns	464/528	88%

14.1 The issues considered in this section are closely related to those examined in section 11. The assessment and management of risk and the planning and delivery of care are inherently interconnected aspects of mental health care. Risk assessments inform the development of care plans, while care plans provide the framework through which identified risks are managed in practice.

14.2 The reports analysed show a range of treatment and care planning failures and equally a range of reasons behind this.

14.3 A structured approach to care coordination has long been intended to provide a framework through which individuals with more complex mental health needs receive consistent and co-ordinated care. Such approaches typically involve the development of a documented care plan, the identification of a clinician responsible for coordinating care, and arrangements for reviewing treatment and responding to deterioration in an individual's condition. Care planning should also incorporate crisis or contingency arrangements and clearly identify the roles of the different professionals involved in supporting the individual.

14.4 However, the material reviewed by the ILT indicates that these arrangements were operated inconsistently in practice. Investigation reports frequently identify circumstances in which care plans were incomplete, were not reviewed when new information emerged, or were not effectively implemented across services. In some cases, the absence of a coordinated care plan meant that services lacked a clear strategy for responding to changes in a patient's presentation or for managing risks associated with relapse.

14.5 Difficulties in maintaining engagement with patients in the community also arise repeatedly within the reports examined. These difficulties may arise where individuals struggle to recognise the nature of their illness or the importance of treatment, or where services encounter challenges in sustaining contact with patients following discharge from hospital. In such circumstances, investigation reports frequently identify a lack of escalation or adaptation in the treatment approach when engagement begins to decline.

14.6 One of the other witness statements provided to the Inquiry (further to the questionnaire process) was from the father of a patient with a longstanding diagnosis of schizoaffective disorder. He describes a prolonged history of repeated relapse and re-admission to mental health services over a period of approximately 20 years. The evidence records that the individual had been detained under the Mental Health Act on multiple occasions and has, following discharge, repeatedly experienced deterioration in his mental state associated with discontinuation of prescribed medication. The statement does not fall within the criteria for inclusion in the Inquiry's questionnaire cohort, as it does not concern a fatal attack, but provides relevant insight into the operation of services in cases involving chronic relapse and risk. The statement maker describes a

pattern in which periods of stability have been followed by relapse after medication is stopped, with subsequent escalation in behaviour, including increasing aggression, police involvement, and further detention. The witness reports that, despite efforts by the family to support adherence to treatment and engagement with services, the cycle has persisted over many years.

14.7 The themes identified above can also be observed in a number of the questionnaire cases examined by the Inquiry. A selection of those cases is summarised below by way of illustration:

Case #R9

Case R9, previously mentioned in section 11, concerned a fatal incident in which a woman was killed by her daughter. At the time of the incident, both individuals were receiving care from the same NHS Trust.

The investigation report identified concerns regarding the continuity of care following a reconfiguration of mental health services within the Trust. Prior to the reorganisation, the patient had been receiving a relatively intensive level of support from specialist services. Following the reconfiguration, the level of support available to her was significantly reduced.

The investigation found that this change had not been accompanied by a clear reassessment of the patient's needs or by the development of a structured plan for monitoring her mental state following the transition between services. As a result, early indicators of deterioration in the patient's mental health were not recognised or addressed.

Case #R30

Case R30, which has been discussed in sections 7 and 12 in this report, concerned the fatal assault of a care home resident by another resident who had previously been admitted to a conventional hospital setting, where there had been repeated episodes of violent and threatening behaviour.

In the context of care delivery, the investigation report identified concerns regarding the clinical understanding of the perpetrator's underlying condition. The patient had developed Wernicke-Korsakoff's Syndrome as a consequence of alcohol misuse, a condition which presents distinct clinical challenges and may be associated with behavioural disturbance and aggression.

The report concluded that services had not fully explored whether the patient's presentation might also reflect additional underlying mental health needs. As a result, opportunities to consider alternative treatment approaches or more structured support arrangements were not pursued.

Case #R33

Case R33, which was also referenced in sections 10 and 11 of this report, is also relevant when considering the delivery of care. By way of brief reminder, the case concerned a fatal incident in which a patient violently assaulted another patient on an acute mental health ward, resulting in the victim's death several days later.

The investigation report identified concerns regarding the absence of a structured care plan following the perpetrator's admission to the ward. Although the patient had been admitted due to a deterioration in his mental state, there was no evidence that a care plan or observation and engagement plan had been developed during the early stages of his admission.

The investigation emphasised that a care plan serves as the central document through which clinicians identify the patient's needs, determine the interventions required to support recovery, and clarify the roles of professionals involved in providing care. In this case, the absence of an agreed care plan meant that the clinical team lacked a clear framework through which the patient's needs and risks could be assessed and managed.

The report also noted that the patient had not been provided with one-to-one engagement time with nursing staff during his admission. Such engagement may have assisted clinicians in developing a clearer understanding of the patient's presentation and in establishing a therapeutic relationship that could inform treatment planning.

Section 15: Mental capacity

Issue	Cases	**Percentage of cohort**
Concerns over capacity / incapacity of perpetrators under the MCA	31/528	6%

15.1 Mental capacity and the issue of assessment of capacity was rarely a feature of the clinical care provided before the attacks considered. It was also rarely considered by the post-incident investigations.

15.2 In one of the statements provided to the Inquiry (previously referred to at paragraph 14.6 above), the father of a patient expressed concern that in circumstances where his son's insight was limited and there was a well-established pattern of relapse linked to non-adherence, reliance on patient choice may undermine the effectiveness of treatment and increase the risk of further deterioration.

15.3 One case in which mental capacity assessment was raised in relation to the attacker in the investigation report was case #R20:

Case #R20

This case concerned a fatal incident in which the perpetrator drove a vehicle into a group of pedestrians, resulting in the death of a child and multiple injuries.

The investigation report identified a prolonged period of contact between the individual and mental health services, during which he was assessed under the Mental Health Act on multiple occasions. The report identified a failure to adequately consider the individual's mental capacity. Despite a pattern of disengagement from

services and a denial of illness, there was limited evidence that a structured assessment of capacity had been undertaken in relation to his decision-making. The investigation noted that this limited the ability of services to determine whether further statutory intervention or protective measures were required.

The investigation concluded that these shortcomings reflected a broader failure to apply statutory frameworks in a manner that fully addressed the risks arising from the individual's presentation, including the interaction between capacity, engagement and the use of compulsory powers.

Section 16: Discharge planning

Issue	Cases	Percentage of cohort
Previously discharged from hospital or community services	477/528	90%
Concerns regarding discharge planning	402/528	76%
No or inadequate discharge / treatment plan	345/528	65%

16.1 Discharge from inpatient or custodial settings, or between community teams, represents a critical stage in the care pathway for individuals receiving mental health treatment. Effective discharge planning requires not only the identification of ongoing clinical needs, but also the coordination of services, the involvement of relevant stakeholders, and the implementation of arrangements to monitor and manage risk in the community.

16.2 The material reviewed suggests that discharge represents a point at which previously identified risks may not be adequately mitigated, particularly where there is limited planning for non-engagement, relapse, or deterioration in the individual's condition.

16.3 These issues are closely linked to the matters considered in earlier sections of this report. In particular, shortcomings in risk assessment, care planning and medication management often become most acute at the point of discharge, where individuals transition from more structured or supervised environments into the community.

16.4 A number of recurring themes emerge from the investigation reports reviewed by the Inquiry. These include:

- the absence of clearly defined discharge plans;
- lack of consultation with family or primary care in discharge planning;
- variability in multi-disciplinary and multi-agency input into discharge decisions;
- failures to respond to concerns raised following discharge;
- limited coordination between agencies; and
- discharge decisions made in the context of known non-engagement with services. In some cases, non-engagement appears to have become an operative factor in discharge decision-making, rather than a trigger for enhanced efforts to maintain engagement or to implement more structured forms of supervision.

16.5 The themes identified in the wider dataset can also be observed in a number of the questionnaire cases examined by the Inquiry. A selection of those cases is summarised below by way of illustration:

Case #R15

This case concerned a fatal incident in which the perpetrator killed his mother shortly after being discharged from an inpatient mental health ward.

The investigation report identified shortcomings in the discharge process. In particular, there was no documented discharge care plan. Although the individual was understood by the treating team to be subject to the Care Programme Approach, this was not formally recorded on the clinical system and the required CPA documentation had not been completed.

The report also identified a lack of involvement of the individual's family in discharge planning. Family members were not provided with a care plan or contingency plan, and no carer's assessment had been completed, notwithstanding that the individual was returning to live with his mother, who was both frail and acting as his primary carer.

Further concerns were identified in relation to communication with primary care. There was no evidence that the individual's general practitioner had been notified of his discharge at the relevant time.

The investigation concluded that, at the point of discharge, there was a lack of clarity as to how mental health services would support the individual in the community, and that the arrangements in place did not adequately address the risks associated with his return to a vulnerable home environment.

Case #R21

Case R21, previously discussed in section 11 of this report, is also relevant when considering discharge planning. By way of brief reminder, the case concerned a fatal incident in which a father was killed by his son following a period of treatment under the Mental Health Act 1983.

The investigation report identified concerns regarding the management of the discharge process, in particular the absence of effective liaison with the family in relation to the individual's return to the home environment and the risks arising from that placement.

Following discharge, there was a pattern of declining engagement with services, including missed appointments, non-participation in rehabilitative activities and non-compliance with medication. The investigation found that warning signs of escalating risk — including aggression, substance misuse and concerning behaviour within the home — were not recognised as indicators of risk to others, but were instead addressed primarily as clinical matters. The report found that because of this there was not an appropriate response which would have included increased home visits and further hospital appointments.

Case #R34

This case concerned a fatal incident involving an individual who had recently been discharged from inpatient care into supported accommodation.

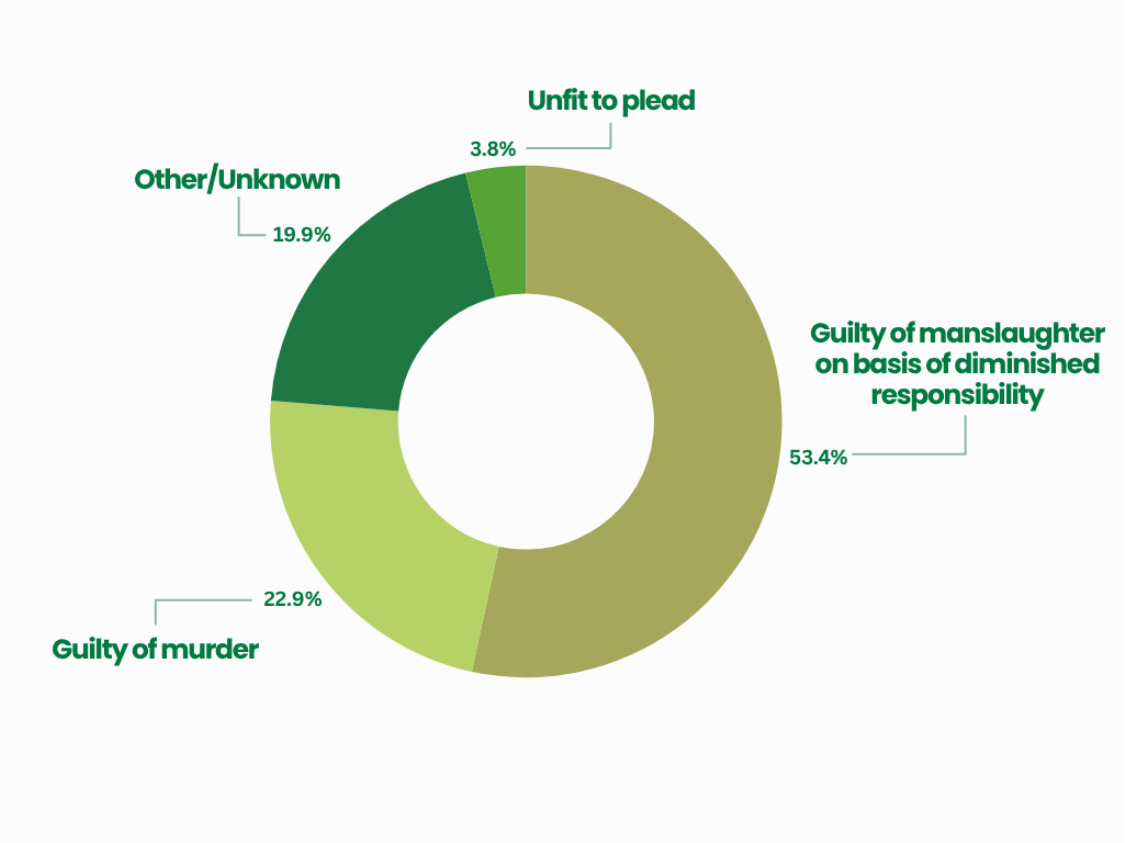
In the context of discharge planning, the investigation identified concerns regarding the clinical management of the individual's medication at the point of discharge. In particular, the individual's Clozapine levels were significantly below the range advised by the manufacturer in the period immediately prior to discharge. Although a blood test had been undertaken, the result was not acted upon or incorporated into discharge decision-making.

The investigation concluded that this may have warranted further consideration of medication compliance, dosage, or broader clinical management prior to discharge.

Section 17: Criminal justice disposal

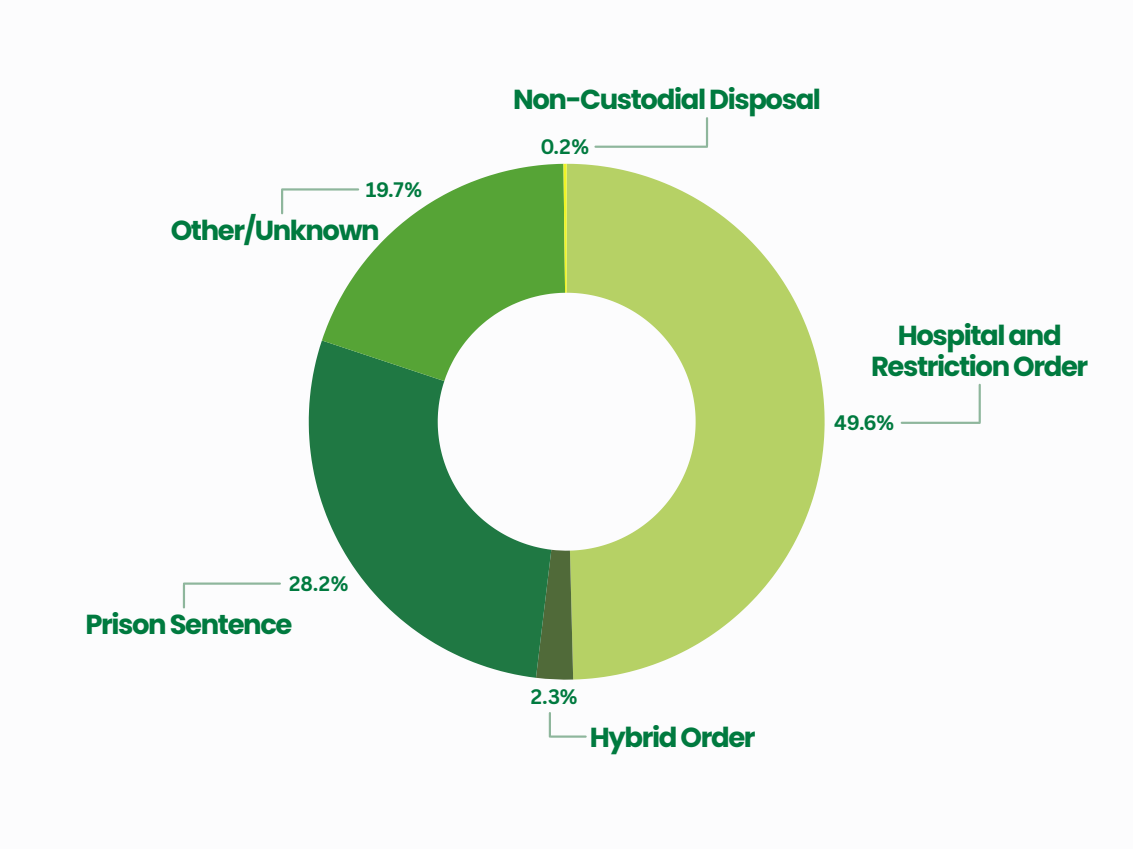
17.1 The dataset was analysed to understand how the actions of the attackers were disposed of in the criminal courts.

17.2 With respect to offence outcomes, the breakdown is as follows:



17.3 The category of “Other” within the offence outcome data requires brief explanation. In the majority of cases this classification does not reflect a distinct category of outcome but rather limitations in the available material. In many instances, the offence outcome was not clearly identified or confirmed in the report. In others, the death or suicide of the perpetrator rendered the criminal process obsolete. There were also cases in which the precise form of manslaughter was not specified or not confirmed to be on the basis of diminished responsibility, as well as a small number involving alternative offence outcomes, such as findings of insanity or other offences.

17.4 With respect to the disposal of the cases analysed, the breakdown is as follows:



17.5 A “hospital order” is an order under s.37 MHA 1983 authorising admission to and detention in hospital.

17.6 A “restriction order” is an order under s.41 MHA 1983 authorising special restrictions of offenders that are detained under s.37.

17.7 A “hybrid order" is an order made under s.45A MHA 1983 under which an offender is taken to hospital for treatment but treated as if transferred from prison. This provision came into force on 1 October 1997.

17.8 The category of “Other” within the disposal data similarly reflects limitations in the available material rather than a discrete category of outcome. In many cases, the disposal was not clearly identified or confirmed in the available report. In others, the death or suicide of the perpetrator rendered disposal unnecessary. A small

number of cases involved alternative disposals, such as conditional discharge or subsequent transfer from prison to hospital detention.

17.9 The offence outcome for just over half of the cases (53%) was manslaughter on the basis of diminished responsibility. Similarly, half the cases were disposed of via hospital and restriction orders (50%).

17.10 Hybrid orders were only used in 2% of cases. Julian Hendy, founder of the Hundred Families charity, has stated that the families he supports would like to see a greater use of hybrid orders to ensure a penal element is attached to the disposal of mental health homicides.[7] He also notes a dissonance between family expectations at sentencing hearings - when hospital orders are said to be "indefinite" - and the outcome wherein the vast majority of patients are released in less than 10 years.[8]

17.11 Amidst the smaller subset of questionnaire cases, 38/67 (57%) of the total respondents informed that they were dissatisfied with the sentence or court order. In multiple questionnaire cases including cases #R2, #R4, #R12, #R17 #R19, #R20, #R25, #R32 and #R36, respondents indicated that the sentence or disposal imposed was not sufficiently severe.

17.12 Respondents in cases including #R6, #R23 and #R28 expressed concern about the management of the perpetrator following sentence, including the speed of progression through to less secure settings and the conditions under which leave or release was permitted. These concerns were often framed in terms of a perceived lack of reassurance as to future public protection.

17.13 A further witness statement provided to the Inquiry describes how the perpetrator of the attack was sentenced to imprisonment but then transferred to a medium secure hospital on the day of sentencing. The family of the Deceased were not informed until two months later. Concerns are raised regarding the lack of clarity surrounding the basis for the transfer, the processes governing future decision-making, and the circumstances in which the perpetrator might be released.

17.14 In case #R7 the perpetrator had previously been convicted of manslaughter on the grounds of diminished responsibility and was given a hospital and restriction order. Less than three years later, the perpetrator was discharged into the

[7] WITN0258001_0028
[8] WITN0258001_0029

community. The fatal attack on the Deceased occurred just five years after being given a hospital and restriction order for a previous manslaughter.

17.15 Several of the respondents considered that the outcome of their cases should have been murder and not manslaughter on the basis of diminished responsibility – see for example cases #R14 and #R19.

17.16 The respondents in cases #R2, #R11, #R15, #R22, #R39 and #R40 reported their concern that hybrid orders were not used. The respondents in #R2 and #R11 specifically reported that the length/duration of the hospital order imposed at the sentencing hearing, which was described as “indefinite”, had not been properly explained to them and they were deeply concerned by the speed with which release was considered thereafter. Case #R10 described parole board hearings after sentencing as re-traumatising.

Section 18: Concerns as regards Trust reports

Issue	Cases	Percentage of cohort
Concerns as regards Trust investigations after the event	267/524	51%

18.1 The analysis of this issue was limited to cases in which an independent report was available. Such independent reports were generally preceded by a Trust level report and the independent reviewers regularly commented on the quality of the earlier investigation.

18.2 The analysis revealed that the independent investigations noted concerns with the Trust level reports in just over half of the cases. The nature of the criticisms were varied. Particular concerns included failure to engage the family of the deceased, failure to obtain key records or accounts, and the failure to consider important clinical issues.

18.3 57 out of 67 (85%) of the questionnaire respondents informed that they were dissatisfied with the information shared with them by the relevant Trust.

18.4 A common theme was respondents reporting that they felt they had to struggle or fight to get relevant information and/or any investigation at all – see questionnaire cases #R3 #R4, #R11, #R13, #R24, #R27, #R35, #R36.

18.5 Long delays in contact from the relevant Trust were a feature of several cases – #R29 (two years for sight of internal investigation); #R33 (three years and still waiting for a Trust level report).

18.6 Several cases complained that they had had no contact at all from the relevant Trust – #R7, #R18 and #R43.

18.7 A number of respondents reported that they had to wait for other investigations before getting information or answers. For example, coronial investigations – see cases #R22, #R24 and #R35.

18.8 A number of respondents were concerned that the Trusts involved were keen to minimise their responsibility – #R10 and #R37.

18.9 The average time between incident and independent report, where the information was available, was over 3 years. In 66 identified cases, the independent report was delayed by over 5 years.

Section 19: Recommendations in the reports

19.1 The recommendations made are, as would be expected, varied. But several recommendation types were more prominent:

(a) Strengthening risk assessments and risk management plans, including standardisation of approach, the use of tools, gathering adequate information, updating risk assessments in light of new information, quality assurance and auditing of risk assessments.

(b) Improved care planning and adherence to the Care Programme Approach and s.117 MHA aftercare.

(c) More comprehensive discharge planning, including a multi-disciplinary approach, consultant oversight, engagement with the social and family context, clear lines of responsibility, routes of escalation, provision of information to community teams and GPs, monitoring plans and follow-up.

(d) Development of protocols for oversight and monitoring of medication concordance, as well as escalation pathways where necessary. Such recommendations were a particular feature in relation to depot injections and clozapine.

(e) Greater family engagement, including the development of Trust policies as regards contact and interaction with family/care-givers and greater professional trust for family views.

19.2 A number of reports also explicitly recommend steps to promote patient engagement, including assertive outreach.

19.3 The issues above appear over the course of the period considered. But some types of recommendations are more prominent in specific periods. Establishment and implementation of the care programme approach and basic risk assessment protocols appear more so in the earlier period (1990s to early 2000s), before there is a greater focus on structured risk assessment tools, assertive outreach and crisis resolution teams, as well as multi-agency risk frameworks such as MAPPA/MARAC (up to around 2015). The last decade or so has seen a greater focus on workforce capacity, quality assurance, governance, information sharing and multi-agency working.

19.4 Professor Appleby, Director of the *Confidential Inquiry into Suicide and Safety in Mental Health*, has referred in his witness evidence to research undertaken by his inquiry into past mental health homicide investigations.[9] One of the conclusions of that research was that recommendations lacked specificity, were vague and were difficult for mental health trusts to implement or monitor. It was also opined that reports often lacked an implementation plan with deadlines to ensure delivery and that recommendations were often repeated from one report to another, suggesting that the investigation system was not leading to changes in care.[10]

19.5 Recent recommendations as regards discharge planning tend towards pointing trusts to follow basic steps, legislation and/or local policy rather than assisting with specific structures or measures to put in place:

Case #R15

"…. admission and discharge process to be reviewed to reflect any known CPA status, to ensure risk assessments and care planning is held and documented before discharge and shared with consented significant others."

Case #R16

"Recommendation 2: [Trust] must ensure that discharges from Section 117 aftercare enacted…in keeping with the Section 117 aftercare legislation.

Recommendation 6: [Trust] must ensure that there is clearly documented communication and liaison with a patient's clinical team when considering a patient's needs prior to discharge from an independent provider. DPT must also ensure that there is a shared and agreed plan if detention under the Mental Health Act is rescinded by independent providers commissioned by DPT.

[9] WITN0069001_007
[10] WITN0069006

Case #R3

"R9: Conduct post-discharge follow-ups in accordance with policy and national guidance."

19.6 Risk assessment recommendations in recent years have generally been reluctant to specify one type of risk assessment approach over another or to point to one model or guideline to follow. Recommendations are instead, at best, a statement of good principles of risk assessment. At worst, they are a statement that risk assessments need to improve. See for example:

Case #R21

"That all agencies are explicit when risk assessing victims and family members about why an assessment is being undertaken and to be able to identify and evidence their assessment of the nature, level of seriousness and imminence of the risk they believe exists. If professionals believe victims to be minimising the risk posed by a family member, they should use their professional judgement to make HRDA referral in line with learning from the Standing Together research."

Case #R30

"The Trust should introduce risk formulation using for example and amongst others: history; analysis of antecedents; behaviours and consequences and patients' own accounts of why they behaved in such a way; the impact of recent events and associated mental and medical conditions into risk assessments. The risk formulation should be used to establish levels of risk and risk mitigation plans."

Case #R33

"Risk assessment and risk management is a key aspect of mental health practice. The trust should assure themselves that the systems and arrangements in place on [the] ward effectively maintain the trust's approach to risk management, and that the quality of risk assessment and safety management plans is robust and meets the standards required."

Case #R26

"Trust services did not always complete risk assessments in line with policy.

The Trust must review risk management training and guidance to ensure staff know to complete a new risk assessment and risk management plan when risks change, or when new risks are identified. This training must emphasise the importance of triangulation and seeking and listening to the views of those who know the patient best. Training should include formulation skills, ensuring that staff can bring together historical risk factors, current clinical presentation and additional risk information from other agencies and services to inform care planning and risk management.

All service users must have a comprehensive person-centred risk assessment and management plan, completed in line with Trust policy, with reviews undertaken in response to changes in presentation and new information."

Case #R38

"Recommendation 2: The Trust is planning to continue to implement the NHSE inpatient mental health transformation programme. As part of this, the Trust will use its safety module to explore and deliver a project to move away from risk stratification towards formulation and safety planning. The Trust will review risk assessment and care planning arrangements. The aim is to ensure that there is clarity of assessments, and communication of risk of violence to others and ensure that information about care and risk are more closely woven together."

19.7 Recent recommendations on the issue of medication compliance/monitoring point towards the need for additional guidance, audits, governance and planning at Trust level:

Case #R34

"Recommendation (3) – Clozapine
3 (a) Carry out an audit of individuals who are prescribed Clozapine in the community to assess the pathway from blood test to medical review to delivery of any change in prescription.

3 (b) Implement a system which facilitates easy access to the most recent serum Clozapine levels for routine consideration against prescribed dose and current symptomology at ward rounds."

Case #R26

"Recommendation 2: Medication
The team derived false assurance about [the perpetrator's] compliance with medication from the weekly collection of medication. We had additional concerns about medication reconciliation and review within the community team.
The Trust must ensure that patients who receive their medication from the CMHT have a plan in place outlining the requirements of this, including the monitoring and review arrangements.

The Trust should ensure sufficient guidance is available to staff relating to assessing and improving adherence with medicines and monitoring compliance."

Inquiry Legal Team

May 2026