RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

If a patient commits a homicide:

A resource for psychiatrists

June 2024

GUIDANCE BOOKLET

Contents

How to cite this publication:
Royal College of Psychiatrists (2024) If a patient commits a homicide: A resource for psychiatrists

College reports and position statements constitute College policy and have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

About this guide

This guide was developed following two surveys of psychiatrists who had experience of patient-perpetrated homicide (PPH) (Mezey et al, 2021; Hussain et al, 2023), a review of the literature, and from accounts of personal experiences.

The guide aims to provide psychiatrists who may be affected by a PPH with information about an exceptional event which may be hard to discuss, and where there may be few obvious sources of support. Its purpose is to demystify some of the formal processes that accompany a homicide, to reduce feelings of isolation and uncertainty, and to help psychiatrists cope with what is likely to be a very difficult time.

For illustration, we have used quotes from two surveys of psychiatrists – we are grateful to these colleagues for sharing their experiences. We also draw attention to the videos and resources on the relevant page of the Royal College of Psychiatrists' website.

This guide covers the following sections:

- Some facts about homicide
- The impact of PPH on psychiatrists
- How to look after yourself
- What might help you to prepare for the experience of a PPH
- The formal processes following a PPH
- Relationships with carers and service users (including the families of the perpetrator and victim)
- Psychiatrists' suggestions about resources and activities that they found helpful or wished they had access to following a PPH
- Concluding remarks
- Resources, further reading and sources of support for psychiatrists
- Resources and support agencies for family and friends

Some facts about homicide

Homicide is a comparatively rare event in the UK, with between 650–700 deaths of this nature per year in England and Wales. This figure has been stable for decades in England and Wales although unexpected deaths can skew the data. For example, in 2019, the annual figure for homicide was inflated by the deaths of 23 refugees who died in a lorry. The rate of homicide was about 50% higher in Scotland from the 1950s, peaking in the mid 2000s. Since then, there has been a sustained fall to around 50–60 homicides a year – a similar rate to that in the rest of the UK. Northern Ireland has a similar rate of homicide to England; however, alcohol is a factor in a greater number.

Homicide and mental illness

The majority of individuals who kill others have no history of mental disorder or violence and are not in contact with mental health services at the time of the alleged offence.

Although the contribution of mental disorder to violence in society is low (Walsh and Fahy, 2002) there is a significant association between mental disorder and homicide, particularly in people diagnosed with schizophrenia and substance misuse disorder (Fazel, 2010). Around 11% of homicides in England are committed by those who have been in contact with mental health services in the last year (NCISH, 2017).

Domestic homicide

In peacetime and in most social democracies, most victims of homicide are known to the perpetrator and the fatal violence occurs in the context of a complex relationship between the two (UNODC, 2013).

The majority of homicides are committed by men (90%) and men also make up the majority (80%) of victims. Homicides of women ('femicides') are usually perpetrated by men who are known to them (UNODC, 2020) and are therefore considered 'domestic homicide'. 73% of victims of domestic homicide are women and 88% of the perpetrators of domestic homicide are men, with the relationship of the perpetrator most frequently being partner/ex-partner (The Home Office (HM Government), 2021). PPH involving domestic homicide usually involves the additional process of a domestic homicide review in England and Wales and the way it is perceived by the public can differ from a patient-perpetrated stranger homicide. Scotland established a taskforce in 2022 to provide leadership on the development of a national multiagency Domestic Homicide Review model for Scotland.

Homicide and risk assessment

Historically, many communities and societies have perceived people with mental illness to pose a risk of serious harm to others, and such stigmatising public perceptions persist. Related assumptions also persist, such as the belief that violence by people with mental disorder can, and therefore should, be prevented by mental health care professionals. In fact, there is little evidence that violence can be predicted with any degree of certainty. Severe violence is a rare event and arises from an interaction of multiple factors. Use of risk assessment instruments does not appear to improve accuracy of prediction and false positives are common, which can lead to harm to patients through extended detention and stigma (Fazel, 2010). Nevertheless, it is important to note that certain factors are associated with increased risk of fatal violence including domestic homicide: substance misuse, paranoid mental states, and significant relational ruptures in the previous year (Elbogen et al 2009, Home Office 2021a). Deprivation is also recognised to be associated with young male-on-male homicides (Home Office, 2020).

Concerns about the formal processes that follow a PPH

NHS England commissions an external investigation when a patient under the care of mental health services commits a homicide. Concerns that these inquiry processes lead to scapegoating of professionals have been raised repeatedly for over 25 years (Eastman, 1996; Szmuckler, 2000). There are also concerns that such inquiries use methodologies that lack an evidence base and that the cost associated with them would be put to better use in improving community and social care that might help reduce the risk of violence (Salter and Turner, 2005). For example, such funds could go towards societal and multi-sector interventions that address domestic violence and abuse, alcohol and substance misuse and poverty, factors that are implicated in national homicide trends and are overrepresented in populations accessing mental health services due to complex and overlapping antecedents (Home Office, 2020). The Violence Reduction Unit in Scotland targeted the carrying of knives by young men in public leading to a substantial fall in weapon carrying and an associated fall in homicides (Crichton, 2017).

In Scotland there has been a concern that there is too little in the way of reviews after a PPH. Evidence submitted to Scottish Government revealed only 25% of PPHs resulted in an internal Serious Adverse Event Review, less than 2% led to an independent Mental Welfare Commission Inquiry, and Fatal Accident Inquiries were similarly rare (Mental Welfare Commission, 2022).

In Northern Ireland all cases of PPH trigger a Serious Adverse Incident Review and in certain circumstances this can be escalated by the Department of Health to an Independent Inquiry.

The impact of PPH on psychiatrists

Recent surveys of psychiatrists who have experienced a PPH report a range of impacts (Mezey et al, 2021; Hussain et al, 2023). Some psychiatrists cope relatively well, but others report serious difficulties in relation to their emotional wellbeing, their functioning at work, and their personal lives. Details of the homicide event itself, anxiety about the potential for legal, professional and organisational scrutiny, and the impact of such processes, can induce levels of distress similar to those of people exposed to trauma. Emotional responses include fear, anger, sadness, shame and guilt. People often reported feeling isolated from colleagues and a sense of being responsible for the homicide. The following section includes quotes from psychiatrists who participated in the surveys.

> **It felt like a personal bereavement but more complicated. I "coped" well in my own view at the time but in fact it was appalling beyond words… it has been life-changing for me and contributed to an eventual decision to go part-time and then take early retirement.**

> **I became suicidal, low mood, more alcohol, anxiety, high arousal, poor sleep, anxious.**

Some also reported feeling that they had no right to feel distress and their feelings had no value compared to those bereaved. A significant number also reported an impact on their personal relationships:

> **It changed who I am. I am scarred by the experience, and it caused me to distance myself from my husband to protect him from the details of events. This has never been healed.**

> **I couldn't really talk to family, I kept to myself for months. I coped by switching off emotionally . . . It had a terrible impact on my relationship with my partner.**

Some psychiatrists said they were still affected by the homicide, years after the event:

> **Even now if my mobile phone goes off if I'm at home, relaxing with the children/family... my heart misses a beat... in case it's someone telling me that a patient has killed... committed suicide... or escaped.**

> **It happened 18 years ago... but I still remember clearly how it made me feel... My blood ran cold... it was the most devastating experience of my career... everyone's worst nightmare.**

These kinds of feelings were exacerbated by the formal processes and the need to consult lawyers and medical defence organisations. The kinds of processes that people experienced included:

- giving testimony as a professional witness at a coroner's hearing or Fatal Accident Inquiry
- giving testimony at the patient's trial
- giving evidence to internal Serious Untoward Incident (SUI) inquiries or Serious Adverse Event Reviews (SAER)
- giving evidence to externally convened inquiries
- giving evidence at disciplinary hearings
- psychiatrists may naturally be anxious about potential for referral to the GMC but in practice this is rare.

Feelings of being unfairly blamed and injustice were common. One respondent reported that they felt they were being treated as though they were the perpetrator of the homicide. Other negative experiences included:

- fearing that they would lose their job
- being unsure whether they would be supported by their employers or whether their employers would take up an adversarial position towards them
- feeling that they had to keep going due to their clinical workload and responsibilities and could not take time to process what had happened
- feeling uncertain about their future
- being scapegoated and singled out for blame, and a loss of collective team responsibility.

> **The internal inquiry blamed everyone and was poorly managed. The interview was very traumatic... a panel of eight people, arguing with each other... I physically collapsed afterwards... I had no solicitor, no support.**

> **I learned the meaning of the term Kafka-esque... being prosecuted for something but you don't know what, and... things around you keep changing in an inexplicable way.**

As a result of these experiences many psychiatrists reported withdrawing from potential sources of support and, in some cases, becoming mistrustful of their colleagues.

> **It made me feel unable to trust colleagues who tried to shift blame from themselves.**

> **Everyone was trying to cover their back. I needed to be there to stop them pinning it on me.**

The majority of psychiatrists did not seek professional support and for some this was due to a lack of recognition of their needs at the time, feelings of responsibility to their team or service, and/or lack of availability:

> **In retrospect I ought to have given more weight to the impact of this on me and taken time away. This wasn't suggested though.**

> **Looking back, I got quite depressed... not knowing what was going to happen next... assuming the worst... assuming my career was over, before it had even started... I kept thinking I should have done more... it was a potentially career-ending event.**

However, those who worked in environments where support was provided often found this helpful.

> **My team, manager, clinical director and CEO were utterly amazing. The CEO called me to check in. The team looked after me. My manager called ahead to a meeting I was chairing to make sure they looked after me.**

Some psychiatrists who responded to the surveys said that the PPH was an important learning experience that could lead to positive change in their clinical practice.

> **It confirmed my existing beliefs about the importance of accurate record keeping, including formalising leave cover. It was the hardest thing I have ever dealt with but taught me a lot early on. I have been able to support colleagues who have experienced similar things.**

How to look after yourself

It is to be expected that a PPH will have some impact on you. This impact can vary. It is important to recognise that you may need to do things a bit differently in the period after you hear about the homicide for the benefit of your own health and wellbeing. The following strategies may be helpful.

The first few days

There are often many demands on psychiatrists in the immediate aftermath of a PPH. You are likely to have urgent duties to carry out as well as your normal ones. You will be able to perform these tasks better if you pay attention to your own welfare.

- **Ask for help and support.** Your capacity to look after yourself may be impacted by the inevitable denial that follows such a shocking event. Don't hesitate to reach out for assistance.

- **Connect with the people around you.** If you feel fear and anxiety, it can make it far harder to reach out and ask for help. Evidence about support after traumatic events indicates that those who fare best tend to be those who are able to connect with their natural support systems, such as family, friends, colleagues and communities. Many psychiatrists find it helpful to talk confidentially to a colleague who has been through similar experiences or other clinicians involved in caring for the patient.

- **Look after your emotional and physical health.** You may have experiences similar to a grief reaction. Consider if these emotions interfere with your ability to carry out your clinical duties. Have some structure to your day (particularly if you need time off work to recover), including activity and rest times.

- **Consider adjusting your workload and consider whether you need time off.** Some psychiatrists can find it hard to take a break from work even though they know they need one and others find work is very important in containment. Think what is best for you and your patients.

The medium and longer term

Individuals recover at their own pace, and this is influenced by many factors. In PPH the time it takes for the formal processes to conclude is likely to impact on the time it takes for you to recover. If you are still having difficulties several weeks or months on, or only begin to have difficulty at a later stage, this is not unusual and not something you have to struggle on with. You may benefit from some additional support.

Signs that this may apply to you include the following:

- frequent intrusive thoughts about or images of the events around the PPH
- feeling fearful, or a sense of dread going into work
- nightmares and disturbed sleep
- being more irritable, tearful or anxious
- avoiding people or situations that remind you of the PPH, or where you may need to make difficult clinical decisions
- taking longer than usual over work tasks, doubting your judgement or having difficulty concentrating
- low mood
- thinking about leaving your job or leaving psychiatry altogether.

Like other doctors, many psychiatrists find it difficult to admit they are in emotional difficulty. Concerns about confidentiality and not understanding the support structures available are key obstacles to seeking help. You may find it easier to speak to someone outside of your workplace initially. This may be a friend or relative, although your GP may also be a good starting point.

Seeking more formal professional help

A few psychiatrists experience significant mental health difficulties following a PPH, including depression, anxiety or PTSD. Consider speaking to your GP in the first instance. Remember that counselling or therapy is an option if you prefer to speak to someone independent. Some deaneries or occupational health departments offer this, or you can access NHS Practitioner Health, national helplines or private therapy (see the section on resources at the back of this booklet). There are effective treatments out there and most psychiatrists who access this sort of help find it beneficial.

> **Therapy is what helped me process the trauma and guilt and manage to return to work. I would have left my job and the Trust otherwise, with hindsight.**

> **A professional development group for psychiatrists affected by PPH was helpful.**

Navigating scrutiny of the care provided

Following a homicide, the serious nature of the event and the release of profound unconscious dynamics often prompt a search for someone or something to blame. This tendency to seek a simple cause helps avoid confronting deeper, unsettling emotions and can cause harm to individuals who are unfairly singled out and held responsible for a complex and multifactorial event. This scapegoating can hinder the mourning process and block the path to genuine learning from such events. It's vital to distinguish between unjustified blame and legitimate investigation into the care provided, with the latter aimed at fostering future learning. The pressure in such circumstances can be significant, so ensure you have support. Unfounded blame is counterproductive and damaging, while constructive scrutiny is valuable.

What might help to prepare you for the experience of PPH

The following are suggestions of where you can learn more about what to expect:

- **Workshops and resources**
  In England, trust and medical indemnity organisations run workshops on legal processes and have articles about how to write a statement to the coroner or prepare for an inquest. In Scotland the School of Forensic Mental Health and medical indemnity organisations run similar workshops to prepare for a Fatal Accident Inquiry.

- **Other psychiatrists**
  Some psychiatrists are willing to share their experience at academic meetings or in local professional support groups.

- **Learn about local processes**
  It can be very helpful to find out about how your organisation responds to serious incidents, and to get involved in these processes, before you experience them yourself.

- **Learning opportunities such as attending conferences**
  The Royal College of Psychiatrists hosted a one-day conference on PPH in 2022 and further sessions are planned for future RCPsych International Congresses.

- **Literature**
  As doctors, we often learn by reviewing the available literature. A few key references are included at the end of this booklet.

The formal processes following a PPH in England, Wales and Northern Ireland

The inquest and the coroner

In England and Wales, sudden and unexplained deaths are reported to the coroner, who is an independent judicial officer and a qualified solicitor or barrister. Some are also medically qualified. A coroner must hold an inquest if a death is found to be unnatural, occurred in prison, police custody or in hospital.

In cases of homicide, the coroner orders a post-mortem to determine the medical cause of death. However, where a person may be charged with an offence of homicide, the coroner must suspend an inquest whilst criminal proceedings are ongoing. Usually, where there is a conviction as a result of a criminal trial, the coroner will not resume an inquest. However, it remains their prerogative to resume an inquest at this point and is more likely where the coroner believes that there are Article 2 European Convention of Human Rights (ECHR) issues which need to be explored. Where an inquest follows a criminal trial, the outcome of the inquest as to the cause of death must not be inconsistent with the outcome of criminal proceedings.

The inquest is not a trial, and its role is **not to apportion blame**. The role of the inquest is to discover the facts about:

- who has died
- how they died
- when and where the death happened.

This is with the aim of giving a verdict so that the death can be officially registered.

Being a witness at an inquest

If you were directly involved in the patient's care, the coroner is likely to request a statement from you via your employing organisation's legal department. The coroner may also ask you to attend the inquest as a witness. Families sometimes have their own legal representative at the inquest, so that they have someone who can guide them through the process, give them advice and ask questions.

Your employing organisation's legal department will usually act as your link with the coroner, and they will provide legal advice and support if you are asked to write a

statement for the coroner and/or are called as a witness for the inquest. Information to include are:

- the patient's demographics including their name, date of birth and address
- your qualifications
- how you became involved in the patient's care
- a timeline of the patient's care, mental state and progress while they were being treated by you and your team
- a brief summary of your statement at the end.

Your professional indemnity insurance organisation can provide you with advice about your statement once it has been fully anonymised. You may find it useful to read previous statements to the coroner from colleagues who have been in your position in the past, particularly if this is the first time that you have been required to write a statement.

Sometimes, during the inquest, the coroner can become concerned about an aspect of care provided to the person identified as the perpetrator. In this case they may make a Prevention of Future Deaths (PFD) report. The provider organisation must respond within 56 days, stating what action it has taken over the area of concern. These reports are sent to the Chief Coroner and published electronically.

There are clear guides to the inquest process. See the Ministry of Justice's Guide to Coroner Services for Bereaved People and also John-Smith et al (2009) (referenced at the end of this booklet).

Internal investigations within the trust

As with any patient safety incident, when there is a suspected PPH, the provider organisation has a statutory duty of candour (Health and Social Care Act 2008 Regulations, 2014). Following initial notification of the suspected PPH, the provider must contact the affected parties, provide an account of what is known about the event, advise them of the further inquiries that are required, and offer an apology for any distress and suffering caused; this is not an admission of liability. This must be recorded in a written record.

Following a PPH there will be an internal investigation within the trust, sometimes called a Serious Incident (SI) Review, Patient Safety Incident Investigation or similar.

- This investigation should not be about finding out about, or commenting on, the responsibility for the homicide; this should be determined at the criminal trial.
- It is an opportunity to look at the pathway of care provided to the patient and whether anything can be learned from an examination of this. The aim is to identify, both good practice and areas for development, and make recommendations that can improve future care of other patients.
- These processes are about rational fact-based organisational learning and not for providing emotional support for the clinicians involved.

A member of the mental health service's team investigating the SI makes contact with the family and asks for their views to be added to the investigation.

Formal processes when a patient kills a child (not in Northern Ireland)

This is an extremely rare event. When a child under 18 dies, a process is automatically started to check every aspect of what has happened.

- This is the responsibility of the Child Death Overview Panel (CDOP). Their inquiry runs alongside the inquest, and its aim is to protect other children and young people. The CDOP reports to the Local Safeguarding Children Board, and both work with the coroner to share information.
- The Local Safeguarding Children Board includes a Rapid Response function, which is a comprehensive and multi-agency review of all unexpected child deaths. Professionals involved in this process provide initial support to the family and help to inform the subsequent CDOP review process. The aim of the CDOP is to classify the cause of death, identify modifiable factors, decide on preventability of death, consider whether to make recommendations and to whom they should be addressed.

Domestic Homicide Reviews (DHRs)

DHRs were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. The Act describes DHRs as "a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom they were related or with whom was or had been in an intimate personal relationship, or
- a member of the same household as themselves."

DHRs are not about establishing culpability but concerned with learning lessons to prevent future domestic homicides. Northern Ireland does not have DHRs.

If either the perpetrator or victim (or both), of a domestic homicide are known to the mental health organisation, there is a requirement to produce an individual management review (IMR). The trust's safeguarding team will lead on completion and attend panel meetings as required. The IMR cannot be completed by the professionals directly involved or by the line manager of the professional. You will therefore not be part of the process. All overview reports are anonymised and made publicly available.

Police inquiry

If the services are impacted by a police inquiry, then the staff team may be advised against talking to one another about the event and care they provided. This should not prevent them from seeking support, advice and help from the organisation's pastoral services, employee assistance programmes and their union and defence organisations. Clinicians may also continue to work with each other in the same team and can seek and provide emotional support to each other as needed. Leaders and managers in organisations should be aware of these difficulties and proactively provide advice – supportive and legal – to the team as needed.

The formal processes following a PPH in Scotland

Duty of candour

Where a potential PPH has occurred, a duty of candour (DoC) response should be triggered. This must be followed as soon as possible after an organisation providing health, care or social work services receives confirmation that, in the opinion of an independent health professional, a person has experienced an unintended or unexpected incident which appears to have resulted in harm or death. The death or harm should not be related to the natural course of the illness or underlying condition for which the person is receiving treatment or care. In cases of PPH, both the perpetrator and the victim's families are 'relevant persons' to whom separate DoC responses are owed.

The procurator fiscal

In Scotland, sudden and unexplained deaths are reported to the Scottish Fatalities Investigation Unit, part of the Crown Office and Procurator Fiscal Service (COPFS). There is the discretion to hold a Fatal Accident Inquiry (FAI) under the Fatal Accident and Sudden Deaths Act 2016 for any death which is sudden, suspicious or unexplained, where it is in the public interest to do so. There is a requirement for an FAI in certain circumstances, for example a death in custody or a death caused by an accident at work. This is a judicial inquisitorial process held in the Sheriff court and the resulting determinations regarding the facts surrounding a death are published. A determination may include recommendations of steps that can be taken to avoid deaths in the future. It is not the function of an FAI to apportion blame but a determination may include criticism from which fault can be inferred. Witnesses at FAIs are not required to answer questions which tend to show they are guilty of a crime. FAIs following PPH are vanishingly rare.

Being a witness at an FAI

If you were directly involved in the patient's care, you may receive a citation to attend an FAI. If you are employed by NHS Scotland, you should seek permission from your line manager to seek representation from the Central Legal Office (CLO), the in-house legal team of the part of the NHS National Services Scotland. You should also inform your medical defence organisation who are unlikely to become actively involved unless there is a difference between the interests of the NHS and your own.

Internal investigations within the Health Board

Following a PPH there may be an investigation within the Health Board, called a Serious Adverse Event Review (SAER). SAERs are carried out in the NHS where events have resulted in unexpected death or harm. Reviews are focused on analysing factors that have contributed to the adverse outcome and follow the National Framework guidance published by Health Improvement Scotland (HIS). The Framework is now in its fourth iteration and was published in December 2019 (HIS, 2019). HIS have a role in collating information from all SAERs and Health Boards must inform HIS of all SAERs.

The Mental Welfare Commission for Scotland

The Mental Welfare Commission for Scotland (MWC) is a non-departmental public body responsible for safeguarding the rights and welfare of people in Scotland with an intellectual disability, mental illness or other mental disorder. Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 gives the Commission the power to carry out investigation as it considers appropriate into a patient's case and to make such recommendations as it considers appropriate. The same legislation gives broad statutory authority to hold inquiries and obtain records.

The MWC define a mental health homicide as any homicide where the perpetrator had a mental disorder at the time of the offence and was under the care of the specialist mental health and learning disability services or under their care within the last 6 months. These cases should be notified to the MWC in addition to local reporting arrangements. Further details on notification to the MWC can be found at: www.mwcscot.org.uk.

The MWC have submitted proposals to Scottish Government to streamline a single notification and mental health homicide pathway across Scotland and are awaiting approval.

> **"There was no support of any kind or advice from colleagues or the employer... I was made to feel like a pariah... the Trust saw me as a threat... I was not provided with any information about the Trust response to the SUI [serious untoward incident] or the inquiry."**

> **"Very good. Interviewed for 3 hours… by trust lawyer the next day who drafted my statement that I needed for the next 2+ years… really wise and helpful."**

Formal processes following the death of a child

In Scotland, a learning review (previously known as a significant case review) should take place if a child has died by alleged murder, culpable homicide, reckless conduct, or act of violence. The aim of the learning review is to improve the protection of other children and young people. This includes areas where practice needs to be improved and examples of good practice (Scottish Government, 2021).

A learning review should focus on understanding:

- what happened
- how some assessments were made
- how people saw things at the time
- what knowledge was drawn on to make sense of the situation
- the resources available
- the emotional impact of the work
- effective practice.

It should also identify learning points and set out how these should be actioned and implemented in the future.

In Scotland, the key guidance for carrying out learning reviews is National guidance for child protection committees undertaking learning reviews (Scottish Government, 2021). The process is initiated when the local child protection committee (CPC) is notified about a case that might meet the criteria for a learning review.

Domestic homicide reviews (DHRs)

There is currently a taskforce considering the introduction of DHRs in Scotland.

Psychiatrists' experience of the formal processes

The formal inquiry processes ensuing from a PPH can be experienced as challenging, particularly if you feel vulnerable. The data from the surveys mentioned earlier indicated that psychiatrists can find inquests and internal investigations helpful or unhelpful depending on the attitude of the coroner, the investigators and the mental health organisations.

If these processes were experienced as hostile or persecutory, the psychiatrists said it was harder to recover emotionally. If they were experienced as understanding and compassionate, it was reparative for them.

The aim of the investigation should be to find out what happened and not to blame you, however in some cases, due to the intense feelings around a PPH, this is not the experience. It can therefore be very important to have a supportive colleague accompany you to inquiries (and inquests).

Psychiatrist can be frightened of professional sanctions, however there is no need to inform the GMC, and in nearly all cases they will not be involved.

Relationships with carers and service users

(including the families of the perpetrator and victim)

It's important to acknowledge the profound impact and the needs of families and other loved ones of both the perpetrator and the victim. Their needs should be carefully considered by the leadership of the organisation and compassionate communication facilitated at all times. Some families will wish to continue the relationships with care providers; others may not. Families and carers may want support or feel angry towards the organisation or professionals involved in the care of their loved one. Each case needs consideration on its own merits. Often meetings are requested/set up between the victim's family members and trust representatives. Victims' family members may want to speak with the consultant whose patient killed their loved one. You may feel that you want to contact the families yourself immediately after the death. What you feel is in the best interests of the family may be coloured by your own emotional state at this time. Think about this and take advice. Also ensure that any police views regarding contacting families at this early stage have been taken into account.

Psychiatrists' suggestions about resources and activities

There are some resources and activities that psychiatrists have found helpful or wished they had access to following a PPH.

The survey respondents were asked to rate various suggestions for support following a PPH. In order of popularity, these included:

- Access to a senior clinician who understands the impact of PPH and is able to offer confidential advice and support, possibly a trust lead in suicide and homicide support in England.
- Having support for the formal processes following a PPH.
- Access to a confidential reflective practice group or similar.
- Having contact from someone who has been through a similar experience to provide guidance and support (e.g., a 'buddy' scheme).
- Information, training and workshops from clinicians who have experienced a PPH to share experiences and gain information about the processes following PPH.
- Counselling and therapy.

Concluding remarks

A PPH may well be one of the most challenging and painful experiences you will face in your professional career. You are not alone – some of your colleagues have been through a similar experience. The emotional pain will generally ease with time. Make sure to look after yourself and do not underestimate the care you might need from others or from yourself. Psychiatrists notoriously find it difficult to attend to their own emotional needs, but this is the best thing you can do for yourself, your team, your family and your patients.

It is also important not to collude with the idea that you are to blame for this death. Blame implies that the responsibility lies with one person only. This is clearly not the case and denies the complex reality of homicide and the diverse nature of responsibility. Whilst we may have some responsibility for an aspect of the care provided or not provided, to assume too much responsibility for an act we often cannot understand and can seldom, if at all, foresee, and the uncertainty of which cannot be resolved, is not reasonable. It is our role as psychiatrists to maintain engagement with reality and, in this way, to help others in this challenging task, as well as helping ourselves.

The content of this booklet was based on information from two surveys of psychiatrists and on clinical and research experience by a multidisciplinary group of professionals, many of whom had the experience of a patient-perpetrated homicide. By sharing this information our aim is to support psychiatrists at all stages of their career, to reduce isolation and to recommend helpful resources for those psychiatrists who experience a PPH. We hope that you will find this booklet useful and will share it with anyone you think may benefit from it.

The format of the booklet is based on a similar booklet produced by the Oxford Centre for Suicide Research (Keith Hawton, Karen Lascelles, Anne Carbonnier, Fiona Brand, Allison Croft, Gislene Wolfart, Rachel Gibbons) to provide support for clinicians following the suicide of a patient. (If A Patient Dies by Suicide: A Resource for Psychiatrists).

Clinicians involved in the production of this booklet included: Gwen Adshead, Rob Ferris, Philippa Greenfield, Rachel Gibbons, Helen Killaspy, Gill Mezey, Smita Pandit, Mayura Deshpande, John Crighton, Ihsan Kader, Thomas McKeever.

References

Eastman N (1996) Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *BMJ*, **313(7064)**: 1069–71.

Szmukler G (2000) Homicide inquiries: what sense do they make? *British Journal of Psychiatry Bulletin*, **24(1):** 6–10.

Turner T and Salter M (2005) What is the role of a community forensic mental health team? *British Journal of Psychiatry Bulletin*, **29(9)**: 352.

Crichton JHM (2017) Falls in Scottish homicide: Lessons for homicide reduction in mental health patients. *British Journal of Psychiatry Bulletin*, **41**: 185–86.

Elbogen EB and Johnson SC (2009) The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of general Psychiatry*, **66(2)**: 152–61.

Mental Welfare Commission for Scotland (2022) *Proposals for the investigation of mental health homicides*. Final report to the Scottish Government. Available at: https://www.mwcscot.org.uk/sites/default/files/2022-05/MWC_MentalHealthHomicideReport_2022.pdf [Accessed 02 May 2024].

Fazel S and Grann M (2004) Psychiatric morbidity among homicide offenders: a Swedish population study. *American Journal of Psychiatry*, **161(11)**: 2129–31.

Fazel S, Buxrud P, Ruchkin V and Grann M (2010) Homicide in discharged patients with schizophrenia and other psychoses: a national case-control study. *Schizophrenia Research*, **123(2–3)**: 263–69.

Flynn S, Ibrahim S, Kapur N, Appleby L and Shaw J (2021) Mental disorder in people convicted of homicide: long-term national trends in rates and court outcome. *The British Journal of Psychiatry*, **218(4)**: 210–16.

John-Smith P, Michael A, Davie T (2009) Coping with a coroner's inquest: a psychiatrist's guide. *Adv Psych Treatment*, **15**:7-16.

The Home Office (HM Government) (2020) *Trends and drivers of homicide: Main findings*, Research report 113. Available at: https://assets.publishing.service.gov.uk/media/5e5f912fe90e077e3477e49a/trends-and-drivers-of-homicide-main-findings-horr113.pdf [Accessed: 14 June 2024].

The Home Office (HM Government) (2021) *Corporate report: Domestic homicides and suspected victim suicides during the pandemic*. Available at: https://www.gov.uk/government/publications/domestic-homicides-and-suspected-victim-suicides-during-the-pandemic [Accessed 14 June 2024].

The Home Office (HM Government) (2021) *Key findings from analysis of domestic homicide reviews: October 2019 to September 2020*. Available at: https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews [Accessed: 07 June 2024].

The National Archives (HM Government) (2009) *Coroners and Justice Act 2009*. Available at: https://www.legislation.gov.uk/ukpga/2009/25/schedule/1#:~:text=(a)if%20at%20least%20seven,new%20jury%20must%20be%20summoned [Accessed: 02 May 2024].

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) *Annual Report: England, Northern Ireland, Scotland and Wales*. Available at: https://documents.manchester.ac.uk/display.aspx?DocID=37560 [Accessed: 02 May 2024].

United Nations Office on Drugs and Crime (2013) *Global study on homicide: trends, contexts, data*. Available at: https://www.unodc.org/documents/gsh/pdfs/2014_GLOBAL_HOMICIDE_BOOK_web.pdf [Accessed: 02 May 2024].

Hussain Q, Killaspy H, McPherson P and Gibbons R (2023) Experiences and support needs of consultant psychiatrists following a patient-perpetrated homicide. *BJPsych Bulletin*, 1–7. doi:10.1192/bjb.2023.15.

Martinez R Jr, Nielsen AL and Lee MT (2003) Reconsidering the Marielito legacy: Race/ethnicity, nativity, and homicide motives. *Social Science Quarterly*, **84(2)**: 397–411.

Mezey G, Rowe R and Adshead G (2021) Impact of homicide by a psychiatric patient on forensic psychiatrists: national survey. *BJPsych Bulletin*, **45(3)**: 183–89.

Walsh E and Fahy T (2002) Violence in society: Contribution of mental illness is low. *BMJ*, **325(7363)**: 507–08.

Resources and sources of support for psychiatrists

Resources and further reading for psychiatrists

- **Royal College of Psychiatrists leaflet: Post-Traumatic Stress Disorder**
  Online information on post-traumatic stress disorder, detailing symptoms, treatment and links to sites providing further help.

  Available here: https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-traumatic-stress-disorder

Sources of support for psychiatrists

- **BMA Counselling**
  24/7 helpline, individual counselling and Doctors Advisor Service (peer support). Free telephone support for all doctors and medical students.

  Website: http://www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service
  Tel: 0330 123 1245

- **DocHealth**
  Independent psychotherapeutic consultation service for doctors. Based in London but available to all doctors in the UK. Fees payable.

  Website: http://www.dochealth.org.uk
  Tel: 020 7383 6533

- **Improving Access to Psychological Therapy services (IAPT)**
  Primary care mental health services in England offering a range of evidence-based treatments for common mental health problems via telephone, online and face-to-face services. Accept self-referral. Search 'IAPT' for your local service contact information.

- **NHS Practitioner Health**
  Free, confidential NHS treatment service for doctors working in England with mental health or addictions problems.

  Website: https://php.nhs.uk/
  Tel: 020 3049 4505

- **Private therapy**
  - BABCP accredited CBT therapists: http://www.cbtregisteruk.com/
  - UKCP accredited psychotherapists and counsellors: https://www.psychotherapy.org.uk

- **Royal College of Psychiatry Psychiatrists Support Service**
  Free, confidential support and advice service for psychiatrists at all stages of their career.

  Website: https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service
  Tel: 020 7245 0412

- **Sick Psychiatrists Trust**
  Free helpline for psychiatrists with drug or alcohol issues.

  Website: http://sick-doctors-trust.co.uk/
  Tel: 0370 444 5163

- **The Samaritans**
  Charity aimed at listening to people who are angry, depressed and suicidal any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

Resources and support agencies for family and friends

- **Cruse Bereavement Care**
  A confidential bereavement service.

  Website: https://www.cruse.org.uk/
  Tel: 0808 808 1677

- **The Compassionate Friends**
  Charitable organisation supporting bereaved parents and their families after a child dies.

  Website: www.tcf.org.uk
  Tel: 0845 123 2304

- **Samaritans**
  Charity aimed at listening to people who are angry, depressed and suicidal any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

- **The Way Foundation**
  Supporting young widowed men and women as they adjust to life after the death of their partner.

  Website: https://www.widowedandyoung.org.uk/
  Tel: 01332 869 222

- **Winston's Wish**
  A national grief support programme for bereaved children.

  Website: https://www.winstonswish.org/
  Tel: 08452 03 04 05