ELFT Suspected Homicide Thematic Review

Prepared for the ELFT Quality Committee, March 2026

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Dedication

The findings and recommendations from this report arise as a result of tragic loss of life at the hands or through the acts of someone under our services. Every life lost, whether taken in a homicide or a death by driving, leaves behind a legacy, and family, friends, and communities whose lives will never be the same.

This review is dedicated foremost to the victims and their families. We are immensely grateful to have access to information relating to their tragic losses, via the safety reviews undertaken, to take learning and drive any identified improvements to clinical care.

We also wish to recognise the patients, to whom we have/had a duty of care, and their affected loved ones, many of whose lives have also been irreparably changed by these incidents.

Executive Summary/Key messages

A review of SI/PSII safety reviews into suspected homicides* perpetrated by ELFT service users between 2020 and 2025 was carried out by a team of Senior Psychiatrists, the trust [redacted] Quantitative and qualitative methodologies were applied, with input from our [redacted] Follow-on analysis of safety action and improvement work completed or underway, aligning to these themes was completed, with recommendations based on these findings.

Quantitative data analysis findings included:

- North East London does not appear to be an outlier in terms of homicide events in recent years, relative to other ICBs in London. Equivalent data is not yet available for Bedfordshire but will be reviewed once available.
- Analysis shows a small rise in the 3-year average in 2025. It is too early to determine if this is a sustained increase and should be interpreted with caution given the low absolute numbers and heterogeneous nature of the cohort.

Thematic Review Findings:

Patient themes included:

- Perpetrator ages ranged from 15 to 46, with most perpetrators [redacted] aged between 23 and 46 and an equal spread between people in their 20s, 30s and 40s. The vast majority were male [redacted] with only [redacted] female perpetrators.
- Most victims were known to the perpetrators, with family members frequently targeted, but the proportion of homicides towards an intimate partner was lower than in wider population data.

- Perpetrators from ethnic minority or mixed ethnicity backgrounds overrepresented relative to those recorded as white UK.
- A history of past violence, misuse of drugs, broader social issues and a diagnosis of psychosis.

Service-related themes included:

- All perpetrators were under the care of ELFT mental health services with the majority under North East London [redacted] rather than our Luton and Bedfordshire services [redacted], and a distribution of location of incidents in directorates in keeping with wider data on rates of violence in these areas.
- No pattern or cluster found in terms of which individual service/team involvement.
- The majority [redacted] patients were in the community and under community services at the time of the incident, with [redacted] was [redacted] at the time the incident occurred.
- Evidence of a wealth of good practice characterised by teams working proactively, communicating well, and coordinating effectively across disciplines. Assessments and treatments as thorough, evidence-based, and responsive to changing needs. Patients and families experiencing regular, flexible, and supportive communication, with risks managed appropriately and escalated when required. Overall, care remaining firmly needs-led and guided by clear therapeutic principles.
- Non-engagement with services was a common finding amongst the group, with reliance on families and remote methods rather than F2F input, for communication and updates.
- Other less dominant themes arose relating to medication management, issues relating to use of MHA and CPA, Risk Assessment and Management, Staffing and Workload, Staff Competence and Professionalism, Operational Systems and processes, Service Availability, Liaison with Police or other agencies and/or Specialist Input and Co-working between services.

Following a gap analysis undertaken of safety actions recommended in individual reviews and existing improvement work, a range of **recommendations** have been made in the following areas:

- Victim safety planning
- Learning from good practice
- Risk management where there is a history of violence
- Assertive and Intensive cohort offer
- Dual diagnosis and Substance Misuse Care
- Non-engagement policy and processes
- Use of Very Long-Acting Injectables
- Processes to follow missed/refused depots
- Police liaison
- Oversight of mental health community team staffing and workloads.
- Interface between forensic and general adult services.
- Ongoing Monitoring of homicide data both within ELFT and in collaboration with NHSE and NCISH.
- Integrated sharing of learning from homicides

* [redacted] cases were categorised as suspected homicides at the time of writing, with [redacted] additional [redacted] included categorised as [redacted].

Background and Introduction:

The Office of National Statistics lists homicides in the general population, and the 2024 dataset shows that homicide rate remains low, with 9.5 homicides recorded per million population during the year ending March 2024. Of these, around 5% of the perpetrators each year are convicted of manslaughter based on diminished responsibility due to mental disorder. Between 2012 and 2022 there were 658 victims of patient homicide, an average of 60 per year across the UK. Patients represented 11% of people convicted of homicide. (NCISH, 2022).

Homicide by service users under mental health services remains an extremely rare outcome at a national level. It is widely acknowledged that homicides are very difficult to predict or prevent. A review in 2023 found that in a series of 105 independent reviews of mental health homicides, only (4%) were deemed to be both predictable and preventable, ten (9%) were preventable but not predictable, five (5%) were predictable but not preventable, and 86 (82%) were neither predictable nor preventable (Deshpande et al, 2025).

Whilst every homicide is a tragedy deserving of individual in-depth review for learning and improvement, the Trust is also keen to monitor and review collectively for any significant patterns or clusters needing special attention and focus.

The Office of National Statistics highlights that data on yearly numbers needs to be interpreted with considerable caution: "As homicide is a relatively low-volume offence, there tend to be fluctuations in numbers from year to year. This is especially true where data have been broken down further for analyses of sub-groups of the population. Figures should therefore be interpreted with caution." (ONS, 2024).

Purpose of this review:

In mid-2025, ELFT executive team commissioned this internal thematic review into the care of service users who had perpetrated homicides whilst under care of the Trust, to identify any learning and improvements to take forward. It was decided that a focus on homicides with the last five years would be most useful, to ensure applicable and relevant learning from current service configurations and care offers.

Thematic reviews are recognised by NHS England as a valid and useful safety tool in Mental Health Trusts. They are a way of detecting prominent and repeating themes for learning and improvement purposes. These themes can then be considered when learning lessons and planning or re-focussing services.

The focus of this review was agreed with the [redacted] as follows:

1. For safety learning and improvement, to establish any common themes, trends or patterns in the demographic profile, good practice identified, investigation findings and/or the system factors identified in internal safety reviews undertaken.
2. To explore any common themes in relation to the improvement actions required and establish any areas requiring further improvement action based on any gaps between the learning arising and the improvement action recommended/taken.

Review Questions:

What was the quality and safety of care provided to service users who have been suspected or found to have perpetuated homicides within the last 5 years, as identified via the findings from ELFT safety reviews undertaken following the incidents? To what extent do the safety actions proposed, or any other trust improvement work undertaken, appear to address the themes in the findings and recommendations arising? What, if any, are priority areas for further learning or improvement identified from this review?

Definition of Homicide in this review:
Within the trust, all suspected homicides incidents are logged as 'homicide' at the time they occur and reported. For this review, cases were included suspected homicide, regardless of subsequent court outcomes. In addition, child death initially identified as a homicide, were included in the homicide figures to ensure accurate reporting.

Limitations:

1. **Small group of cases.** When conducting the review, we were aware of the limitations of taking learning from a small group of only eleven cases, and those which have been chosen based on an outcome that is both rare and multifactorial in nature. In doing so, we could not draw any firm conclusions about causality, or what factors may lead to a good or non-eventful outcome, rather than a tragic one.
2. **Near misses not included.** "Near misses" or non-incidents were not included, as these have not historically undergone safety review. These positive outcomes are often invisible, and so it has not been possible to learn from patients with positive outcomes, or the times in these patient's journeys when another incident may have been prevented or avoided.
3. **Based on Safety Review Findings and Methodology** The review material used here was from internal ELFT safety reviews, and so inevitably any findings were determined by the quality of investigation, analysis method applied, and the lens through which care was seen. Whilst ELFT safety reviews are conducted by skilled and experienced safety reviewers, with subject matter expertise input, some of the older reviews applied root cause analysis, which we now know to be a flawed methodology for understanding system factors. Newer reviews used the PSIRF methodology, but as it was early in the ELFT transition to PSIRF, the application of systems methodology was still relatively new to the team and so may have limited the learning taken.
4. **Availability of safety review material** The review was limited to inclusion of findings from those investigations which were complete or brief preliminary reviews (72-hour reports or After-Action Reviews) in cases where an in-depth SI/PSII had not yet been completed, so there is potential that some learning could not be taken at this stage.
5. **Limited time frame of each review**. The safety reviews also were limited to a focus on the time leading up to the incident (e.g. the year prior to it), and stopped after the incident, and so learning was limited to this period of care and not from earlier care provided, nor from assessments and insights from after the homicides.

Methodology:

1. **Terms of reference** for the review were agreed with [redacted]
2. ICS footprint data was requested via contacts at NHSE.
3. **Cases were identified** by the Risk and Governance team for inclusion by searching the InPhase incident reporting system and Datix legacy reporting system for all incidents reported by reporters as homicides or infanticides within the time under review.
4. **Quantitative analysis was undertaken** looking at absolute numbers, days between homicides and 3-year rolling averages, to ascertain any trends in the data.
5. **Data cleansing was undertaken**, removing any cases where the incident did not meet the inclusion criteria (see below).
6. A **second manual search** of both Datix and LFPSE was conducted to catch any incidents that may have been mis-categorised in the original search.
7. The **thematic review team was established** – including [redacted]
8. **Terms of Reference and scope were cross-checked and approved** by the CNO and CMO.
9. Where a PSII or SI was available, this formed the main source of thematic data, but where a PSII was not yet complete the reviewers made use of 48-hour report/72-hour report findings, and/or AAR findings.
10. **Inductive theming** was undertaken by two members of the review team independently on the following sections of data:
    a. Good practice
    b. Diagnosis and treatment offered
    c. Findings
    d. Recommendations.
11. The review team brought together their individual sets of themes together to ensure maximal **harvesting of learning and inclusion of multiple perspectives**.
12. **Theming of safety actions** agreed/undertaken was undertaken in parallel and gap analysis performed in relation to the emerging learning themes.
13. **Gap analysis undertaken** in collaboration with local and trustwide leaders, triangulated with existing improvement work across the trust to identify gaps or potential for further improvement work.
14. **Final draft review** brought to PSIRF Learning Response Sign-Off Panel for feedback, discussion and sign-off.
15. Onwards sharing of final draft to the **Quality Committee** for sign off and on to the **Quality Assurance Committee**, for oversight.
16. Final report to be shared via the **ELFT Patient Safety Learning Committee** and other relevant working groups for onward learning.

Inclusion Criteria: Suspected homicides perpetuated service users under ELFT community mental health care where:

- Index incident occurred between 1st August 2020 and 1st Aug 2025
- Incident categorised as suspected homicide at the time of reporting and irrespective of the later determination of outcome.

- Learning has been identified from either SI reviews, PSIIs, 48 hour/72 hour report and/or AARs conducted.

[redacted]

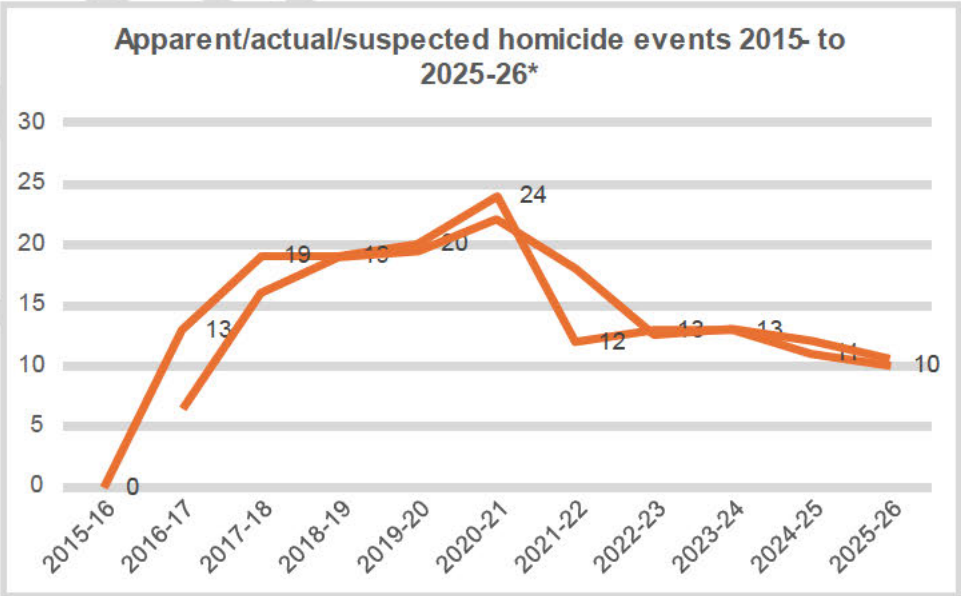
Exclusion criteria:

- Case falls outside the time in question 1 Aug 2020 – 1 Aug 2025.
- Although initially suspected as one, the case was eventually found to not be a homicide.
- Little or no input from ELFT in the vicinity of the incident, meaning that no meaningful learning is available, other than where the findings of the reviews suggest that the lack of input was secondary to failings in care provision.
- Case has not yet had any complete review and therefore cannot be included.
- See appendices 1 and 2 for list of cases excluded and included, and rational.

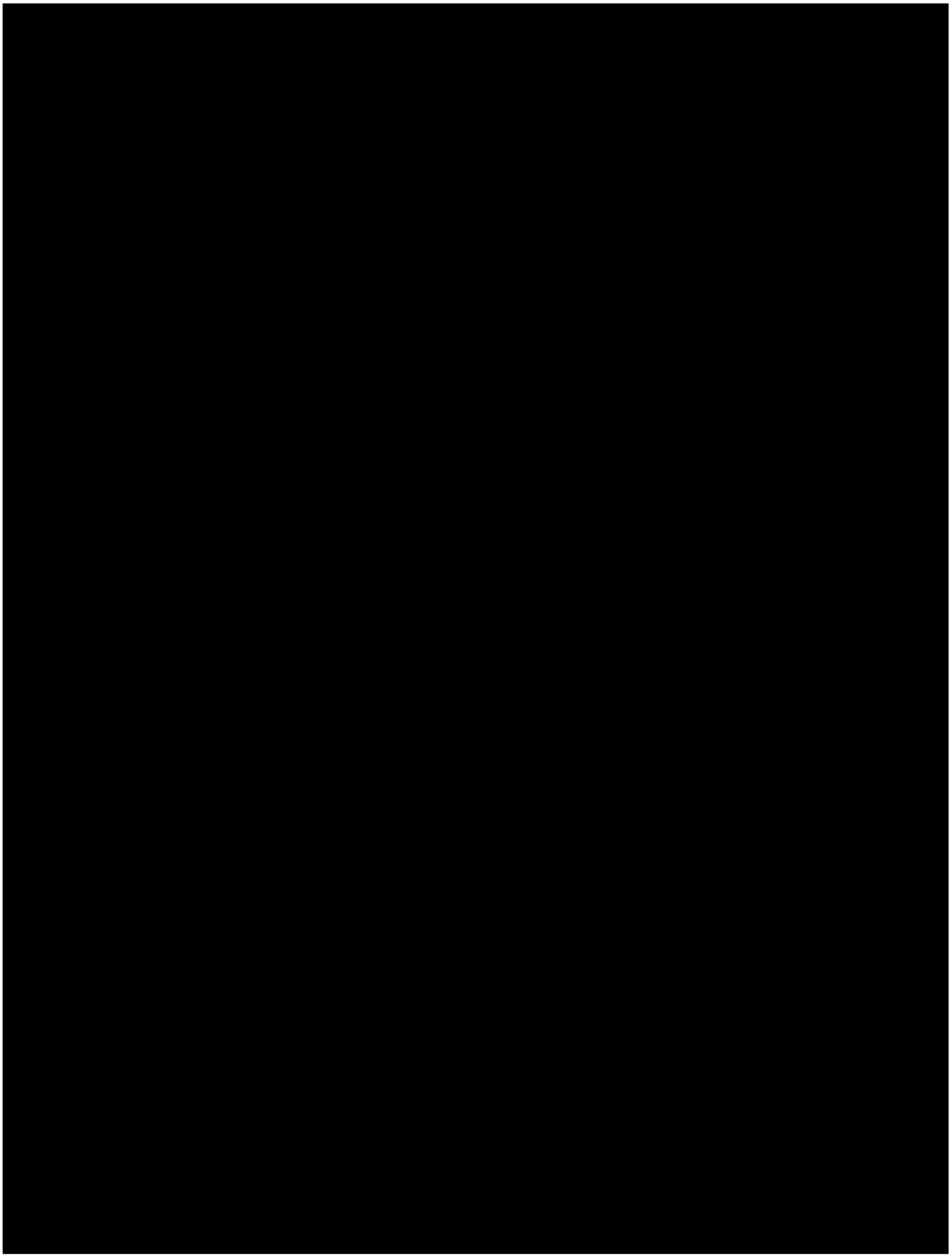
Review Findings – Quantitative - London-Wide Service Users:

NHSE have kindly provided data on homicides by service users under health services across London and in London ICBs over this period to help us identify any trends. Equivalent data has been requested from NHSE relating to East of England and is awaited.

We also contacted the National Confidential Inquiry Team at the University of Manchester (NCISH) for any learning we could take from our data submitted to them. NICSH unfortunately had paused data gathering and analysis for homicides over this time, and were unable to help,



but agreed to link with us going forward to ensure we can take learning from their work on homicides which is restarting this year.

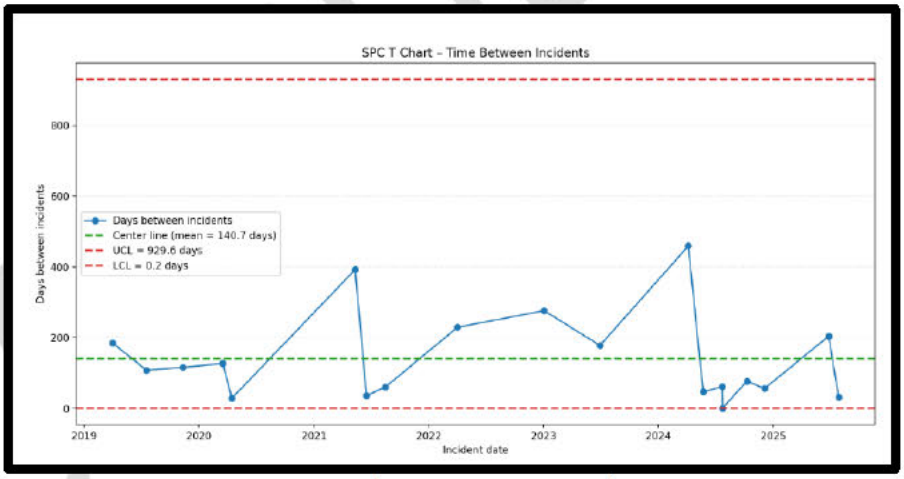


Review Findings – Quantitative - ELFT Service Users

See graph A below which is a statistical process chart outlining the number of homicides over time, since 2018. The graph uses a t-chart, with data points as length of time between incidents, which is agreed as the most helpful measure to assess patterns in rare events. It is noticeable that there was a period in 2024 where homicides were occurring more frequently than previously. However, the t chart is reassuring in showing no evidence of special cause variation, suggesting that this apparent increase could be explained by chance alone, and did not reach statistical significance

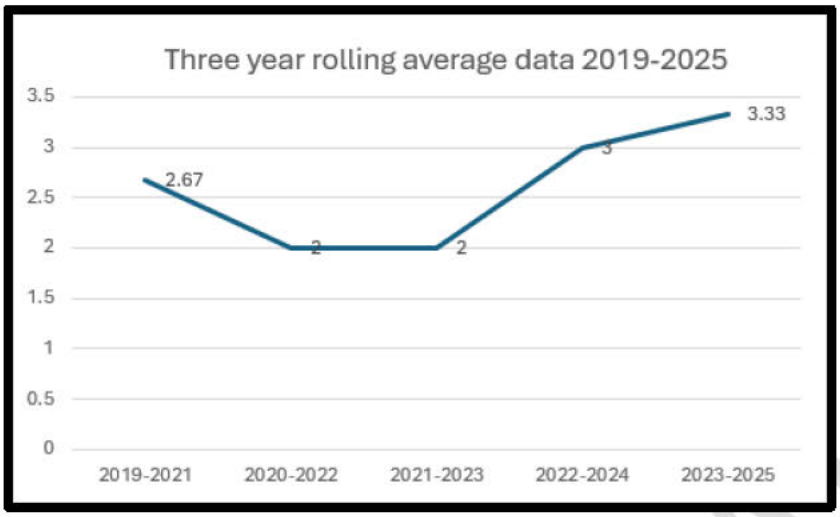
Graph B

We also approached [redacted] helped us



calculate the rolling three-year average (shown in Graph C).

A rolling three-year average is a way to smooth out data over time by calculating the average of a specific metric across three consecutive years, then updating that average as each new year's data becomes available. It has the advantage of reducing noise from year-to-year fluctuations, highlights trends more clearly over time and supports proportionate learning by focusing on patterns rather than isolated spikes.



Graph C

In the graph above, we can see a small increase (0.36) in the three-year average, but we cannot tell if this is significant or will be part of an ongoing upward trend. It has gone up owing to 2024 data with the number that year being the highest of the past seven years recorded. Considerable caution must be applied in terms of drawing any conclusions from this pattern, given the absence of further longitudinal data and the small absolute numbers, in a very heterogeneous set of cases.

Recommendation:

ELFT to continue regular monitoring of homicide numbers, with use of three-year rolling average and/or time-between incidents analysis via Learning from Deaths panel dashboard.

Findings - THEMATIC ANALYSIS

Themes were identified in terms of patient-factors and service-related factors. These are discussed in more detail, along with the corresponding gap analysis findings and recommendations in the section below.

The two tables below show the main themes arising from the inductive theming, and the cases in which these themes arose.

Patient Themes	Good Practice	Service Themes
•Age - 20s-40s •Gender M>F •Ethnic Minorities •Previous Violence •Serious Mental Illness •Comorbid Drug Misuse •Broader Social Issues •Engagement Difficulties	•Assertive and proactive input •High quality assessments and treatment •Liaison between professionals •Regular, supportive and flexible communication •Multidisciplinary approach and oversight •Attentive risk management •Needs- and principle-focussed care	• Good Practice •Engagement Difficulties •Reliance on Family for Updates •Communication Difficulties with Police & other agencies •Staff Behaviour/competence • Delays & system/process failures. •CPA and MHA Issues •Medication Management •Risk Management Variability •Staffing or workload Challenges

[redacted]

1. Perpetrator demographics:

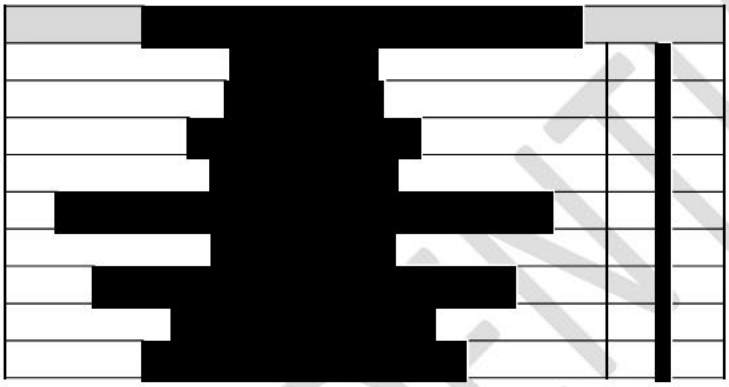
Perpetrator ages ranged from 15 to 46, with most perpetrators [redacted] aged between 23 and 46 and an equal spread between people in their 20s, 30s and 40s. The majority were male ([redacted] with only [redacted] female perpetrators. The non-domestic homicides were exclusively perpetrated by males, which

is in keeping with research findings that men make up most perpetrators of stranger homicides nationally.

2. Ethnicity:

At a population level, ethnic minority groups are overrepresented as homicide suspects in London and England, compared to white people (ONS dataset) reflecting complex social and structural factors and inequalities. Research also shows that ethnic minorities have higher rates of mental illness, driven by structural racism, unequal access to care and differences in treatment.

In keeping with these findings, in the reviewed cohort there was an overrepresentation of patients from ethnic majority and/or mixed heritage backgrounds, relative to the general and/or ELFT patient population, with [redacted] patients from either mixed or non-white backgrounds. This underlines the ongoing need to continue work to address societal and health inequalities affecting access and mental health and broader social outcomes like crime.



Gap Analysis Findings: Under the Improving Equity programme, ELFT has undertaken a substantial of work over many years to embed equity focus in all care provided under the trust. This continues to be a strategic priority and continues to be worked on via the implementation of PCREF across the Trust, co-produced with service users.

Each ELFT borough has areas of focus based on data looking at 'access, experience and outcomes' of racialized service users in respective localities. Using this data, local PCREF steering groups are developing action plans to address identified inequities.

Recommendations:

- Ensure that the ELFT service offer for the Assertive and Intensive cohort is focussed on ensuring equity of access and experience.

3. Location of incident:

The vast majority [redacted] patients were in the community or waiting for or under community services at the time of the incident, with [redacted] being an [redacted] at the time the incident occurred.

4. Relationship between Victim and Perpetrator

Most of the victims were known to the perpetrator prior to the homicide, which is in keeping with research findings that homicides on strangers by those with mental illness are rare events, and more often involve family members or acquaintances.

Of the known victims, there was an equal proportion of friends/acquaintances and relatives (including a child, mother, sister-in-law, grandmother and girlfriend) more frequently those living in the same

house as the victims, again in keeping with national statistics on violent crime. However, it was noticeable that there was only one intimate partner amongst this cohort, and a lower proportion of domestic homicides relative to other homicides than one would expect to find in the general population. This may be a chance finding but also may be related to the fact that this is a cohort of people with serious mental illness, and on average people with serious mental illness are less likely to be in long-term partnership.

We found no themes connecting the homicide circumstances or characteristics of the perpetrators for the four stranger homicides other than that they were under ELFT mental health service and in the same location as the perpetrator at the time of the incident. They include a member of TFL staff, a fellow ward patient and two other strangers in the community at the time of the deaths.

Gap Analysis Findings:

Victim safety planning is a core component of effective risk assessment and management. Routine Enquiry into Domestic Abuse remains a strategic priority for ELFT (2025-26), aligned with NICE Quality Standard QS116, and is increasingly embedded across adult mental health services.

ELFT has established processes to identify potential victims and provide support to those most at risk, with continued strengthening through workforce training, ambassador roles and quality assurance mechanisms. However, learning from recent homicide reviews indicates that identification of domestic abuse risk is not always consistently translated into explicit consideration of risk to others within formulation and risk management plans.

Use of DASH risk assessment tools and a "Think Family" approach was evident in safety actions from relevant safety incident reviews PSIIs [redacted] Nevertheless, identification of individuals at risk such as carers or family members can still rely on clinician judgement rather than consistent system prompts. Visibility of risk information across multidisciplinary teams and at transition points, including discharge and transfers, also requires further strengthening.

The Trust Domestic Abuse Steering Group is progressing actions to address these gaps, including strengthening prompts within RIO risk assessment and formulation templates, embedding consideration of "risk to others" in training and supervision, improving multidisciplinary information sharing, and evaluating the impact of routine enquiry and training on earlier risk identification and preventative action.

5. Good practice

Evidence of good practice was one of the most consistent and prominent themes was the demonstration of a wide range of high-quality good practice by reviewers, which was evident in 100% of cases. This reminds us of the fact that tragic violent outcomes can happen despite the provision of high-quality care.

There were common themes across the range of the good practice described in the safety reviews including:

- Care teams taking an assertive and proactive input
- Evidence of high-quality assessments and treatments
- Good liaison between professionals
- Regular, accessible, supportive and flexible communication with patient and family:
- Taking a multidisciplinary approach and oversight
- Appropriate risk management, onward referrals & escalation of risk issues

- Descriptions of needs-focussed and principle-focussed care

See Appendix for examples of good practice arising under each of these themes.

Gap Analysis Findings: It was notable that whilst good practice was commented on in all the safety reviews conducted, safety action plans did not include actions to spread and systematise good practice, other than onward sharing via learning seminars. There may be an area of opportunity for the trust to grow the Safety 2 focus (learning from everyday work/where care goes well) here, as indicated in the recommendations below.

Recommendations:

- ELFT to continue to work on growing the focus on learning from care has gone well, via the trust Safety Plan, PSIIs and other PSIRF learning responses.
- Sharing of the examples and model of good practice that has emerged from this review to the group working on the ELFT assertive engagement offer, to inform the action plan, and within the ELFT Safety Learning Seminar programme.
- Ongoing work to increase the proportion of safety actions identified within safety reviews that build on, share and systematise identified good practice, processes and systems at ELFT.

6. ELFT Service Involvement

All the perpetrators of homicides included in the review were under mental health services, rather than our primary care or community health services. This may relate to the fact that ELFT provide mental health care to a much larger patient population than in our community services, and only to a small number of GP practices. Our community services are also skewed towards a more elderly and frail population, so less likely to be represented in a perpetrator cohort.

At a population level, violent crime rates are higher in Luton (ONS data) than in London, and Bedfordshire has a lower rate than London. However, [redacted] over this time within our Bedfordshire services and no homicides in Luton services. Whilst this is important to note, it is likely that the timeframe is too short, and numbers too small, to draw any conclusions.

In terms of the London services, ELFT serves some of the boroughs with the highest violent crime rates in London, with both Newham and Tower Hamlets ranking in the top 10 in London for violent crime, and Hackney having a similar rate to Tower Hamlets. Newham has a violent crime rate of 13 per 1000 people, making violence and sexual offences its more reported category. Tower Hamlets also ranks high in overall crime, with a reputation for gang- and drug-related crimes, though its violence rate is slightly below average compared to similar boroughs. Hackney has a relatively high violent crime rate relative to average. This pattern is mirrored in the spread of homicides across ELFT services, with a larger number in Newham, followed by our North East London forensic services, the other NEL boroughs and only one incident in Bedfordshire. It is worth noting that ELFT do not provide forensic services in Bedfordshire.

Service Area	Number of Homicide Cases within reviewed cohort
Newham Adult Mental Health Services	[redacted]
North East London Forensic Services	
City and Hackney Mental Health Services	
Tower Hamlets Adult Mental Health Services	
Bedfordshire Mental Health Services	
Luton Mental Health Services	
City & Hackney CAMHS	

7. Past Violence

The presence of a previous history of violence was one of the most prominent themes to arise in the analysis, which is seen in the above data showing a number of these patients already being in our forensic system, and is in keeping with decades of research findings in this area.

However, violence is common amongst adult mental health population, whilst homicide is a rare outcome, so whilst this finding has relevance, it is unlikely to be a sensitive predictive indicator of homicide as an outcome.

Many of the cases had histories of serious violence. [redacted]

Learning Point: This finding, and the corresponding finding that [redacted] of the homicides were already under forensic services, reminds us that serious violence is very difficult to both predict and prevent, even when assertive high-quality care is being provided by highly skilled professionals working in well-resourced settings. It also underlines the importance of identification of previous violence and targeting of assertive violence prevention efforts towards this high-risk cohort.

Gap Analysis Findings: Risk assessment and formulation, including a focus on ensuring high quality risk assessment and management, historic risk was documented and communicated was a focus of many of the safety action plan arising from the cases reviewed [redacted]

8. Misuse of drugs

Regular substance misuse also emerged as a factor [redacted]

Gap Analysis Findings: [redacted] safety reviews within this cohort has already led to action around the improvement of substance misuse provision on ELFT wards [redacted]). In terms of wider dual diagnosis provision, improvement work is ongoing including the revision of the Dual Diagnosis Policy, a working group and workplan for Dual Diagnosis care in Luton and Bedfordshire, the introduction of a commissioned drug and alcohol service in Hackney, and access to drug and alcohol within the Barnsley Pilot Service. However, further improvement work may be needed to address the needs of this high-risk population, as outlined below.

Recommendation:
Dual Diagnosis Policy to be ratified with assertive work to translate recommendations/standards into practice.

Each borough to have **Individual Dual Diagnosis Improvement Workplans** overseen at Directorate Management Plan level, to mirror that in place in L&B), in agreement with incumbent D&A services, with work to translation of policy into practice and including a proactive offer, focused on joined up care, assertive safety planning for those with substance misuse in combination with SMI and past violence, full participation in drug and alcohol boards in each borough and longer term strategic work towards bringing drug and alcohol services in-house in NEL (as we do in L&B). Workplans to agree a suitable governance structure for oversight.

9. Mental State and physical health factors

Unsurprisingly, most service users in the group reviewed had evidence of mental health conditions and/or symptomatology, [redacted]

Lack of clear acute mental illness immediately preceding offence: In [redacted] cases the perpetrators were not obviously mentally unwell shortly before the homicide, with mental state reviews shortly before many of the incidents, sometimes even the day before. These were mostly not concerning. Some patients were calm, on treatment, or stable on depot. In some cases, psychiatric symptoms emerged on assessment after the event, or retrospectively.

Partial or equivocal mental illness contribution: In a minority of cases, however, patients were either equivocally or demonstrably unwell. In these cases, however, risk assessments prior to the offence were not reporting any increase or escalation in risk of violence to others. [redacted] n these cases, the illness may have contributed to disorganisation or impulsivity, but the causal chain to the offence is unclear.

Treatment was present and broadly appropriate: For individuals who were under mental health teams, appropriate mental health treatment had usually been initiated or maintained according to standard practice. Many examples showed evidence that the treatment was also effective for the patient.

Poor predictability of the offence: Across cases there was little predictability preceding the violence, in that there is not a clear escalation in the risks and severity of presentation indicating an imminent serious event. Even where illness was active, the specific acts appear abrupt/impulsive or opportunistic rather than preceded by warning signs that services could reliably detect.

Impulsivity and situational triggers: [redacted] incidents appeared to be driven by impulsivity, frustration, or situational conflict rather than psychotic motivation. These resemble general violence risk rather than mental illness–specific risk.

Gap Analysis Findings:

Individual safety actions arising from the safety reviews have included focus on the illness and treatment-related factors. [redacted] The trust has a physical health in mental health group who continue to work towards optimisation of physical health for those patients with serious mental illness.

A programme of Trustwide Improvement work is also in place via the Assertive and Intensive Workstream, to improve identification of the cohort and provide a service that meets core standards consistently including monitoring, maintain and enhance standards of care and treatment for these service users. The workplan focuses on developing a consistent definition of the cohort, keeping sight of the cohort across the trust, clarifying the service offer, and strengthening partnership working with shared oversight of quality, safety and outcomes.

Recommendation:
Findings from this thematic review to be shared with the Assertive and Intensive working group to ensure both patient and service factors are given consideration in service model design and development.

10. Patient - broader social/societal issues

As one would expect, broader societal and social issues featured in many of the reviews, [redacted]

This reminds us of the multitude of social and system factors that are often present and interact with each other, to impact on our capacity to provide effective treatment and impact outcomes in patients with mental illness under our care.

A large body of work is underway to reduce health inequalities and address wider social determinants of health under our population health strategy. Homelessness prevention and employment support are two specific targets of our work. More specific within our safety

improvement work, recent work has been undertaken to embed data monitoring on our top three social determinants within safety incidents at ELFT, to enable us to strengthen awareness and target improvement efforts in this area.

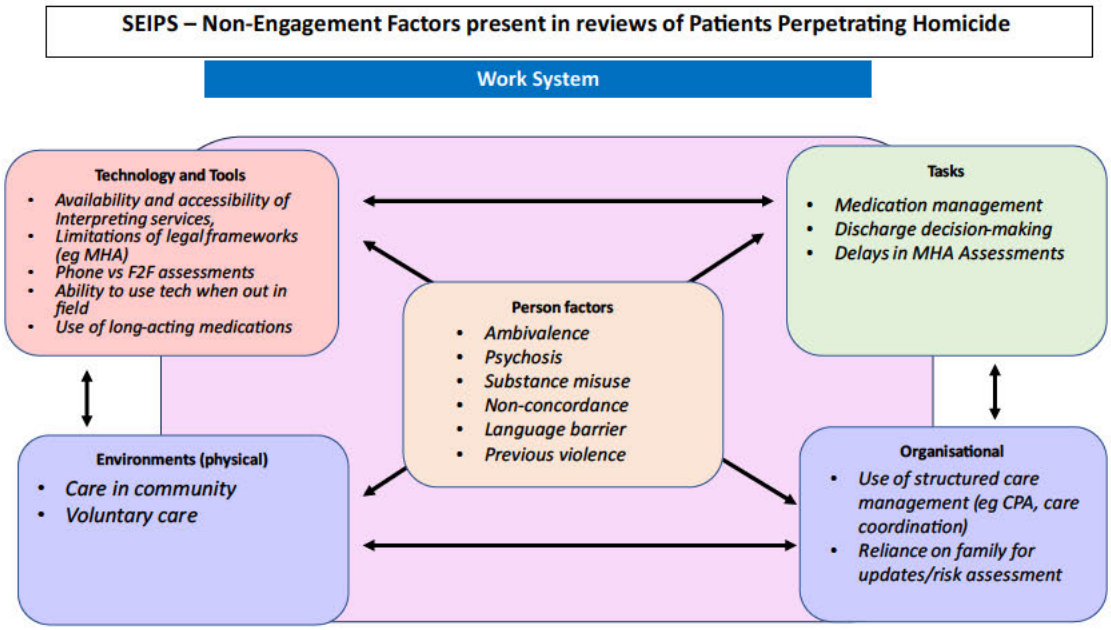
11. Non-Engagement with Services:

In [redacted] of the cases reviewed [redacted] the findings included issues around engagement of the patient in community mental health care. [redacted]

For those service users where non-engagement was a factor, there was a common (but not exclusive) profile of service users with concomitant substance misuse, medication non-concordance, psychosis, previous violence and a pattern of reliance on family for updates on well-being because of non-engagement.

Links/interactions were identified between non-engagement and several other factors, namely the quality of language interpreting tools available, the voluntary nature of care/lack of ability to use a legal framework [redacted]

The dynamic and complex interactions between system and person factors relating to non-engagement amongst this group of patients can be seen in a simplified form via a SEIPS diagram:



Gap Analysis Findings: The system factors identified relating to non-engagement has been the focus of several safety actions triggered by the individual safety reviews conducted to date [redacted] Actions have included improved supervision of care coordinators, monitoring of use of CPA with this cohort, improved use of interpreters, assertive face-to-face input and reviewing trust policies re F2F care.

Providing services for mental health service users who cannot readily be reached via traditional service models has been recognised to be a challenge, locally and nationally, and has been the focus of much ELFT improvement work over many years and is ongoing via a large-scale QI programme focused on reducing non-attendance in the community.

Ongoing work to strengthen care for this group of service users under mental health services is being via the Intensive and Assertive Community Mental Health Care Working Group. There are also wider community MH care work streams in the trust. National strategies such as the Personalized care framework (PCF) and the Modern Service Framework will also be triggering a review of community MH offer in the year ahead and so give opportunities to incorporate the learning from the homicide review.

Recommendations:
The learning from the homicide review will be shared with the trustwide Intensive and Assertive Mental Health Improvement Group, at the stage when the group agrees the specific offer and will also be used to inform parallel community mental health improvement work.

12. Medication Management

The review found recurrent theme around missed medication, non-concordance and changes in medication amongst the review group. However, this is not surprising given the patient profiles indicating a combination of serious mental illness, dual diagnosis and non-engagement.

Across the cases, [redacted] individual medication-related issues were identified, [redacted]

Although the majority where not on depot medication, there is also learning to be taken from the fact that despite [redacted] patients being on depot medication, the tragic outcome took place, reminding us of the potential for serious violence despite assertive treatment. The findings also remind us of the risks and importance of vigilance [redacted] and the importance of non-concordance as a red flag for serious violence.

Gap Analysis:
ELFT have an active trustwide Medicines Safety Group, led by trust medicines safety officers and with oversight from the medicines management committee.

In terms of medication adherence, the trust is actively exploring how to strengthen the discharge medicines process, particularly through more consistent discharge counselling and an electronic discharge medicines checklist. Improving the quality and reliability of this step should support better patient understanding of their medicines and reduce the risk of non-concordance once they return to the community. In addition, another mechanism in place to improve adherence is the Discharge Medicines Service (DMS), which enables referrals to community pharmacies so patients can receive follow on medication once they return to the community. In addition, we already have the Discharge Medicines Service (DMS) in place, which enables referrals to community pharmacies so patients can receive -concordance once they return to the community. In addition, we already have the Discharge Medicines Service (DMS) in place, which enables referrals to community pharmacies so patients can receive follow-up support and advice. This is another mechanism that contributes directly to improving adherence.

Following learning from a safety incident [redacted], the trust is also exploring whether EPMA can generate a trigger report when medicines are stopped or suspended, prompting pharmacy review. This is intended to help mitigate risks associated with abrupt or unreviewed changes.

In relation to missed depots, the trust has a plan to move depots onto EPMA as part of the Digital Medicines Board roadmap. Once implemented, this should help reduce gaps in transfer of care and improve visibility of administration schedules, which in turn supports continuity and reduces the risk of missed doses.

Recommendations:

Share review findings with Trustwide Medicines Safety Group, Digital Medicines Board and Community mental health workstream, to identify suitable safety actions relating to the findings including:

- Consideration of the use of Very Long-acting injectable Medications in those on CTOs, or with high-risk profiles, as part of an assertive care plan to ensure ongoing engagement in this context.

- Review of both clinical and digital systems & processes at digital medicines board that supports the safe and effective use of depots across the trust, including processes relating to missed or refused depots.

13. Family liaison and involvement:

Good practice findings in the reviews highlighted strong, regular and accessible communication with patients and families, including consistent progress updates, open and honest dialogue following incidents, and active consultation about care, treatment, decision-making and risk. Staff demonstrated a flexible, personalised and collaborative approach, using interpreters where needed and integrating cultural considerations into care plans. Reviews also noted effective communication and advice provided to relatives, alongside support for partners, ensuring that both patients and their families were well-informed and involved throughout care.

As mentioned previously, family members were more commonly victims of homicides in this cohort than other people, and they were also subject to violence prior to the incident more often.

The strongest family involvement theme to emerge, present in [redacted] cases, was that professionals were relying on family for updates secondary to non-engagement between patient and the service. This can be seen as a strength – in that teams were involving families and being proactive to reach service users, however it also introduced a risk around reliance on second-hand information for assessment of well-being and could mask the fact that service users were out of sight to services at that point.

There was also evidence of utilising telephone, rather than F2F updates, [redacted] particularly in the cases where family were being relied upon due to non-engagement, with telephone interpretation not always functioning well.

Gap Analysis Findings:

Improvements in family and carer engagement were frequently included in relevant safety action plans, including review of the patient contact policy, recommendation around use of interpreters, assertive input to face-to-face care and fostering of relationships with families and carers ([redacted] Involvement of and listening to service users' carers and family and addressing of non-engagement issues are also incorporated within the assertive and intensive care workplan and is a priority area within the new ELFT Strategy.

Learning from Domestic Homicides and Domestic Homicide Reviews:

A Domestic Abuse Related Death Reviews (DARDRs, previously known as Domestic homicide reviews) are statutory reviews conducted when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by either a relative, a spouse, partner or ex-partner or a member of the same household. The purpose is to identify opportunities for learning and improvement.

[redacted] of the suspected homicides within this review are subject to DARDRs and [redacted] further suspected homicides have been subject to a statutory Child Safeguarding Reviews. The Corporate Safeguarding Team ensures that learning from Domestic Abuse Related Death Reviews is systematically embedded across the Trust through structured communication, training, and governance mechanisms. Key themes are synthesised into concise practice briefings and shared via safeguarding newsletters and corporate bulletins. Learning is incorporated into Level 3 Safeguarding and Domestic Abuse training, alongside reflective discussions and supervision prompts to support application in practice. Themes are triangulated with incident reviews, audit findings, and routine enquiry data, with actions monitored through InPhase and overseen by the Safeguarding Committee. This provides Board-level assurance that review findings translate into measurable improvements in risk assessment, safety planning and multi-agency working.

14. Liaison with police and other agencies

The interface between mental health services and police is a known area of challenge nationwide and locally, and one that is already a focus for ongoing improvement work within ELFT. As such it is unsurprising that issues relating to communication and joint working between our services and the police arose in [redacted] cases in this review ([redacted]

[redacted] patients within the cohort were either being investigated by or had been reported to [redacted] when the incident occurred. [redacted], [redacted].

Liaison with other agencies was a both an area of strength, seen in good practice comments, and a challenge cited in several reviews, including liaison between ward and community team, between ELFT adult and child services and between ELFT and social care colleagues.

Gap Analysis Findings:

Following changes due to the Right Care Right Person initiative, and concerns regarding depletion of mental health liaison teams, ELFT have launched a Senior Police Liaison Group, set up and chaired by the trust Chief Operating Officer and attended by borough directors and relevant superintendents. This group is providing strategic oversight and support for interface issues and has been effective to date. Local police liaison meetings also are in place with representation from clinical managers and police liaison colleagues.

Recommendations:
Via the Senior Police Liaison group:

- ongoing work to strengthen relationships, systems and liaison with police partners in relation to high-risk patients and situations.
- Awareness raising for staff around expectations and limitations of police roles, responsibilities and limitations following Right Care Right Person changes.
- Work at operational level to reduce barriers to Police National Checklist Checks e.g. refusal due to misunderstandings on basis of consent.

15. Use of the Mental Health Act (MHA)

Whilst most of the cohort of patients were under voluntary community care at the time of the homicide, [redacted]

The finding that consideration of the MHA, assessment for use of the mental health act and issues relating to use of the MHA arose not infrequently in the case reviews, is not surprising given the frequency of psychosis and serious mental illness in the cohort. [redacted]

Gap Analysis Findings:
Lapses in mental health act sections are closely monitored within the trust and remain a very rare occurrence with no evidence of an increase in concern recently. In contrast, delays do occur frequently and are invariably linked to lack of bed availability. It is the ICBs' statutory duty under S140 of the MHA to commission beds and to notify local authorities of where they are. Local authorities facilitate admissions (through AMHP services) and keep data on delays. ELFT have a S140 policy which spells out how to escalate bed issues and feed this data back to the ICBs to inform commissioning. ELFT have strong relationships with our partner local authorities, partner acute trusts and ICBs.

16. Use of the Care Programme Approach

In most of the reviews, there was no finding relating to CPA usage, but in a subset, there were issues relating to non-use of CPA when it may have been useful, CPA documentation being out of date and/or the policy not being followed [redacted]

Gap Analysis Findings:

[redacted] reviews have included actions relating to this theme [redacted] and coordinated trustwide improvement work is also underway, under the oversight of the [redacted] relevant safety reviews [redacted] still ongoing and so further actions are also likely to arise in due course [redacted]

ELFT remains committed to person-centred care aligned with national and local policy, using CPA and building on DIALOG+. Although NHS England recommended stopping CPA from April 2024, ELFT has chosen to keep it to keep stability and quality of care for service users, including those with high intensive and assertive needs.

Community service transformation has highlighted the need to identify people with more complex needs who require active, regular formal care planning, reinforced by learning from the Nottingham independent review.

A Trust-wide group led by the [redacted] is reviewing DIALOG+ implementation to strengthen routine use of outcome measures, improve consistency and identify training needs; RIO care-planning templates are also being redesigned to improve clarity and accessibility of documentation.

17. Risk assessment & management

Risk assessment and management is complex, with risks being dynamic and dependent on clinical judgement. Safety reviews often rely on written notes, which provide limited insight into the nuanced thinking of clinical teams. Post-event exploration is also constrained by memory limitations, and team discussions are not always fully reflected in documentation.

As risk assessment and management are central to mental health care, it is unsurprising that they emerged as a major theme, identified both as good practice and as an area needing improvement.

Examples of good practice included clear documentation, timely and thorough risk management plans, prompt escalation of concerns, and appropriate referrals. Broader strengths in assessment and treatment quality were also noted.

Some reviews suggested that staff beliefs had affected risk decisions— [redacted] However, as risk assessment is largely based on clinical judgement, staff beliefs and opinions inevitably influence decisions and it is important to recognise that such evaluations are subjective, and vulnerable to hindsight bias.

Another recurring theme was limited staff awareness of patients' longitudinal clinical histories. In [redacted] cases, teams lacked key risk information [redacted] This issue was linked to variable quality and completeness of risk documentation, with plans not always up to date, information dispersed across records, or risk and safety plans left incomplete.

Structured risk assessment tools can support decision-making, particularly around violence risk (e.g., the Brosset Violence Checklist or DASH domestic violence tool). Reviewers identified [redacted] cases where such tools would have been helpful but were not used, making, particularly around violence risk (e.g., the Brosset Violence Checklist or DASH domestic violence tool). Reviewers identified [redacted] cases where such tools would have been helpful but were not used, particularly around violence risk

(e.g., the Brosset Violence Checklist or DASH domestic violence tool). Reviewers identified [redacted] cases where such tools would have been helpful but were not used.

Gap Analysis Findings: A wide range of safety system and practice improvements relating to risk management were recommended in the individual safety action plans reviewed [redacted]

Risk assessment and management remain central to safe care. The Trust updated its Risk Assessment and Management policy in 2024 to reflect emerging evidence and learning. Risk assessment is also the focus of a major piece of improvement work underway within the trust, under the oversight of the [redacted] services and trust Suicide Lead. The trust is currently moving away from a risk prediction approach to one that is more formulation-based, in line with national guidance (NICE, NHSE). This shift to a more dynamic and therapeutic approach of risk formulation and safety planning promotes holistic assessments that address patients' needs rather than relying on risk prediction and stratification. As part of this process the adult risk assessment form in RIO has been redesigned, to reflect the above recommendations. The updated form will lead clinicians through the process of risk formulation and mitigation, underscoring the importance of a dynamic model. The rollout of the form (planned for Spring 2026) will be accompanied by training package for staff including videos, e-learning and in-person teaching. The trust risk assessment policy has also been updated to reflect new guidance.

Recommendation:

Via the Risk formulation workstream:

- Ensure that processes to identify and capture all known previous violence are embedded within ELFT risk management systems and service operating models, in an accessible way including raising awareness of availability of Police National Computer Checks where clinical suspicion exists.

18. Staffing & Workload Issues

[redacted] of the reviews highlighted issues relating to both inpatient and community mental health team staffing and workload, often interacting at a work system level with the ability of staff to provide the level and quality of care needed [redacted]

On the ward, teams reported operating at full capacity, difficulties with recruitment and staffing, and challenges in meeting required staffing levels, [redacted] These demands also impacted MDT meetings, which were at times constrained by the high volume of patients requiring discussion.

Gap Analysis Findings:

As well as safety actions in each PSII where this arose, safer staffing has been identified within the Trust as a safety priority, with assertive monitoring and improvements in place to address shortfalls in

staffing for in-patient teams. National frameworks (PCF and the Modern Service Framework) will also trigger a review of the community MH offer over the coming year, creating opportunities to incorporate learning from homicide reviews and review staffing and workload. In parallel, a Trust-wide group is reviewing caseload sizes to improve consistency and escalation processes.

19. Staff Competence and professionalism issues:

As can be seen in the appendix, a wealth of evidence of positive staff behaviour and professionalism was shared in the reviews. This included staff taking a personalised, compassionate, proactive, flexible approach to care with high quality assessments and treatment, and determined efforts around communication with patients, families and liaison with other agencies.

In a [redacted] of reviews, issues were highlighted for improvement in this area ([redacted] Where these arose, there were often [redacted] system and individual factors to explain staff inability to follow expected practice which have been taken up in safety review action plans. [redacted]

Gap Analysis Findings:

Safety improvement actions have been recommended to address all staff competence issues highlighted in the individual reviews. [redacted] A trustwide improvement plan including actions to address staff behaviour, and a large-scale QI programme has also been undertaken and is ongoing, involving in-patient wards, with a focus on therapeutic engagement and observations to continue to improve in this area.

20. Organisational and healthcare operational processes and systems:

As one would expect in a complex healthcare system, problems with functioning of operational care processes and systems arose as a finding in most of the cases.

[redacted]

Often these problems arose in a context of overstretched services reliant on complex and error-prone care processes and pathways, with multiple interfaces between services, and happened despite the best efforts of skilled professionals working hard individually. They highlight the need to focus improvements at a system level – for example by means of simplification, automation and standardisation, to make it easier for professionals to navigate the care processes and provision.

Gap Analysis Findings: Ongoing System and process improvements are central to our extensive trustwide Quality Improvement work and methodology. Furthermore, the new PSIRF systems approach to incident response has a dedicated focus on developing actionable effective improvements in systems and processes, to support best care. QI work is ongoing to ensure safety actions from

incidents are at the strong end of the action hierarchy, to ensure effective solutions, and making use of our Quality Improvement methodology.

21. Service Availability, Specialist Input and Interface with Forensic Services:

Access to specialist services was a topic for consideration in all the reviews. In [redacted] cases, patients were already accessing a wide range of evidence-based treatments and services that were able to be flexible, provide MDT input and access the specialist care needed. It was more common in this group to find that specialist services were available but social and illness-related factors made it difficult for patients to make use of them. It is also likely that the complexity of the landscape and interfaces between services made them less accessible to the patient group.

In [redacted] cases, gaps were identified in the services offered and available. [redacted]

[redacted]

These findings would have been in part influenced by counterfactual reasoning and hindsight bias but taken at face value they do say something about a culture and system where adult team clinicians feel disempowered relative to their forensic colleagues when forensic input may be needed.

Gap Analysis Findings:

Several safety improvement actions have been recommended within individual SI/PSIIs or 72-hour reports relating to access to specialist input, referrals to teams and gaps in access to learning disability specialist care [redacted]

Relating to co-working with, and access to forensic services, the systems in place in our London boroughs differs from our Luton & Bedfordshire services. ELFT are the provider of Forensic services in London, on behalf of the North East London Provider Collaborative. However, in Luton and Bedfordshire, Forensic services are provided by another provider (SEPT), on behalf of the East of England collaborative.

For the London boroughs, ELFT have systems in place to ensure that mental health teams have access to forensic psychiatry input both for consideration of admission, and for advice, with the consultation system tailored to the needs of the individual borough. Bedfordshire does not have community forensic team and forensic assessments are done via MHA Assessments within custody suites and advice provided on a goodwill basis.

[redacted] learning lessons session co-led by forensic psychiatrist,

has also been agreed, aimed at general adult staff to further strengthen learning from findings within this review.

Upon reflection with the [redacted] there was a recognition that it may be useful to consider more structured opportunities for general adult psychiatry and MDT colleagues to maintain awareness around referral thresholds, systems for gaining advice and making referrals, services escalation processes and resources available, and to support the maintenance of positive working relationships for support where issues arise.

Recommendations:

A discussion will be held at the Medical Managers Forum in March 2026, regarding the current systems used to connect community forensic teams (where they exist) with non-forensic mental health teams to ensure ongoing awareness of forensic services in terms of eligibility, referral systems, thresholds, escalation process and resources available with the aim of identifying gaps and agreeing on next steps.

DISCUSSION

As outlined above, homicides in the UK are rare, often unpredictable and difficult to prevent. This review sought to better understand both the quantitative picture of homicides perpetuated by ELFT service users, in terms of any trends or patterns, and any themes in the individual safety review findings warranting further learning and improvement work.

The review findings were limited by the small numbers analysed, the fact that some more recent cases were still under review with full in-depth reports unavailable, and that the data analysed was filtered through the lens and methodology of the safety review itself. The group was collated based on a rare outcome, and so in this review there was no learning available about what might be the ingredients of care leading to a non-event/positive outcome. However, many of the patients had long histories of contact with services, providing a wealth of evidence of high-quality care to learn from.

Whilst every homicide is a major tragedy deserving of review and reflection, the found that for patients under ELFT, in quantitative terms, there was **no special cause variation** in the pattern of incidents since 2018. However, the rolling 3-year average did show some **early signs of an upward trend** which is to early to draw conclusions from but is worth continuing to monitor. It was good to see that despite providing care to boroughs with high rates of violent crime, ELFT was **not an outlier** in terms of absolute numbers of homicides relative to other ICB areas of London. The distribution of cases within our directorates also mirrored the patterns of those wider communities in terms of violent crime, and there was **no evidence of a cluster** either within a service or area.

Whilst there was significant heterogeneity in the homicides reviewed and the mental health profiles of perpetrators, the thematic review did identify some themes around perpetrator and victim characteristics. The most **typical perpetrator** among this review was a man, aged between 20 and 40, from an ethnic minority group, living in the community and under voluntary community mental health care. He was likely to have psychosis or evidence of serious mental illness but not necessarily diagnosed, concomitant drug misuse and a history of past violence. There would be evidence of difficulties engaging with mental health and drug services, poor concordance with medication and a reliance on family members for telephone updates around care. The victim was most likely to be a known contact or family member, but not necessarily an intimate partner.

Whilst there were no consistent service provision themes discovered that relate to the whole review group, typically, care was of a high quality, with evidence of a wealth of good practice, assertive efforts at engagement and often highly specialised input. For the cases where psychotic illness was present, it was usually treated appropriately and not clearly escalating in severity. Many incidents appear more impulsive and situational, occurring in people who happened to have contact with mental health services, rather than acts that were clearly caused by untreated or mismanaged illness and as such may reflect patterns of violence in the general population.

Findings about care provided highlighted issues relating to a range of known safety challenges and system issues, such as non-engagement with services, Availability/interface between services, variability in risk assessment and management, medication management, liaison with police and other agencies, family liaison and use of the mental health act and CPA. Our gap analysis found good follow up of issues with relevant safety actions, and often linking in with existing and robust large-scale quality improvement plans and programmes. The authors have linked with relevant leads across the trust to ensure that any identified gaps have led to suitable recommendations.

The review identified several recommendations to support ongoing learning from homicide data at ELFT. See below.

Recommendations to support continuous learning:

- Report summary and key learning to be presented at ELFT trust safety learning seminar and Patient Safety Learning Committee for onward sharing of learning.
- ELFT to introduce a system for ongoing time series data monitoring of homicides within Learning from Deaths panel in ongoing way to enable early identification of trends.
- [redacted] to agree an integrated system for ongoing system for sharing thematic learning from domestic and non-domestic homicides.
- ELFT to continue to triangulate with NHSE ICB footprint homicide data for any patterns and support NHSE to make use of time series data, including obtain and reviewing East of England data, once available.
- Collaborate with and provide case information to NCISH to learn from national data and themes. [redacted] to join NCISH homicide review stakeholder group, for ongoing learning from National homicides of patients under mental health services.

Acknowledgements and thanks:

The review team would like to foremostly acknowledge and thank the victims and families whose lives were tragically impacted by the events discussed in this review and the patients whose safety reviews have been included. We recognise that any learning is too late for the families involved but we endeavour to continue learning and improving care quality in the hope of protecting lives and quality of life for our communities and patients going forwards.

We would also like the thank the individual safety reviewers for the high-quality safety reports which we depended upon to conduct this review, the wide range of colleagues who have inputted or shared examples of improvement work being undertaken and our partners at NCISH and NHSE for sharing of useful intelligence and data.

Appendix 2: Examples of Good Practice categorised under key themes:

ASSERTIVE INPUT:

- Assertive care coordinator input and support
- Diligence of professionals despite challenging circumstances
- Regular input from care coordinator
- Frequent offers of psychology support
- Keeping on caseload when keen to disengage
- Assertive efforts to support patient despite poor engagement.
- Proactive follow up
- Home visits
  /Multiple home visits/Home visits including interpreter
- Risks regularly reviewed
- Assertive and collaborative team working
- Assertive and flexible attempts to engage service user in initial assessment, despite non-engagement.

HIGH QUALITY ASSESSMENTS AND TREATMENT:

- Good care overall
- All care considered appropriate.
- Offering a range of evidence-based treatments
- Good psychological assessment
- Number of assessments
- Detailed assessments
- Thorough mental state assessment with good recognition of deterioration and risks, with suitable care management.
- Thorough consideration of patient care by involved teams.
- Integrated in-patient psychology
- No gaps in care
- Proactive physical health checks, blood tests and evaluation thereof.

LIAISON:

- Good liaison between teams and involved professionals
- In-reach liaison to prison after incident
- Liaison and regular communication with police
- Liaison with police
- Clinicians attending multiagency meetings
- Thorough liaison and follow up by psychologist
- Good liaison and risk mitigation approaches
- Prompt escalation of concerns within organisation and to police
- Frequent communication between community mental health teams
-

REGULAR, ACCESSIBLE, SUPPORTIVE AND FLEXIBLE COMMUNICATION WITH PATIENT AND FAMILY:

- Regular progress updates to patient
- Open and honest communication after incident
- Flexible working with patient
- Patient consulted re care and treatment
- Communication with family members
- Provision of advice to family

- Communication with relatives
- Use of interpreter
- Interpreter
- Personalised and flexible care
- Collaborative approach to care
- Patient involvement in decision making and risk consideration.
- Acknowledgement of cultural aspects of patients' life, and integration into care plan.
- Support for partner

MULTIDISCIPLINARY APPROACH AND OVERSIGHT:

- Good multidisciplinary approach and input
- Well-attended multiprofessional meetings
- MDT involvement via CPA meetings
- Regular supervision
- Use of supervision
- Good MDT CPA documentation

APPROPRIATE RISK MANAGEMENT, ONWARD REFERRALS & ESCALATION OF RISK ISSUES:

- Thorough risk assessments
- Thorough safeguarding referral
- Onward referrals (mentioned 3 separate times)
- Appropriate triggering of MHAA
- Use of 1/1 nursing for risk management
- Prompt management by liaison team in emergency department
- Exploration of risk factors
- Risk management plan
- Historic and current risk info available on electronic record system

NEEDS AND PRINCIPLE-FOCUSSED CARE:

- Needs-led care (mentioned in two reviews)
- Least restrictive principle applied (mentioned in two reviews)
- Flexible approach to where care delivered

CARE PROVIDED AFTER THE INCIDENTS

- good information sharing, emotional support to staff and family, and practical management

Appendix 3 – Review Themes organised by SEIPS Systems Factors:

Person (Patients, Staff, Families)

- Mental State and Physical Health Factors
- Drug and Alcohol Misuse
- Previous/History of Crime or Violence
- Cultural Factors – Conception
- Symptomatic on Discharge
- Self harm Risk
- Diagnosis/Referral
- Family Involvement/Liaison Issues
- Staff Behaviour/Situational Awareness/Professionalism/Competence
- Staff Requesting Forensic Services/Challenging Decisions

Tasks (Work Activities and Processes)

- Non-Engagement or Issues with Non-Attendance at Appointments
- CPA/Care Coordination/CETR (Structured Management Approaches) Usage
- Victim Safety Planning
- Escalation Pathway
- Escorting Patients
- Admission/Discharge/Inpatient Management
- Unplanned Discharge
- Legal Hearing Looming

Tools and Technologies (Resources, Equipment, IT Systems)

- Medication Factors
- Documentation
  - Physical Environment (Setting and Infrastructure)
- Access to Services
- Lack of Resource
  - Homelessness

Organisation (Policies, Culture, Communication, Collaboration)

- Communication with Police and Social Care
- Referrals
- MHA Related Issues
- Broader Social/Societal Issues

Appendix 4: Full List of Recommendations

Safety	Recommendation
Learning from Regional Homicide Data	Learning from deaths panel to incorporate system for review of both London and Bedfordshire homicide data and National NCISH data, once available, to support learning.
Monitoring	ELFT to continue regular monitoring of homicide numbers, with use of three-year rolling average and/or time-between incidents analysis via Learning from Deaths panel dashboard.
Reducing Health Inequalities	Ensure that the ELFT service offer for the Assertive and Intensive cohort is focussed on ensuring equity of access and experience.
Learning from where Care has Gone Well	ELFT to continue to work on growing the focus on learning from care has gone well, via the trust Safety Plan, PSIIs and other PSIRF learning responses.
	Sharing of the examples and model of good practice that has emerged from this review to the group working on the ELFT assertive engagement offer, to inform the action plan, and within the ELFT Safety Learning Seminar programme.
	Ongoing work to increase the proportion of safety actions identified within safety reviews that build on, share and systematise identified good practice, processes and systems at ELFT.
Substance Misuse	**Dual Diagnosis Policy** to be ratified with assertive work to translate recommendations/standards into practice.
	Each borough to have **Individual Dual Diagnosis Improvement Workplans** overseen at Directorate Management Plan level, to mirror that in place in L&B), in agreement with incumbent D&A services, with work to translation of policy into practice and including a proactive offer, focused on joined up care, assertive safety planning for those with substance misuse in combination with SMI and past violence, full participation in drug and alcohol boards in each borough and longer term strategic work towards bringing drug and alcohol services in-house in NEL (as we do in L&B). Workplans to agree a suitable governance structure for oversight.
Patient and Service factors, non-engagement	The learning from the homicide review will be shared with the trustwide Intensive and Assertive Mental Health Improvement Group and will be used at the stage when the group agrees the specific offer and with parallel community mental health improvement workstream, to inform ongoing improvement work.
Medicines Management	Share review findings with Trustwide Medicines Safety Group, Digital Medicines Board and Community mental health workstream, to identify suitable safety actions relating to the findings including: • Consideration of the use of Very Long-acting injectable Medications in those on CTOs, or with high-risk profiles, as

	part of an assertive care plan to ensure ongoing engagement in this context. • Review of both clinical and digital systems & processes at digital medicines board that supports the safe and effective use of depots across the trust, including processes relating to missed or refused depots.
Liaison with Police	Via the Senior Police Liaison group: • ongoing work to strengthen relationships, systems and liaison with police partners in relation to high-risk patients and situations. • Awareness raising for staff around expectations and limitations of police roles, responsibilities and limitations following Right Care Right Person changes. • Work at operational level to reduce barriers to Police National Checklist Checks e.g. refusal due to misunderstandings on basis of consent.
Risk Management	Via the Risk formulation workstream: Ensure that processes to identify and capture all known previous violence are embedded within ELFT risk management systems and service operating models, in an accessible way including raising awareness of availability of Police National Computer Checks where clinical suspicion exists.
Service Availability	A discussion will be held at the Medical Managers Forum in March 2026, regarding the current systems used to connect community forensic teams (where they exist) with non-forensic mental health teams to ensure ongoing awareness of forensic services in terms of eligibility, referral systems, thresholds, escalation process and resources available with the aim of identifying gaps and agreeing on next steps.
Continuous learning from homicides	Report summary and key learning to be presented at ELFT trust safety learning seminar and Patient Safety Learning Committee for onward sharing of learning.
	[redacted] to agree an integrated system for ongoing system for sharing thematic learning from domestic and non-domestic homicides.
	ELFT to continue to triangulate with NHSE ICB footprint homicide data for any patterns and support NHSE to make use of time series data, including obtain and reviewing East of England data, once available.
	ELFT to collaborate with and provide case information to NCISH to learn from national data and themes. Director of Safety to join NCISH homicide review stakeholder group, for ongoing learning from National homicides of patients under mental health services.