Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards – May 2007

Madeleine and Lauren O'Neill

Executive Summary

Report Issued by WHSSB and EHSSB on 27 March 2008

EXECUTIVE SUMMARY AND RECOMMENDATIONS

INTRODUCTION

From evidence obtained by the PSNI which has been disclosed to the Independent Inquiry Panel, and which has not yet been subject to a Coroner's Inquest, it would appear that Mrs Madeleine O'Neill took her daughter's life and then her own life on 12 July 2005. At the time of her death Mrs O'Neill was 40 years old and her daughter, Lauren, was 9 years old.

BACKGROUND

Prior to her death Madeleine had been suffering from depression for a number of years and was receiving treatment from her GP. Although her mood fluctuated over time, it was the GP's view that Madeleine's depression was minor with reactive/situational elements. However in the period April – May 2005, following her recent separation from her husband, her condition appeared to deteriorate and on 22 April 2005 she was referred to the Cognitive Behavioural Therapy Service, South and East Belfast Trust, (SEBT), at her own request by her GP. The referral stated that she had an active depressive disorder at this time. During a further visit to her GP on 16 May 2005 there was a marked change in her demeanour and it was the GP's view that she was clearly depressed although not actively suicidal. Her medication was increased at this time and a review date was set for two weeks later.

However, on 18 May 2005, Madeleine was found unconscious in her bedroom by her mother having taken a deliberate overdose of various medications. She was taken by ambulance to the Accident and Emergency Department, Belfast City Hospital where the Consultant Physician in Acute Medicine made a diagnosis of deliberate self-poisoning.

Following treatment for her overdose, Madeleine was assessed by a Specialist Registrar in General Adult Psychiatry the next day and was referred to the Crisis Response Team, SEBT and to the Hospital Social Worker who was asked to make an urgent onward referral to the Family and Child Care Initial Assessment Team, SEBT. The Specialist Registrar asked the Crisis Response Team to refer Madeleine to Outpatient Psychiatry at Knockbracken

Healthcare Park. Madeleine was discharged from Belfast City Hospital on 19 May 2005.

Two members of the Crisis Response Team visited Madeleine at her home the next day, 20 May 2005. The team members carried out a Risk Assessment of Madeleine and decided that she did not present a high risk to herself nor did they have concerns with regard to Lauren. Following the visit the team members made a routine referral to the Consultant Psychiatrist at Knockbracken Healthcare Park, SEBT.

A Social Worker from the Family and Child Care Initial Assessment Team visited Madeleine at her home on 7 June 2005. Overall, from her assessment, the Social Worker had the impression that Madeleine had very good family support and good friends and despite her suicide attempt was now moving on with her life. The case was discussed in supervision with a Principal Social Worker on 29 June 2005 when a decision was taken to close the case.

Madeleine had been attending a Private Counsellor since late April 2005 and had a number of sessions over the next few weeks. When she attended for a session on 8 June 2005 she appeared to be extremely upset and had great difficulty in focusing. The Counsellor was very concerned that Madeleine was having suicidal thoughts and also that she made reference to taking Lauren with her, although she did not indicate a specific plan to harm the child. The Counsellor advised Madeleine's father that additional support and an emergency referral to psychiatric services was required for Madeleine due to concerns about her suicidal ideation and the possible threat to Lauren.

Madeleine's father immediately took her to her GP who was very concerned that she was actively suicidal and had expressed intention to include her daughter in a suicide attempt. Following assessment the GP contacted Knockbracken Healthcare Park with a view to admission and Madeleine agreed to be admitted as a voluntary patient. A bed could not be found for Madeleine that evening and the GP had to become involved again the following day to ensure that she was admitted to Knockbracken Healthcare Park. Madeleine was assessed by a Senior House Officer at Knockbracken Healthcare Park on the afternoon of 9 June 2005 and as a result was admitted as an in-patient because of her clinical depression, her thoughts of suicide and her thoughts of

taking Lauren with her. On the day of admission the possibility of moving Madeleine to Gransha Hospital in Londonderry was discussed and following this discussion the Consultant Psychiatrist in Knockbracken Healthcare Park contacted a Consultant Psychiatrist in Gransha Hospital with a view to arranging her move. During the course of their conversation the Consultant Psychiatrist at Knockbracken Healthcare Park described Madeleine's clinical condition and the risk of suicide but cannot recall if he made any mention of a risk to Lauren; the Consultant Psychiatrist at Gransha Hospital is adamant that there was no mention of a threat to Lauren. The Consultant Psychiatrist at Gransha agreed to accept Madeleine and on 14 June 2005 she was taken by car by her parents to Gransha Hospital. Staff at Knockbracken Healthcare Park are clear that prior to Madeleine's departure her notes were placed in an envelope and handed to her father, who was asked to deliver them to staff at Gransha Hospital. Madeleine's father is clear that he did not receive any documentation at Knockbracken Healthcare Park.

Madeleine arrived with her parents at Gransha Hospital in the late afternoon of 14 June 2005. On arrival a nursing assessment was carried out and later that evening the on-call SHO also carried out an assessment. Madeleine stayed in Gransha Hospital from 14 June until 27 June 2005 when she was discharged at her own request. Throughout her stay at Gransha staff were unaware of any threat to Lauren as this information was contained in her notes which had not arrived at the hospital. Staff at Gransha Hospital did not at any stage attempt to discover the whereabouts of Madeleine's notes or to contact Knockbracken. Madeleine's diagnosis in Gransha Hospital was that she was suffering from either a major or moderate depressive disorder with somatic symptoms, probably due to her marital situation.

On 7 July 2005 the file which had been compiled by Gransha staff during Madeleine's in-patient stay was taken from Gransha Hospital to the Cityside Community Mental Health Team offices, Londonderry. On 14 July 2005 when news of the deaths of Madeleine and Lauren was received, the file was retrieved in the Cityside Community Mental Health Team offices and when opened was found to contain the notes from Knockbracken Healthcare Park. The Independent Inquiry Panel carried out a detailed investigation to determine how these notes had been placed in the file, but was unable to reach a conclusion.

MAJOR ISSUES

The Independent Inquiry Panel identified 17 major issues in relation to this case. These were: -

- Communication
- Child Protection / Children in Need
- Competency, Training and Education of Staff in Mental Health
- Mental Health / Childcare Interface
- Assessment / Risk Assessment
- Supervision
- Care Planning
- Discharge Planning
- Bed Management
- Recording of Information
- Interface between Statutory Services and Private Counselling Services
- Next of Kin
- Consultation with and Support to Families
- Inter Hospital Transfer of Patients and their Records
- DHSSPS Guidance (May 2004)
- Trusts' Reports
- Madeleine's Gransha File – Security Issues

Communication

Multidisciplinary Professionals

There is evidence of poor communication in both Knockbracken and Gransha Hospitals between different professionals involved in Madeleine's care and there was no evidence in either hospital to demonstrate the involvement of Social Work personnel in any multidisciplinary discussions. Throughout Madeleine's stay in both Knockbracken and Gransha there is no evidence of a "joined up" "holistic" approach by multidisciplinary teams in either hospital.

Admission to the Hospitals

At the time when a bed was being urgently sought for Madeleine (8/9 June 2005) communication from the Knockbracken Healthcare Park to Madeleine's GP and to her father was very poor. It is likely that if Madeleine's GP had not made strenuous efforts to contact the hospital again on 9 June 2005, she may not have been admitted at this time of crisis. At Gransha Hospital there are concerns about the lack of communication between the accepting Consultant Psychiatrist and the SHO who carried out the initial assessment.

Consultant to Consultant

Although two telephone conversations took place between the Consultant Psychiatrist at Knockbracken and the accepting Consultant Psychiatrist at Gransha it was very concerning to note the apparent lack of information shared regarding the threat to Lauren. Within Gransha Hospital itself there was an absence of meaningful communication between the Consultant who agreed to accept the patient and the Consultant under whose care she was subsequently placed.

Hospital to Hospital

Independent Inquiry Panel members were concerned in relation to: -

- The process for transfer of documentation between Knockbracken and Gransha Hospitals.
- The lack of communication between the two hospitals to ensure and confirm the safe arrival of the patient at Gransha Hospital.
- The fact that staff at Gransha Hospital did not seek information from Knockbracken when documentation did not arrive with the patient.

Between Professionals and Family

There is little evidence of systematic communication with the patient's family either in Knockbracken or Gransha, although some collateral history was taken at the time of Madeleine's admission to Knockbracken. Neither is there any evidence of involvement of the family in discharge planning or future care arrangements. There is

no evidence of involving Madeleine's husband concerning the impact which Madeleine's illness might have on her ability to care for Lauren, nor is there any evidence that information about the threat to Lauren was shared with Mr O'Neill, with the result that he was not given any opportunity to protect her.

Overview

It was the Panel's view that neither Madeleine nor Lauren were well served by the communication process between professionals, between the two psychiatric hospitals where Madeleine was an in-patient in June 2005 or between professionals and relatives.

Child Protection / Children in Need

During the period May to July 2005 when Madeleine was in contact with services there were a number of times when professionals should have been alerted to childcare concerns and should have taken appropriate action. These issues and concerns are highlighted in the main body of the report.

It is clear from the Panel's analysis that the threats to Lauren's life were known to practitioners and staff at a number of points, but no direct action was taken to deal with or minimise the risk. It was the Panel's view that had direct referrals been made when Madeleine expressed a threat to Lauren's safety and well being, Lauren's death could have been prevented.

The Panel was also concerned by the lack of general awareness of child protection / children in need issues. It was clear that many staff lacked even basic understanding of issues such as recognition of risk, the proactive nature of the children in need concept, or the signs and symptoms of child abuse.

Competency, Training and Education of Staff in Mental Health

A common theme in this case was an apparent lack of understanding of severe mental illness and it appeared that the significance of past deliberate self-harm was missed by many staff.

Mental Health / Childcare Interface

Throughout this case the focus of mental health staff was entirely on Madeleine with no attempt made to assess risk to Lauren, even though threats to her life and well being were quite clear. No attempt was made to involve Mr O'Neill in discussions about his daughter's future welfare and care arrangements or to involve child protection services.

The Panel was particularly concerned that so many staff working in the field of adult mental health were clearly unaware of their responsibilities in relation to Child Protection Policies and Procedures and Children in Need Procedures.

Assessment / Risk Assessment

The Panel was concerned that Madeleine did not appear to have received adequate care and risk assessment at Knockbracken and Gransha Hospitals and took the view that she should have remained in Knockbracken until a more thorough assessment had been completed over a longer period of time. There were also concerns about the levels of observation of Madeleine at Knockbracken. In addition, there was little evidence of multidisciplinary working between the various community based services within South and East Belfast Trust, which had contact with Madeleine.

Supervision

The Panel was concerned to find evidence of unsatisfactory supervision in a number of situations relating to the care and treatment of Madeleine and the lack of protection offered to Lauren.

Examples included little evidence of managerial, clinical or professional supervision regarding child protection issues; poor oversight of decision making in relation to assessment / risk assessment; incomplete and inaccurate nursing care plans demonstrating lack of managerial supervision; no evidence that Madeleine's condition was discussed with line management in either Knockbracken or Gransha Hospitals.

Care Planning

The care planning process and recording of care plans in both Knockbracken and Gransha fell well short of what would be expected of professional health care staff. The nursing care plans in both hospitals were incomplete and neither hospital care plan was based on a risk assessment.

Discharge Planning

Discharge planning arrangements in both Knockbracken and Gransha Hospitals fell far short of what would be considered good practice; when Madeleine was discharged from Gransha the future care arrangements were very unsatisfactory.

Bed Management

The Panel was concerned about the difficulty experienced by Madeleine's GP in securing a bed for her in Knockbracken. There is clear need for effective bed management systems to be in place in acute in-patient mental health units in Northern Ireland.

Recording of Information

There was evidence of inaccurate recording of information relating to Madeleine at both Knockbracken and Gransha Hospitals.

Interface Between Statutory Services and Private Counselling Services

The Panel highlighted problems relating to the interface between statutory mental health services and private counselling services. The Panel was particularly concerned that Madeleine's Private Counsellor was included in care planning by both psychiatric hospitals without reference to the Counsellor. There is also an issue regarding communication and sharing of information between statutory services and private counselling services.

Next of Kin

The fact that Madeleine and her husband were separated had a direct effect on the recording of next of kin information. This meant

that Mr O'Neill's role as Lauren's primary carer during Madeleine's illness was not recognised and contributed to him not being informed of the threat to Lauren.

Consultation with and Support to Families

There was a general failure to include relatives in discussions about Madeleine's care and treatment, to consult with relatives about her discharge from Gransha hospital, to provide guidance to relatives about the need to monitor behaviour in the period after discharge and to advise Mr O'Neill of the threat to Lauren.
Mr O'Neill's right under Article 8 of the European Convention on Human Rights (right to respect for family life) may have been breached. There was no support offered to relatives after the two deaths occurred in July 2005.

Inter Hospital Transfer of Patients and Their Records

DHSSPS requested Trusts in April 2005 to develop protocols for actions to be followed when patients moved between HPSS organisations.

In the summer of 2005, DHSSPS asked CREST to assist in the development of a regional protocol. The views of The Royal College of Psychiatrists (NI) were requested in December 2005 as CREST was aware that there were particular issues that psychiatric hospitals need to take into consideration and that there were sensitivities regarding psychiatric notes.

A revised protocol document was published and circulated to Trusts in August 2006. In the light of the circumstances leading up to the deaths of Madeleine and Lauren it is the Panel's view that the August 2006 protocol should be reviewed urgently and updated to include guidance on child protection issues and the involvement of relatives in the process of transferring psychiatric patients and their records from one psychiatric hospital to another.

DHSSPS Guidance – May 2004

The DHSSPS Guidance 'Discharge from Hospital and the Continuing Care in the Community with People with a Mental Disorder who could represent a Risk of Serious Physical Harm to Themselves or Others' had not been fully implemented in either

Knockbracken or Gransha Hospitals at the time Madeleine was being treated and cared for in these hospitals. This had serious implications, particularly in respect of child protection measures which might have been initiated in both hospitals and which might have prevented the death of Lauren.

Trusts' Reports

The Panel was struck by the difference in approach adopted by South and East Belfast Trust and Foyle Trust in drawing up their reports following the deaths of Madeleine and Lauren. It was the Panel's view that a common format would be helpful in relation to reports by Trusts on serious untoward incidents and that formal guidance should be issued on this matter.

Madeleine's Gransha Hospital File – Security Issues

The Panel was concerned that Madeleine's file was not properly secured by Foyle Trust following her death and took the view that formal guidance should be issued to Trusts about the need to secure all relevant documentation and files when a serious untoward incident occurs.

Literature Review

The Panel completed a Literature Review which utilised relevant inquiry reports, guidance, research and academic literature to underpin the work of the Inquiry and its learning objectives. The Literature Review highlights the need for further research.

RECOMMENDATIONS

Communication

1. Belfast City Hospital, South and East Belfast Trust and Foyle Trust should review their arrangements for multidisciplinary working and information sharing focusing on: -

- roles
- the nature of services
- treatments and interventions
- structures
- accurate targeting of referrals
- formal and informal processes
- internal and external communication
- recording of information
- case co-ordination/key working
- training
- unit/professional culture

2. South and East Belfast Trust should review its arrangements for admitting patients for in-patient care, with particular reference to a daily waiting list management and bed management system and an ongoing contact system with patients and their carers when beds are not available. There is a need to ensure that systems are in place within Knockbracken which track a request for admission and assist in the management of risk and patients until a bed is allocated.

3. Foyle Trust should review its arrangements for admitting patients for in-patient care to Gransha to ensure in particular that SHOs obtain all relevant background information from the referring GP or hospital and collateral information from the patient's family, as far as is practical, on the day of admission.

4. The DHSSPS and the Boards should instruct Trusts to draw up and implement policies regarding consultation by staff with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

5. Trusts should ensure that there is clarity in the role and function of Crisis Response Teams, Home Treatment Services and Community Mental Health Teams.

6. Trusts should ensure that there are sound arrangements for clinical supervision within Community Teams in general and specialist advice/support in Community Home Treatment and Crisis Response Team services. In constructing these arrangements Trusts should be aware that increasing specialisation of services is likely to make it more difficult for individual practitioners to fulfil a keyworking / co-ordinating role across a care plan.

7. Trusts should ensure that protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient**.**

Child Protection / Children in Need

8. All Boards and Trusts should review the child protection training and awareness of all staff, including access to policies and procedures.

9. DHSSPS in conjunction with Boards' ACPCs should review the content and uptake of child protection training delivered to GPs and should consider making such training mandatory for all relevant staff and practitioners.

10. Counselling bodies should make child protection training including refresher training a mandatory component of ongoing registration.

11. Counselling bodies should require counsellors registered with them to follow the Department's Child Protection Policy 'Co-operating to Safeguard Children' and Regional ACPC Policies and Procedures.

12. DHSSPS should review Co-operating to Safeguard Children and the four ACPCs should review their Child Protection Policy and Procedures to ensure that both documents provide consistent and specific guidance for counsellors and psychotherapists, particularly those working in a private capacity.

13. The DHSSPS should, in conjunction with the Department of Employment and Learning and education providers, review all undergraduate and post graduate training for relevant professions to include a core understanding of child protection issues.

Competency, Training and Education of Staff in Mental Health

14. Trusts should ensure that all SHOs new to Psychiatry should have an induction course covering role clarification and a basic knowledge of common psychiatric disorders, their treatment and management.

15. Trusts should ensure that multidisciplinary staff are aware of the nature of therapeutic relationships and the concepts of transference and counter-transference.

16. Trusts should ensure that staff working in the field of mental health have continuous professional development plans which include in-service training and evidence based practice refresher courses**.**

Mental Health / Childcare Interface

17. DHSSPS and Boards should ensure that each Trust puts in place a joint protocol designed to manage the interface between mental health and child care services, addressing and facilitating the co-working of cases where there are concerns that adult mental health problems may impact on the care of children.

18. The four ACPCs should jointly commission multidisciplinary training across the region for mental health and child care staff, focused on working together in cases where there are adults with mental health issues who have dependent children. This training must explicitly deal with child in need issues as well as child protection matters. The ACPCs should make use of the Crossing Bridges (1998) training resource produced by Department of Health.

19. DHSSPS should ensure that consideration of parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children. (Understanding the Needs of Children in Northern Ireland).

Assessment / Risk Assessment

20. South and East Belfast Trust should review the assessment models used by CRT and FCC IAT in cases where a parent with dependent children has attempted suicide or made a serious threat of self-harm.

21. DHSSPS should develop guidance that would lead to the implementation of consolidated assessments in mental health. Consolidated assessment would underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning which all feature in other recommendations in this report. It would also include assessment of the impact of mental illness on carers and on children and the adequacy of support arrangements for them.

Supervision

22. Boards and Trusts must ensure that supervisory policies are in place which require that: -

- Arrangements are in place to monitor and audit assessment, case management, effectiveness of interventions, record keeping and discharge planning of individual cases.

- Staff understand and adhere to ACPCs' Child Protection Policy and Procedures.

- In all situations where there are concerns relating to children there is an appropriate multi-agency assessment of risk.

- There is a named nurse and named doctor with clearly defined responsibilities to provide a lead role for child protection within mental health services.

Care Planning

23. DHSSPS should review guidance in relation to care planning. The review should ensure that care plans are designed in conjunction with a model of care and include consideration of risk assessment and management, multidisciplinary working, verifying information provided by the patient, and objective, evidence based approaches to care plan changes.

Discharge Planning

24. Both SEB and Foyle Trusts should undertake urgent reviews of their systems for developing discharge plans for patients leaving their hospitals. In addition DHSSPS should consider providing guidance in relation to discharge planning. The basic elements which should form part of future discharge planning would include: -

- Comprehensive Multidisciplinary Team input.
- Identified planned date of discharge.
- Clear discharge pathway to cover all aspects of discharge.
- Professionals or services named in discharge plans must have been contacted and provided informed agreement to their inclusion in the plan.
- Discharge and leave destinations should be known and associated risk assessed, including contingency planning.
- Where there is a parenting role, risk assessment and plan must be recorded.
- Discharge plans should include provision for engagement with follow-up services.
- Consideration should be given to carer involvement.
- A relapse prevention plan should be drawn up, with carers' involvement.
- Parents with serious mental illness should be prioritised for follow-up after discharge.

Bed Management

25. Boards and Trusts must ensure that each in-patient unit has a bed management policy in place, which outlines the bed management system and identifies an accountable named individual.

Recording of Information

26. Both South and East Belfast and Foyle Trusts should have in place as part of their governance arrangements a system to monitor and audit case records within Mental Health services to ensure: -

- Accuracy
- Assessment and management of risk

- Care planning
- Effectiveness of treatment
- Discharge planning
- Correct patient identification

Interface Between Statutory Services and Private Counselling Services

27. DHSSPS in co-operation with responsible Departments in Great Britain should implement its commitment to the statutory registration and regulation of psychotherapists and counsellors as outlined in the 2006 consultation on standards. The associated guidance to psychotherapists and counsellors should aim to improve communication between statutory services and private counselling services, leading to a culture in both sectors where the benefits of co-ordinated care are promoted to patients/clients/service users. The guidance should also take account of Recommendations in the section on Child Protection/Children in Need in this Report.

Next of Kin

28. DHSSPS and Boards should ensure that Trusts have a policy in relation to identifying and recording 'Next of Kin' information. Trusts should also consider the extent to which staff training and/or refresher training should be provided for front-line staff involved routinely in taking personal history details from patients, particularly in situations where patients have family issues relating to divorce, marital separation and dependent children.

Consultation with and Support to Families

29. Whilst acknowledging the planned benefits in 'Protect Life – A Shared Vision' – The Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011 launched in October 2006, including its stated intention to provide support and assistance to families bereaved by suicide, we take the view that some of the proposed 'Actions' in the Strategy document need to be brought forward more quickly than planned. We recommend that the DHSSPS should review this matter urgently and consider whether or not earlier implementation would be possible.

If this proves to be impossible we further recommend that Trusts should be required to urgently establish interim arrangements to

provide support and assistance to families bereaved by suicide, in order to temporarily fill the gap in service provision clearly identified in relation to the lack of support provided to the O'Neill and Gormley families.

Inter Hospital Transfer of Patients and Their Records

30. In light of the circumstances leading up to the deaths of Madeleine and Lauren, the DHSSPS should request CREST or its successor organisation to urgently review its August 2006 Protocol relating to inter-hospital transfer of mental health patients, with a view to including: -

- A section dealing with Child Protection issues (perhaps along the lines of the Child Protection section in the Protocol document drawn up by South and East Belfast Trust [Knockbracken Mental Health Services – Treatment Services] in November 2006) (Appendix 3).

- A specific statement that if transfers of patients are carried out by or with relatives and their personal transport, the patients' records must be transferred separately from the patient and relatives, by secure means.

- A specific statement that transfers of patients must always require pre-move written data setting out core features of the illness, diagnosis and reasons for the transfer, to be faxed or emailed in keeping with approved confidentiality arrangements, in advance to the receiving hospital, and agreed in writing by the accepting Consultant, prior to the actual move.

- Guidance to Trusts on definition and use of the words 'transfer' and 'discharge' in the context of movement of a patient from one psychiatric hospital to another in the province with no intention of the patient returning to the referring hospital, given the apparent interchangeable use of the two words in relation to the movement of Madeleine O'Neill from Knockbracken to Gransha Hospital.

When this further updated CREST protocol is available it should be issued by the DHSSPS to Trusts for implementation as a standard

protocol throughout the service in Northern Ireland, rather than as guidance for the preparation of protocols by each individual Trust.

In addition, within 6 months of issue of CREST's updated protocol, the DHSSPS should require Trusts to provide evidence of specific action undertaken to make relevant staff aware of the updated protocol, the need to adhere to it strictly and the need to formally review the working of the updated protocol at regular intervals of not more than one year.

DHSSPS Guidance – May 2004

31. DHSSPS should ensure that when guidance is issued for implementation by the HPSS on particular service issues, an audit mechanism is included to ensure that the required action is taken within a specified timescale.

32. There are clearly continuing issues of understanding and interpretation of some aspects of the 2004 Guidance apparent within Trusts and the medical profession, (as expressed by the NI Branch of the Royal College of Psychiatrists), which contributed in some measure to the handling of the care and treatment of Madeleine. We note the action taken recently by DHSSPS to establish a Regional Group to review assessment and management of risk in mental health services and the timescale involved but would nevertheless recommend that the DHSSPS takes urgent action to specifically review and update the 2004 Discharge Guidance, in conjunction with Boards, Trusts and the relevant professions.

Trusts' Reports

33. Steps should be taken by the DHSSPS, in conjunction with Boards, Trusts and other relevant bodies such as the Mental Health Commission and ACPCs, to draw up and issue guidance regarding the production of initial investigation reports by Trusts, in situations where there has been a serious incident such as a suicide or homicide, involving a patient or client. Such guidance should, at least, include draft terms of reference for such an investigation, proposed model format of a report and proposed timescale.

Madeleine's Gransha Hospital File – Security Issues

34. We fully endorse and support the recommendation of the Inquiry Panel (McCleery) and the guidance in 'Co-operating to Safeguard Children'. In light of events in this case, the DHSSPS should issue further formal guidance / instructions to all Trusts in relation to the need to secure all relevant documentation and files in such circumstances, as a matter of urgency.

Literature Review

35. DHSSPS in collaboration with corresponding Departments in England, Wales and Scotland should commission UK wide research into all aspects of child killing to ensure that attention is given to increasing the understanding of cases involving parents who are mentally disordered but where there are no pre-existing child care concerns. This work should build on the existing international literature and seek to resolve the problems with definition that have made it difficult to translate research findings into practice guidance that would inform risk assessment. DHSSPS and its partner Departments in this research should ensure that this work is integrated with Child Death Review arrangements and with the work of the new Safeguarding Board for Northern Ireland.

36. When commissioning inquiries DHSSPS and Boards should ensure that inquiry panels have early access to research and similar inquiries of which DHSSPS and/or Boards are aware. This would avoid duplication of effort and support the learning objectives of inquiries.