

EDUCATION AND TRAINING

Impact of homicide by a psychiatric patient on forensic psychiatrists: national survey

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Aims and method To explore the experiences and support needs of consultant forensic psychiatrists, whose patients had committed homicide while under their care. We circulated a survey to all forensic psychiatrists in the UK, through the Royal College of Psychiatrists, asking about their experiences of a homicide by a patient under their care. Respondents were invited to discuss their experiences further in a structured telephone interview and themes were identified from these discussions. Data were analysed quantitatively and qualitatively.

Results One-third of the 86 respondents had had at least one patient who had committed a homicide while under their care. Of these, over three-quarters (78%) reported that the homicide had a significant impact on their personal life, professional life and/or mental/physical health. For some respondents, the impact was severe and long term. Respondents generally felt that they would have been helped by receiving more support in the aftermath of the homicide.

Clinical implications Greater recognition is needed of the impact on treating psychiatrists of homicide by a patient and more support is needed for affected clinicians. Further research is necessary, including the effects of such events on colleagues in other specialties and examination of the costs versus the benefits of mandatory inquiries after homicides.

Keywords Patient homicide; psychiatrist; trauma; post-traumatic stress disorder.

Homicide by patients receiving psychiatric care is a rare event. Between 2006 and 2016, 11% of all homicide convictions in the UK, a total of 785 homicides, were by mental health patients. This is in stark contrast to the high rate of suicide by individuals under psychiatric care: during the same time period, 17 931 mental health patients died by suicide, representing 28% of all suicides in the UK.¹

A recent study by Gibbons et al² found that the death of a psychiatric patient by suicide can have a serious impact on the treating psychiatrist's psychological health, clinical practice and attitude towards their work. Concerns have been expressed about some of the unintended and adverse consequences of a patient-perpetrated homicide, both for the individual clinician and for the organisation,³ but there have been no studies examining these effects directly. In the UK, there have been several cases of psychiatrists being referred to the General Medical Council (GMC) for allegedly failing to prevent a homicide, although as far as we know, no referral has yet resulted in GMC sanction. In France, however, there has been at least one prosecution of a psychiatrist as a result of their failure to anticipate and prevent a patient-committed homicide. The psychiatrist was subsequently convicted of manslaughter, for which she received a suspended custodial sentence.⁴

A mandatory independent inquiry (which refer as the inquiry) into the care of any individual who kills and who has been under the care of psychiatric services at the material time, or the preceding 6–12 month period, was introduced in the UK in the 1990s, following a number of high-profile homicides by psychiatric patients⁵. Concerns have been expressed over the intervening years, about the potential that such inquiries have for bias and errors of judgement, including the shifting of responsibility from the system onto the individual clinician, while failing either to improve patient safety or to reduce risk.^{6–9} Despite this and the acknowledged limitations of accurately predicting risk in psychiatry,^{10–12} the practice of carrying out internal and external (if the circumstances are sufficiently serious) inquiries has continued.

This survey set out to examine the impact on their treating psychiatrist of a patient committing a homicide. Forensic psychiatrists were targeted, as they work with particularly high-risk patients, who have a history of serious violence and who are therefore considered to be at high risk of future violence, including lethal violence.

Method

In 2017 we conducted a national online survey of consultant forensic psychiatrists, asking them whether any of their patients had committed homicide whilst under their care and, if so, how the experience had affected them. An invitation to participate appeared on the Royal College of Psychiatrists website. The survey covered the following areas: impact on personal and professional life, mental and physical health; support sought or received; experience of the mandatory inquiry and associated processes and coping strategies. Everyone who completed the survey was subsequently invited to discuss their experiences further in a structured telephone interview with one of the three

authors. The telephone discussion was led by a topic guide, at least in part informed by the areas covered in the quantitative survey. The discussion was recorded contemporaneously by the interviewer and themes and subthemes were identified and then discussed and refined by the three authors, until a consensus was reached. Data from the survey and transcripts are presented quantitatively and qualitatively, in terms of the main themes emerging from the interviews.

Results

In total, 86 consultants completed the survey, of whom 26 had experienced at least one patient-perpetrated homicide.

Quantitative data

The results of the survey for the 26 respondents are summarised in Table 1. Where a respondent had experienced more than one homicide, they were asked to comment on their worst experience.

The majority of the 26 respondents ($n = 18$; 69%) had experienced one patient-perpetrated homicide; however, just over one in four reported more than one homicide. Half of the 26 consultants had been in post for more than 15 years at the time of the homicide. The homicides had taken place between 4 weeks and 30 years earlier (mean 7 years). The majority of perpetrator patients were male and were living in the community at the time. Half the victims were family members; in only 15% of cases was the victim a stranger.

Just over three-quarters ($n = 21$; 81%) of the respondents reported that the homicide and its consequences had affected their mental health, and around one in four psychiatrists described these effects as having been 'very significant'. Almost a half ($n = 11$; 42%) experienced physical health effects and just over three-quarters ($n = 20$; 77%) reported a negative impact on their personal life. Half the cases had been reported in the local and/or national media and three of the psychiatrists were named in the media. Two individuals were also subsequently referred to the GMC. Ten psychiatrists (38%) reported that their career had been adversely affected as a result of the homicide.

Qualitative data

Eight of the twenty-six psychiatrists who had experienced a patient-perpetrated homicide participated in a further qualitative telephone interview.

The following themes emerged from an analysis of interview transcripts. Themes were identified through independent coding and discussion among the three authors, until consensus was reached.

Homicide as a traumatic event

All consultants recalled the moment they were informed of the killing and the emotional and psychological impact this had on them at the time. Recall of this event remained vivid and painful, despite the homicides having taken

Table 1 Survey data for the 26 respondents who had experienced patient-perpetrated homicide and their patients^a

Respondents	
Consultant gender, <i>n</i> (%)	
Male	19 (74)
Female	7 (26)
Consultant experience at time of homicide (first homicide if more than one), <i>n</i> (%)	
≥15 years	13 (50)
Between 2 and 15 years	11 (42)
≤2 years	2 (8)
Homicides (26 respondents)	
Number of patient homicides, <i>n</i> (%)	
One	20 (70)
Two	4 (16)
Three	3 (12)
Gender of perpetrators, <i>n</i> (%)	
Male	23 (92)
Female	3 (8)
Perpetrator location at time of homicide, <i>n</i> (%)	
In-patient	6 (23)
Out-patient	20 (77)
Time since homicide, range (mean)	4 weeks to 30 years (7 years)
Relationship with victim, <i>n</i> (%)	
Family member/acquaintance	13 (50)
Stranger	4 (15)
Other	9 (36)
Consequences of homicide cases, <i>n</i> (%)	
Referral to General Medical Council	2 (8)
Media reporting	
Local media	16 (63)
National media	14 (53)
Psychiatrist named in the media	3 (11)
Required to give evidence in court, <i>n</i> (%)	9 (34)
Required to give evidence to an external inquiry, <i>n</i> (%)	17 (65)
Adverse impact on career, <i>n</i> (%)	10 (38)
Adverse impact on mental health, <i>n</i> (%)	21 (81)
Adverse impact on physical health, <i>n</i> (%)	11 (42)
Adverse impact on personal life, <i>n</i> (%)	20 (77)

a. Data (for both consultants and patient-perpetrators) relate to the homicide with the worst impacts on the respondents, if respondents experienced more than one.

place, for the most part, years or decades earlier. Respondents clearly recalled where they were, what they were doing and what they had felt on first hearing the news. In most cases, they had been informed about the homicide through a telephone call. Some consultants had received the news at work, others while they were at home or away on holiday:

'It happened 18 years ago ... but I still remember clearly how it made me feel.'

'My blood ran cold ... it was the most devastating experience of my career ... everyone's worst nightmare.'

'It was harrowing, horrible, the worst experience of my life.'

Impact on mental health

Following the homicide, consultants described a range of emotional and psychological problems, including: depression, anxiety, anger; confusion; sleep and appetite

disturbance; loss of interest and enjoyment, poor concentration, social isolation and constant ruminations about what had happened. For some respondents the emotional and psychological impact of the homicide had persisted for years:

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

'I still feel a strong sense of injustice ... bitterness and resentment.'

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

Symptoms of post-traumatic stress disorder, including reliving and re-experiencing symptoms, avoidance and hyperarousal, were common:

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

'I thought about this case a lot and for years afterwards ... I still have images in my head of the photos of [the victims] who were killed.'

Despite very significant distress, none of the doctors interviewed had sought medical help for their symptoms or been formally diagnosed as suffering from a mental illness. Few of them had even previously admitted to themselves the personal toll that the experience had taken on them.

Impact on relationships and family life

Respondents described feelings of personal as well as professional isolation, following the homicide. Most of them had not discussed what had happened with family members or friends, because of feelings of shame, or because they feared that they might be blamed or seen as a failure. Some doctors did not talk about what had happened, out of a wish to protect their family from such a frightening and distressing experience and to retain their home as a safe and protected space, uncontaminated by their work.

Some respondents actively avoided talking or thinking about what had happened, because it only intensified feelings of distress and helplessness. However, this avoidance also resulted in them feeling more isolated and cut off and, in some cases, misunderstood by friends and family members:

'The killing ... had a more profound effect than I would have admitted at the time ... I only realised what a personal and professional toll it took on me, my home life and relationship with colleagues years later.'

'I couldn't really talk to family, I kept to myself for months.'

'I coped by switching off emotionally ... It had a terrible impact on my relationship with my partner.'

Increased use of alcohol was also reported in the months following the homicide, largely as a strategy to block distressing thoughts and to manage anxiety levels and insomnia:

'I started drinking too much ... and it got a bit out of control.'

Impact on clinical practice and career

Some of the direct professional consequences of the homicide included: being suspended; being referred to the GMC; being named in the local or national media; repeated appearances at internal and external inquiries and in court; change of job; and loss of income.

All respondents felt that the homicide had posed a specific challenge to their professional identity and role, including their clinical judgement, competence and confidence:

'I felt isolated and frightened ... but I put on a good show as I had been trained to do.'

Most consultants considered that their clinical practice, as well as the way they thought about their work, changed following the homicide. In most cases these changes were felt to be negative. The most commonly described changes were: feeling more anxious about and avoidant of risk; increased caution and lack of confidence in clinical decision-making; reduced willingness to rely on and trust colleagues; and increased cynicism about the concepts of multidisciplinary team working and collective responsibility:

'It gave me a heightened sense of just how risky this work is ... made me less tolerant of risk.'

'It made me more twitchy about patients and risk averse.'

'I now cannot delegate and I am picky about documentation.'

Respondents frequently expressed a sense of bewilderment about the fact that they alone, rather than any other member of the multidisciplinary team, had been held responsible for what had happened.

'No other member of the team was singled out for similar treatment ... it was me on my own ... nurses claimed to have been frightened, intimidated, claimed no role.'

'I felt exposed ... and responsible ... worried I would be blamed ... that this would affect my career. I felt very alone and vulnerable.'

'As doctors - we think we ought to be unbreakable ... I ended up professionally isolated.'

Despite feeling professionally and personally vulnerable and isolated, all respondents had carried on working and supporting their teams as usual in the aftermath of the homicide.

Scapegoating and professional isolation

Although some respondents felt that colleagues had been supportive, others felt that they had been treated like pariahs following the homicide, which reinforced feelings of shame and stigma. It was not uncommon for colleagues and managers to decline to discuss the case with them, ostensibly on the grounds that they might end up a witness in any future inquiry process or legal action.

Inquiries and hearings

One of the most traumatic consequences of the homicide were the lengthy, complex and often obscure inquiry processes that followed. These included not only the internal and external disciplinary processes and the mandatory inquiry process at trust level, but also frequently a public inquiry, criminal proceedings or coroners' courts in which the respondents were witnesses. Inquiries were experienced

as being highly adversarial and potentially career-ending ordeals, with hidden agendas and obscure rules of engagement, over which they had no control.

Regardless of the outcome, the various internal and external reviews and the inquiry process were emotionally and physically draining. Moreover, the fact that the inquiry processes were commonly extremely prolonged, with lengthy delays between the hearings and the outcome, made it more difficult to begin to recover and move on following the experience:

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

'The internal inquiry blamed everyone and was poorly managed. The interview was very traumatic ... a panel of 8 people, arguing with each other ... I physically collapsed afterwards ... I had no solicitor, no support.'

'It was like a big dysfunctional family ... a bird's nest of bad relationships ... where the abused children turn on each other.'

A number of consultants described how they had been being expected to express remorse and contrition for the homicide, even where there appeared to be a consensus that the homicide could not have been prevented or predicted:

'You had to throw yourself on your sword and go quietly, rather than whinge or complain ... even if you feel you have been treated unfairly.'

'The whole experience was negative, humiliating, criticising.'

'Ultimately you are on your own ... you need to be prepared to defend yourself ... whatever you think, you have got to say you're sorry.'

None of the consultants was able to identify any positive aspects of the inquiry, in terms of learning for themselves, answers being provided to the victim's family, righting wrongs, or driving improvements in patient care and safety:

'I don't think it changed practice ... it was unpredictable, there was not much more I could have done ... I didn't learn lessons at all, just made me very anxious.'

'... other people picking over the bones ... it was all hindsight bias.'

'I saw them as biased and unfair ... it was not until many years later that I could look at ... what had happened ... and think about whether there was something to learn.'

Respondents frequently referred to the outcome of the inquiry being entirely and arbitrarily dependent on the individual panel members, over which they had no say or control. One consultant felt they had been lucky in having had two psychiatrist members of their panel, whose input had been helpful and constructive:

'The saving grace of the independent inquiry was that there were two psychiatrists on the panel who were well disposed ... the psychiatrist on the panel was a life saver ... however, the outcome could have gone either way.'

Another consultant, however, described the psychiatric input in a much more negative way:

'I was very struck by the medical member's punitive approach and the rush to judgement. I also thought that there was some sadistic pleasure in shafting another colleague.'

The psychiatrist member of the inquiry panel was often well known to the respondent, thereby increasing unease about the lack of impartiality. A number of consultants expressed a wish for greater transparency and clarity about how psychiatric and lay members of homicide inquiries are appointed and what training they receive prior to performing this role:

'There is a need for panel members to have appropriate training for the role ... lack of due process in the homicide inquiry.'

Respondents who considered the homicide and subsequent inquiry to have had no significant effect on their clinical practice or approach described this as being a matter of luck, rather than due to anything that they personally had done, or had felt able to influence:

'It had no effect on my career ... but I missed a bullet ... it could so easily have destroyed everything.'

Support sought, offered and received

Although a couple of consultants felt that they had been reasonably well supported by their NHS trust in the aftermath of the homicide, most felt that their trust had been more concerned about protecting the reputation of the organisation, even when this meant blaming the doctor. Expressions that were frequently employed by respondents were being 'scapegoated' or 'thrown to the lions' by their employers following the homicide:

'employers gave no support ... just worried about bad publicity for the Trust.'

'Some people contacted me spontaneously and offered commiseration, including unexpected folk ... But ... managers were defending the organisation.'

'There was no support of any kind or advice from colleagues or the employer ... I was made to feel like a pariah ... the Trust saw me as a threat ... I was not provided with any information about the Trust response to the SUI [serious untoward incident] or the inquiry, although ... later informed that an inquiry had reported.'

In general, consultants were left to work out for themselves who to talk to and where to seek help:

'My organisation turned on me ... The College's psychiatrists support network ... listened but was not really supportive ... I just had one phone call ... no debrief or support within the team ... I just carried on.'

Only one of the respondents reported being offered time off or counselling following the homicide.

Coping and how to survive

When asked 'What helped you get through this?', most respondents cited support from friends, family and close colleagues. However, feelings of shame and an understandable desire not to have to dwell on distressing events often stopped consultants from asking for help even where this might have been on offer:

'I only got through because I was resilient and tough ... but I also did not talk to anyone about how I was feeling, and that had negative effects.'

Most respondents attributed their 'survival' to their own personal resilience and luck:

'[Psychiatrists] are so tough emotionally – you have to be very resistant to stress to survive.'

'I learned that how you are finally dealt with depends on what you do afterwards, how you conduct yourself in the aftermath. People like a survivor.'

As regards support during the inquiry processes, good legal representation was felt to be essential, as well as access to a sympathetic colleague, who had gone through a similar experience. Several respondents suggested that it would have been helpful to have been provided with a 'road map' of possible outcomes, to help prepare them for what was to come:

'It would help to know what to expect, what about GMC referral, what do I do to prepare?'

'Need to instruct a barrister – best you can get.'

'Need for a mentor – someone who has gone through a similar experience ... who will understand what a doctor might be feeling and give practical advice as well as emotional support.'

Suggestions were also made about the need to reconsider how homicides by psychiatric patients are perceived, reported and responded to in the UK:

'The [Royal College of Psychiatrists] needs to stand up against a mob rule mentality ... needs to make sure the public understands that psychiatrists sometimes make mistakes, they do not get it right all the time and are not infallible ... just to understand how complex these issues are.'

Discussion

The psychiatrists who completed this survey described feelings of depression, anxiety, guilt and responsibility, shame and self-doubt following patient-perpetrated homicide. Professional and personal isolation, including scapegoating, were common.

Although some of these responses and experiences are similar to those described by psychiatrists following a patient suicide,^{2,13} there appear to be some important differences in the way that psychiatrists react following a patient-perpetrated homicide compared with a patient suicide. These differences may reflect the way in which society views the killing of a third and 'innocent' party, as opposed to self-inflicted harm; the relative rarity of homicide compared with suicide; and the organisational, societal and legal repercussions following homicide.

The homicide itself represented a psychological trauma similar to that following a traumatic bereavement.¹⁴ For many consultants, it led to a shattering of basic assumptions¹⁵ about the world as benevolent, meaningful and controllable and about the self as worthy. Consultants who had previously thought of themselves as being 'good doctors' found themselves defined, judged and found wanting by this single event. They were transformed overnight from confident and effective clinical team leaders to negligent, reckless and incompetent, and clinical liabilities.

As with many victims of trauma, a sense of actual or threatened loss – loss of job, loss of career prospects, loss of reputation, loss of sense of professional competence and identity – featured prominently.

The parallels with victims of psychological trauma are stark, and yet doctors who found themselves in this position were extremely reluctant to present themselves as vulnerable or distressed. The narrative commonly adopted was that the only people deserving of sympathy were the victim and their family members. Any attempt to usurp that role was felt to be both self-indulgent and distasteful. Moreover, as clinical team leaders, there was often a sense that they needed to be able to support and shield their team and to lead from the front.

Many respondents described a disconnect between the widely proclaimed mantra of multidisciplinary teamwork and collective responsibility and the way in which, in the aftermath of a homicide, they had been held responsible, above all others, for what had happened. They frequently found themselves depicted in the aftermath as dictators and autocrats, which led to feelings of disillusionment and betrayal.

For our respondents, the homicide represented just the start of what was experienced as a long, confusing and painful journey of recovery and redemption, for them as much for the patient perpetrator. Chief among the post-homicide hurdles to be negotiated and survived were the numerous legal and quasi-legal proceedings, such as coroner's courts, perpetrators' trials, GMC referral, disciplinary hearings and the inquiry.

The inquiry process and associated processes were generally experienced as frightening, confusing, punitive and humiliating. Although the process is understood to be inquisitorial in nature, it was in reality experienced as highly adversarial, with the outcome appearing to be entirely and arbitrarily dependent on the experience and beneficence, or otherwise, of individual panel members.

The way forward

The value of post-homicide Inquiries, as currently constituted, has been repeatedly questioned over the years.^{6–9} However, the social imperative to identify a cause and to be able to hold someone responsible appears to outweigh any objections on the basis of lack of fairness or transparency or even due process.

The experience of our respondents suggests that it may be time for NHS England to carry out a cost-benefit analysis of such inquiries and to review the mandatory inquiry policy. It is clearly important for the families of victims to be able to express feelings of grief and anger and to understand why the killing has occurred and what, if anything, could have been done to prevent it. However, it is also important to convey the message that such tragic events are, thankfully, exceptionally rare,^{16,17} that not all of them can be predicted or prevented¹⁷ and that there is rarely any single cause or individual responsible for them. More consideration could also be given to alternative ways to help victims' families, for example using mediation or restorative justice approaches,¹⁸ although it should also always be remembered, when thinking about who does the 'restoration', that the offender in this case is the patient who killed, rather than the doctor who was looking after them.

As with psychiatrists whose patients kill themselves, the psychiatrists in this survey had been offered no or little support following the homicide.² Trusts may need to be reminded that they have a duty of care to their employees,

who require support following an event of this nature. There needs to be more open discussion about how to weigh up the doctor's duty of care towards their patient with their responsibility to protect the public, including the acknowledgement that the two may sometimes appear to be in opposition.¹⁹ The Royal College of Psychiatrists could also play a more active role in supporting its members following a patient-perpetrated homicide, such as by providing confidential telephone support and advice about where to get help and identifying colleague 'buddies' who have been through similar experiences and can provide guidance and support through the process. Early advice from defence unions and identification of senior legal experts are also clearly essential for survival.

The strength of this study is that we were able to elicit qualitative as well as quantitative responses from forensic psychiatrists. Although we focused on forensic psychiatrists, the majority of homicides by psychiatric patients are carried out by patients who are under the care of general adult psychiatrists. It is not clear whether responses of general psychiatrists following a homicide would be any different, and this survey would be worth repeating with a larger sample of psychiatrists from all disciplines to explore potential similarities and differences.

About the authors

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Data availability

The data that support the findings of this study are available from the corresponding author, G.M., upon reasonable request.

Author contributions

The contribution of all three authors is compliant with ICMJE requirements. All three authors devised the survey, conducted interviews, carried out the analysis of data and contributed to the writing of the paper.

Declaration of interest

R.R. and G.M. have both had experience of a patient committing a homicide while under their care. Neither of them completed the survey and their experiences do not constitute part of the results.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.96>.

References

- 1 Healthcare Quality Improvement Partnership. The National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report: England, Northern Ireland, Scotland, Wales. October 2018. University of Manchester, 2018.
- 2 Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G, et al. Effects of patient suicide on psychiatrists: survey of experiences and support required. *BJPsych Bull* 2019; **43**: 236–41.
- 3 Szmukler G. Homicide inquiries: what sense do they make? *Psychiatr Bull* 2000; **24**: 6–10.
- 4 Dyer C. French psychiatrist is convicted of manslaughter after her patient kills an elderly man. *BMJ* 2012; **345**: e8693.
- 5 Department of Health. Guidance of Discharge of Mentally Disordered People and their Continuing Care in the Community (*Health Service Guideline* LASSL(94)4). Department of Health, 1994.
- 6 Eastman N. Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *BMJ* 1996; **313**: 1069–71.
- 7 Salter M. Serious incident inquiries: a survival kit for psychiatrists. *Psychiatr Bull* 2003; **27**: 245–7.
- 8 Petch E, Bradley C. Learning the lessons from homicide inquiries: adding insult to injury? *J Forensic Psychiatry* 1997; **8**: 161–84.
- 9 Reiss D. Counterfactuals and inquiries after homicide. *J Forensic Psychiatry* 2010; **12**: 169–81.
- 10 Fazel S, Singh JP, Doll H, Grann M. Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ* 2012; **345**: e4692.
- 11 Yang M, Wong SCP, Coid J. The efficacy of violence prediction: a meta-analytic comparison of nine risk assessment tools. *Psychol Bull* 2010; **136**: 740–67.
- 12 Singh JP, Fazel S. Forensic risk assessment: a metareview. *Crim Justice Behav* 2010; **37**: 965–88.
- 13 Campbell C, Fahy T. The role of the doctor when a patient commits suicide. *Psychiatr Bull* 2002; **26**: 44–9.
- 14 Barlé N, Wortman CB, Latack JA. Traumatic bereavement: basic research and clinical implications. *J Psychother Integration* 2017; **27**: 127–39.
- 15 Janoff-Bulman R, Frieze IH. A theoretical perspective for understanding reactions to victimization. *J Soc Issues* 1983; **39**: 1–17.
- 16 Large M, Smith G, Nielssen O. The relationship between the rate of homicide by those with schizophrenia and the overall homicide rate: a systematic review and meta-analysis. *Schizophr Res* 2009; **112**: 123–9.
- 17 Nielssen O, Bourget D, Laaiasalo T, Liem M, Labelle A, Hakkanen-Nyholm H, et al. Homicide of strangers by people with a psychotic illness. *Schizophr Bull* 2011; **37**: 572–9.
- 18 Coates R, Umbreit M, Voss B. Responding to hate crime through restorative justice dialogue. *Contemp Just Rev* 2006; **9**: 7–21.
- 19 Adshead G. Duties of psychiatrists: treat the patient or protect the public? *Adv Psychiatr Treat* 1999; **5**: 321–8.

