

‘Alyssa’

Home Office Feedback	Our response
<p><i>It is stated in the overview report that there was an issue with the perpetrator’s GP, who declined to share information with the Panel, citing patient confidentiality. This could have been a missed opportunity to understand John’s mental health issues.</i></p>	<p>We agree. In the absence of any formal power to force disclosure, it is unclear what you are expecting us to do with this information beyond recording the refusal in the report. We have, however, added the following: <i>‘This is regrettable as it was potentially a missed opportunity to learn valuable lessons.’</i></p>
<p><i>There were administrative issues with arranging follow up care provision by the Home Treatment Team for John.</i></p>	<p>We agree. It is unclear what revision you are suggesting?</p>
<p><i>Paragraph 3.2 – the report has not explained whether the contents/finding of the Mental Health Trust Board Level Inquiry were included in this DHR.</i></p>	<p>We disagree. Paragraph 8.1.1 states: Barnet, Enfield and Haringey Mental Health Trust undertook a Board Level Inquiry, and this was accepted in lieu of an IMR.</p> <p>Furthermore, paragraph 8.3 states:</p> <p><i>‘This report is an anthology of information and facts gathered from:</i></p> <ul style="list-style-type: none"> • <i>The chronologies detailed above</i> • <i>The Board Level Inquiry undertaken for Barnet Enfield and Haringey Mental Health Trust</i> • <i>Etc’</i>
<p><i>The report should explain why there was no consideration for a Mental Health Homicide Review under Health Service Guidance (94) 27, which requires such a review when a homicide has been committed by a person who is or has been in receipt of mental health services six months prior to death, which fits the criteria of this case.</i></p>	<p>We assume you are referring to an Independent Homicide Review (IHR) albeit that the criteria you have set out is the criteria for a Board Level Inquiry and not an IHR. Instigating an IHR is a matter for NHS England.</p> <p>As clearly stated in paragraph 3.2, Barnet Enfield and Haringey Mental Health Trust undertook a Board Level Inquiry (BLI). When a BLI is complete, NHS England have the option to request an IHR which involves an external company being commissioned to review the BLI report. This did not happen in this case and is usually only done when the BLI is deemed inadequate.</p>
<p><i>It would be helpful to include whether Alyssa’s family were involved in the</i></p>	<p>As the report clearly states in paragraphs 8.5.1-8.5.3. that the victim’s family were not</p>

<i>selection of pseudonyms for both victim and perpetrator.</i>	involved at any stage, it follows that they did not select the pseudonyms used.
<i>A conclusion section would be helpful in bringing together an overview of the main issues identified with the missed opportunities.</i>	This is contained within section 12 which follows on from a detailed analysis (section 10). Unless there are specific issues you feel are absent, an additional conclusions section would simply repeat the same information as is contained here, adding unnecessary length to the overall report.