Independent Investigations 2018-19 Annual Report

Independent Investigations: 2018/19 Annual Report.

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Contents

1 Foreward

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. In 2019 the NHS launched its first patient safety strategy, this is a significant step towards becoming one of the safest healthcare systems in the world.

The 2018-19 Annual Report details the findings and performance of commissioning of Independent Investigations, primarily those where a homicide committed by those in receipt of mental health services. These tragic incidents can have a devastating impact on families of both victim(s) and perpetrator/s and on those staff and services providing care and treatment to the patient. Independent investigations carried out under the Serious Incident Framework (2015) ensure that mental health care-related homicides are investigated in such a way that effective learning can be identified, and changes implemented to minimise the risk of recurrence.

In 2019 the NHS has experienced a great deal of change including NHS England becoming aligned with NHS Improvement. During 2018-19 there were four Regional Independent Investigation Teams within the national NHS England geography. NHS organisations, in partnership with local councils and other stakeholders have been working towards the Integrated Care System (ICS) model for health and social care. Integrated Care Systems will collectively take responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. We recognise that within each region these relationships are at variable stages.

The 2018-19 Annual Report highlights the high standard of performance relating to the function of independent investigations as shown by the key performance indicators and ongoing work that the Regional Independent Investigation Teams have undertaken in this past year. The number and timeliness of published reports and their subsequent output should not be considered as the sole indicator of performance of the regional function and work programme in respect of independent investigations.
We are assured that regional approaches to commissioning the independent investigations are robust, transparent, effective and responsive to specific case considerations. However, we recognise that further work is required to address the challenge of reducing the timeframe for the publication of independent investigation reports, improving alignment with other agencies' processes and ensuring dissemination of meaningful learning across the system.

The outputs set out in this Annual Report have been accomplished by the Regional Independent Investigation Teams with multiple partners all of whom are committed to improving care for patients.

Finally, we would like to thank the patients, families, staff and all those that have engaged with these investigations to help ensure we continually learn from such tragic incidents.

Dr Maxwell Mclean
Lay member and Co-Chair IIGC

Martin Machray
Regional Chief Nurse London and Co-Chair IIGC

2 Purpose

This document provides an annual report and update on the work undertaken by NHS England's Regional Independent Investigation Teams (RIITs). At the time of reporting there were four Regional Independent Investigation Teams within the national NHS England geography. The portfolio, remit and capacity of each team differs slightly, however the common function is to manage and oversee the Independent Investigation function on behalf of NHS England.

This report details information on the 2018/19 activity and status of independent investigations, predominately mental health homicides, both completed and commissioned across all four regions, the themes of learning identified, governance arrangements and financial information. Data volumes are often small, therefore analyses and assumptions should be considered with caution.

The report provides detail on development activity in all four regions and plans for 2019/20 to strengthen governance arrangements and improve the quality and spread of learning.

3 Introduction

Homicides committed by those in receipt of mental health services are at the extreme end of the spectrum of safety concerns. These incidents have a devastating impact on families of both victim(s) and perpetrator/s and on those staff and services providing care and treatment to the patient. Resultant independent investigations carried out under the Serious Incidents Framework (2015) ensure that mental health care related homicides are investigated in such a way that learning can be identified widely and effectively to minimise recurrence.

Regional ambitions are; to ensure the statutory responsibilities placed on NHS England are fulfilled, promote meaningful and compassionate family engagement, commission high quality independent investigations that lead to influencing and supporting system wide development to aim to minimise reoccurrence.

The NHS Serious Incident Framework and Article 2 of the European Convention on Human Rights sets out the circumstances and criteria when an independent investigation must be considered.

An overview of the criteria is set below:

When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event, however this timeframe serves as a guide.

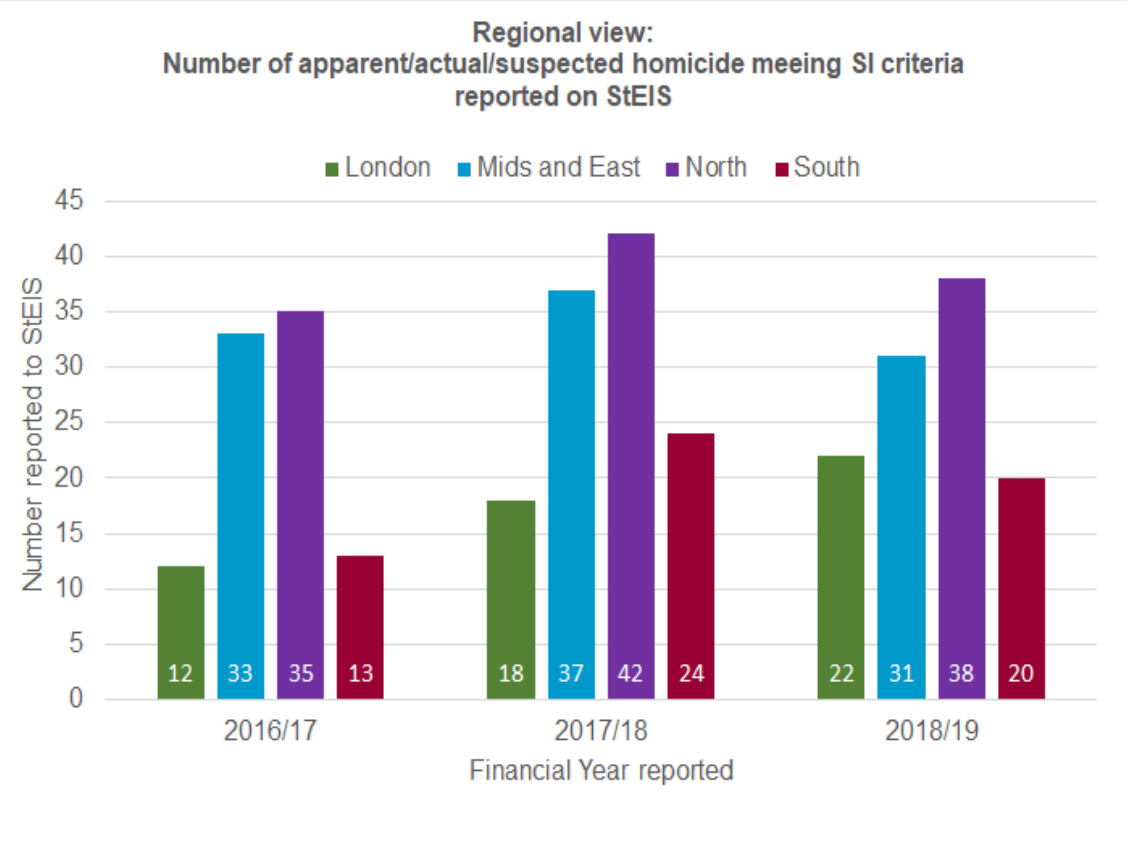
When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be,

responsible for a death or where the victim sustains life-threatening injuries, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.

In accordance with the Serious Incident Framework (2015) all providers of mental health services are required to report all *'apparent/actual/suspected homicide meeting SI criteria'* on the Strategic Executive Information System (STEIS)

4 STEIS reported incidents

Graph 1 highlights the STEIS category of *apparent/actual/suspected homicides* from April 2018 to March 2019 across the four regions. Please note that not all the reported incidents will meet the criteria for an independent investigation as outlined above therefore the figures reported on StEIS will be higher than those commissioned as Independent Investigations



Source: StEIS, NHS England and Improvement analytic team

London: Since 2016/17 there has been an increase in the number of reported Mental Health Homicides on StEIS. In 2018/19 there were n=22 (0.28 per 100,000 population size) reported Mental Health Homicides on StEIS.

In 2018, The Office of National Statistics [1] published that there were:

- 162 (victims) (2.0 per 100,000) homicides reported across London.

Midlands & East:
Since 2016/2017 there has been an increase in reporting of Mental Health homicides on StEIS. In 2018/19 there were n=31 (0.34 per 100,000 population size). This figure is based on all age resident population.

In 2018, The Office of National Statistics published that there were:

- 84 homicides (3.0 per 100,000) reported across West Midlands
- 49 homicides 0.9 per 100,000) reported across East Midlands
- 54 homicide (3.0 per 100,000) reported across East
- 187 total (victims) homicides reported across Midlands & East region

North Since 2016/17, the numbers of reported Mental Health related homicides reported via StEIS have remained reasonably consistent (35), however for the 2018/19 reporting period, the figure noted above (38) reflects those cases which were subsequently considered by the regional IIRG for a commissioning decision. In 2018/19 there were n=38 (0.25 per 100,000 population size) reported on StEIS.

In 2018, The Office of National Statistics published that there were:

- 136 homicides (1.9 per 100,000) reported across North West
- 53 homicides (1.0 per 100,000) reported across Yorkshire and the Humber Region
- 21 homicides (0.8 per 100,000) reported across the North East
- 210 total (victims) homicides reported across the North region

South: Since 2016/17 there has been an increase in the reporting of Mental Health Homicides on StEIS. In 2018/19 there were n=20 (0.14per 100,000 population size) reported Mental Health homicides across the South Region.

In 2018, The Office of National Statistics published that there were:

- 91 homicides (1.0 per 100,000) reported across South East
- 37 homicides (0.7 per 100,000) reported across South West
- 128 total (victims) homicides reported across the South region

Nationally there were 695 homicides (excluding exceptional incidents) at 1.28 per 100,000 population.

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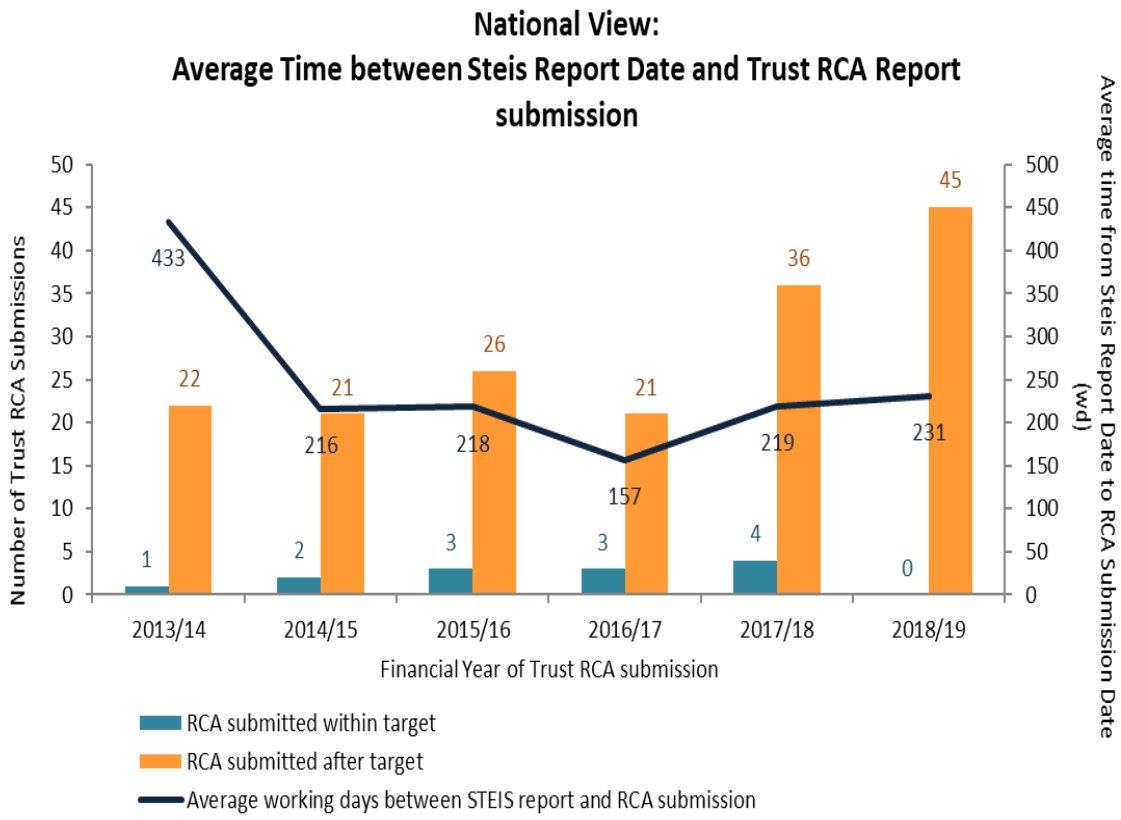
[1] All references related to the Office of National Statistics can be located via the following link https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/appendixtableshomicideinenglandandwales

Graph 2 – Average time between STEIS report date and submission of the Mental Health Provider Level 2 Report (RCA report). Graph 2 highlights the total number of Mental Health Provider Serious Incident level 2 reports submitted, the average time taken to submit the report and whether they were submitted within the target of 60 working days from the report date.



Source: NHS England and Improvement analytic team

London: To support the system with timely submission of Level 2 serious incident reports, the Independent Investigation Regional Team meets with the 10 providers of mental health service on a bi-monthly basis to share learning and identify any challenges with the management of mental health homicide investigations. These meetings identified that the police often requested that providers delay investigations until conclusion of the criminal justice process. The regional team have worked collaboratively with the Metropolitan Police Service and have an agreement to have early conversations to consider if providers could continue with their Level 2 investigations in line with the Senior Investigating Officers strategy. This agreement has shown a slight improvement in the timeliness of the submission of Trust internal homicide investigation reports.

Midlands & East:
Timely submission of Level 2 serious incident reports in certain police districts remains a challenge. Individual forces request investigations are put 'on hold' which influences the completion and timely submission of internal investigations. There is regular monitoring of all reported homicides on STEIS and liaison with providers to gain an understanding of obstacles and barriers. Any identified issues are discussed at bi-monthly network meetings directly with providers.

North: Prompt completion and submission of Level 2 reports is often influenced by the external factors as described above and whilst there is no automatic bar on conducting independent investigations whilst criminal proceedings are underway (Serious Incident Framework 2015) early discussions with Providers and relevant partners such as the Police and HM Coroners are actively encouraged across the North region, to ensure that investigations can commence at the earliest opportunity and any required changes are in put place to prevent recurrence. In support, the North region is contributing to the refresh of the 2006 Memorandum of Understanding, to provide guidance to the NHS to facilitate the early investigation of serious incidents in health care.

South: Timely submissions of Level 2 reports remains a challenge for the system across the South Region, for the reasons detailed above. Monitoring of progress of level 2 reports is in place so that any variation to the timeliness of submissions is transparent.

5 Open Mental Health Homicide Cases

As outlined earlier not all reported incidents will meet the criteria for an independent investigation.

5.1 Status of Independent Investigations (March 2019)

Table 1 provides a high-level position of the four regions, the cases listed below consist of reported homicide/serious assault cases ranging from 2015 to March 2019.

Regional cases	Potential cases	Awaiting Commissioning	Under way Investigation/ awaiting Publication	Total
London	32	5	10	47
Midlands and East	32	6	12	50
North	14	9	11	34
South	13	0	24	37
Total	91	20	57	168

London: There were 47 cases that the London region had oversight of, thirty-two of the cases were potential cases. These cases were pending the outcome of the criminal justice process, waiting for other statutory investigations such as serious case review/domestic homicide review or waiting for the mental health

provider to complete their internal serious incident investigation. They were also inclusive of incidents whereby victims sustained serious assaults.

Midlands & East: There were 50 cases that the Midlands & East Region had oversight of, 32 of the cases were potential where a definitive decision had not been taken on whether an independent investigation was required. Of the under-way investigations 6 were joint investigations (5 joint II/DHR and 1 joint II/Multi-Agency).

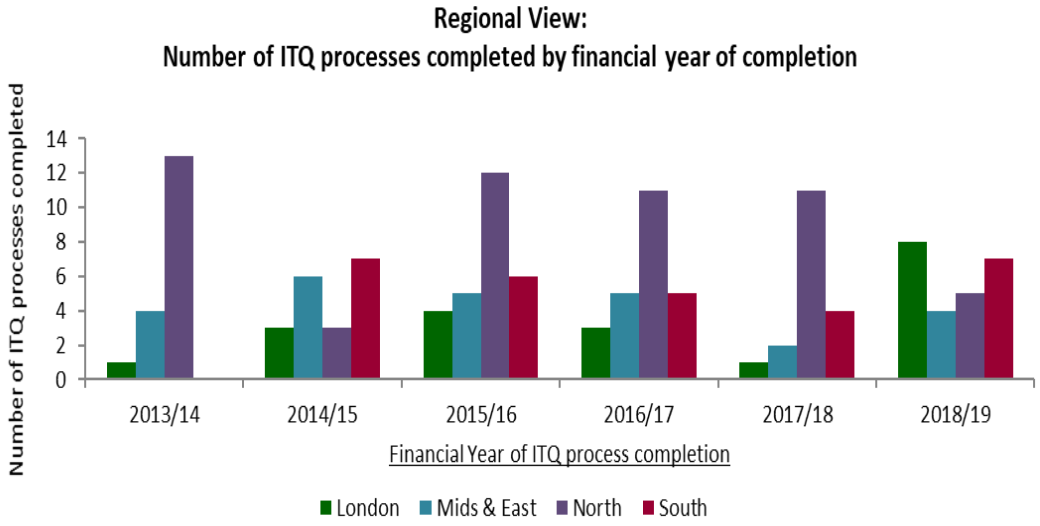
North: In respect of table 1 above, the total of 34, reflects cases at the beginning of the process and does not include those requiring action plan monitoring by CCGs or subsequent assurance reviews following investigations. The North region takes an early position in the consideration of potential cases (14), including those where other statutory review processes may also apply. 23 cases were considered by the IIRG in the reporting period 2018/19

The timeframe from the decision being made to commission an investigation to its commencement continues to be affected by the timeliness of Provider internal investigations and submission of level 2 reports. Whilst an early decision to commission may be reached, internal reports are required to inform the development of robust independent investigative Terms of Reference.

South: There were 37 cases that the South region had oversight of, 13 of which were pending the outcome of the criminal justice process, the completion of statutory investigations (e.g. Serious Case Review/Domestic Homicide Review) or waiting for the mental health provider to complete the Level 2 internal Review.

5.2 Commissioning timescales and completion dates

Graph 3 highlights the number of Invitations to Quote (ITQ) issued within each financial year by region. The ITQ follows the commissioning decision, it is the tendering process, ITQs also include direct contract awards.



Source: NHS England and Improvement analytic team

All regional teams have experienced significant challenges in obtaining a breadth of companies to tender and, this has a direct impact on the number of investigations which can proceed in a timely manner and within a given time period. These challenges have been raised via regional IIRGs, IIGC and risk register reporting.

The following provides examples of some of the ITQ challenges presented to the regions during 2018/19:

- There are currently 12 companies on the framework with only nine actively tendering, although not for every ITQ issued or in every region
- Instances where only one tender is received, reducing the number of competitive awards and possibly restricting value for money. Some of the companies only tender for specific regions which is due to a number of factors such as their internal capacity and geographical location.
- One company has formally withdrawn their interest to tender for Independent Investigations.
- Some of the companies may be unable to tender for cases due to a conflict of interest, examples include:
    - investigators/specialists that work for both the investigation company and the Provider.
    - where the company has undertaken due diligence and assurance exercises for the Provider.
    - where the company has advised the Provider extensively in respect of policy and training.
    - they are commissioned directly by the provider or CCG to conduct another investigation.

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Midlands and East regional team have led, on behalf of all the regions, the renewal of the procurement framework for the commissioning of independent investigations.

The East of England Procurement Hub and Attain (a specialist independent health advisory organisation) have worked with all the regions to explore how the framework can be improved and to stimulate the market with the aim of increasing the accessible pool of investigation companies.

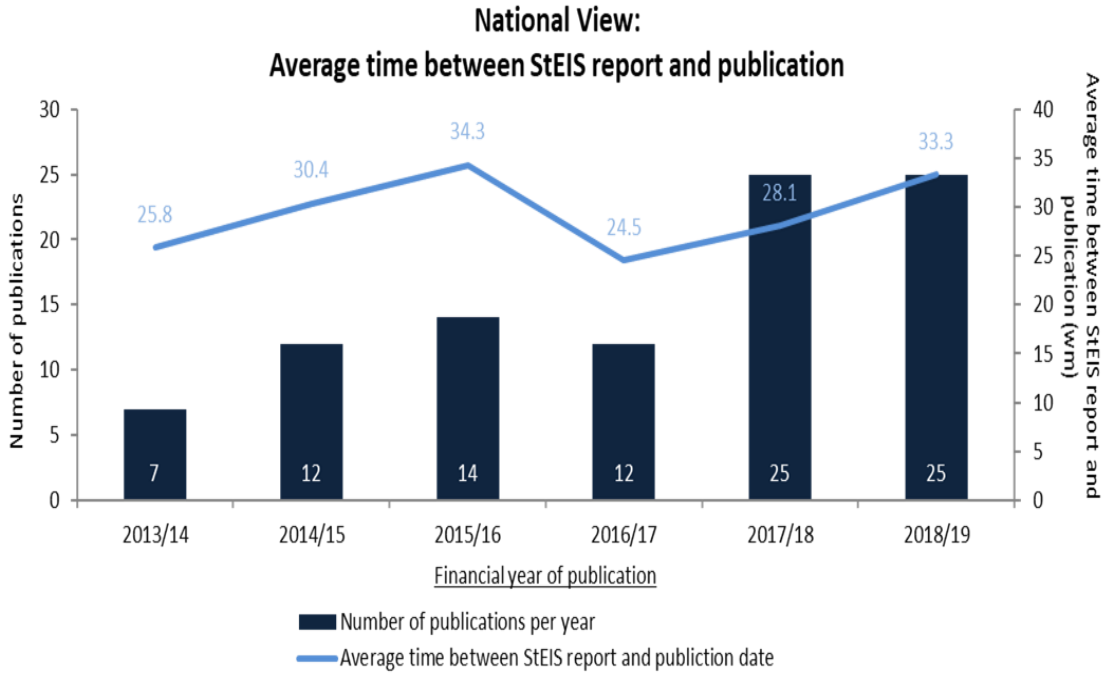
A survey was conducted with existing companies with the results being fed into a procurement workshop. From the results, a revised tendering strategy has been developed which determined multiple 'lots' of investigative services ranging from complex system wide investigations involving multiple partners to local investigations of a Trust or Clinical Commissioning Group which may require a single investigator.

A market engagement event was held in March 2019 to discuss the proposed strategy with the market.

An OJEU compliant tender was launched in May 2019, with evaluation of submissions completed by the end of August 2019. The outcome of the evaluation will be signed-off in September 2019 to allow the new contract to be in place by the 1st November 2019.

Challenges and constraints

Graph 4 highlights the total number of investigation reports published per financial year and the average time (months) taken to publish from the date reported on StEIS, by the financial year of publication. This data is aggregated across all four regions.



Source: NHS England and Improvement analytic team

Responding appropriately and in a timely manner is a key component of the investigative commissioning process however unforeseen and managed delays may adversely affect timescales and completion dates. This is due to external factors and constraints, such as;

- Providers unable to produce a timely comprehensive Level 2 report due to external factors such as Police, other statutory investigations
- Affected Family and Perpetrator considerations, such as ill health and intermittent engagement.
- Obtaining clinical notes in a timely manner
- The intervals between the incident occurring and investigation completion are also an influencing factor
- Pre-publication legal scrutiny

Regional Independent Investigation Teams continue to take a proactive approach to mitigate where possible these delays, escalating issues where required and to manage family expectations.

London: There were 5 publications during 2018/19. Of these cases there were two which were subject to significant delays as one report was awaiting the completion of a Domestic Homicide Review and the other being subject to significant legal scrutiny. These cases had an impact on the national average time between StEIS reporting and publication.

Midlands and East: There were 5 publications during 2018/19, three of which were Assurance Review reports. Two reports were subject to significant delays due to concurrent DHRs as the reports were awaiting completion of the DHRs. Some delays between completion and publishing were experienced due to family engagement.

North: Despite a temporary reduction in team capacity by a third across 2018, the North region published 9 independent reports including one Independent Assurance Review during the reporting period, this represents a reduction of two from the previous year. Of these publications three investigations were subject to significant external delays. One publication is the final remaining ‘legacy’ case from the former Yorkshire & Humber SHA, briefly; criminal proceedings were delayed due to the perpetrator being unfit to stand trial, this individual case also was subject of a legal dispute between the investigative supplier and NHS England which compounded the overall delay in the final report being received and adversely skews the national average time between StEIS reporting and publication.

South: There were 6 Independent Investigation published from the region during this reporting period and a further joint Domestic Homicide Review. Some delays between completion and publishing were experienced due to concurrent investigations (e.g. Serious Case Review and Coroner’s Inquest) affecting the ability to publish in a timely manner, with subsequent impacts on the national average time between StEIS reporting and publication.

5.3 Collaborative and joint investigations

A key element of the Serious Incident Framework (2015) (SIF) is the requirement to elicit lessons to inform systematic learning and improvement, acknowledging the investigative interfaces with other organisations, particularly those with a statutory responsibility to investigate specific types of incidents. The framework advocates a collaborative approach to investigations and recognises that a variety of investigation methodologies may be applied.

In promoting this collaborative approach to investigations and commissioning the SIF does not dictate nor prescribe a specific direction other than there should be early consideration given to joint investigations where possible, although the SIF does acknowledge that in practice this can be difficult to achieve.

Joint investigations continue to be considered across the four regions. Expected benefits of commissioning joint reviews would include;

- Where possible families are included in the decision making of a of singular investigation or multiple review processes.
- Reducing the risk of duplicating processes for NHS providers and other stakeholders involved.
- Enabling learning from these investigations to be disseminated across the widest audience possible. However, in considering any joint investigation must be inclusive of mental health aspect in the joint terms of reference.
- Enabling learning across multiple systems.
- Improved understanding of the independent investigation process with external stakeholders (Local Authorities, Safeguarding Boards and Community Safety Partnerships).
- Collaborative system learning.

Aspects of this type of investigation pose potential challenges in the following areas:

- Addressing the combined effect of the complex requirements of scrutiny, oversight and internal governance processes required by each respective organisation can impact on the timely completion of investigations.
- Determining joint funding arrangements
- Confirmation of lead organisation in developing terms of reference to avoid dilution of overall requirement
- Lead organisation arrangements
- Managing expectations (stakeholders)
- Varying publication procedures (Home Office QA scrutiny etc.)

The effectiveness of this approach does however need to be formally measured both in terms of family and stakeholder satisfaction and added value. An agreed set of principles governing the approach across the regions will be a key deliverable and work priority of the 2019/20 work programme.

Table 2 highlights regions collective summary of joint investigations in 2018/19, the data is inclusive of commissioned and published cases.

Regional cases	Joint DHR	Joint SAR	Joint SCR	Other
London	0	1	0	0
Midlands and East	4	0	0	2
North	3	1	1	0
South	1	0	0	0
Total	8	2	1	2

- London region commissioned one joint Mental Health Homicide Independent Investigation and Safeguarding Adults Review. The London Regional Independent Investigation Team support Domestic Homicide Reviews across London. This is inclusive of the team being full panel members, supporting the Community Safety Partnerships with Chair selection and supporting the DHR Chairs with navigating health and social care. London Regional Independent Investigation Team were supporting nine DHRs during this reporting period.

- Midlands and East: published one joint Prison Probation Ombudsman and Independent Investigation, one joint Multi-Agency and Independent Investigation which didn't meet the threshold for a DHR, but the system acknowledged the need to carry out an investigation, and one joint DHR and independent investigation. Within the region three joint DHR/Independent Investigations were commissioned,

- North: Early discussions with Community Safety Partnerships and Safeguarding Boards have resulted in 5 Independent Investigations being commissioned which take into account DHR/SCR requirements and whilst the benefits of such joint and collaborative approaches are acknowledged by the majority of partners, it is problematic to formally quantify the benefits as the views of affected families in terms of overall impact can be difficult to elicit.

- South region published an Independent Investigation that had a concurrent Serious Case Review and one that had an SCR after completion. The South Head of Investigations has also sat on 2 DHR panels.

6 Published cases

In line with the SIF, there is an expectation that independent reports and their associated action plans will be published: *https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports* and made public in the interests of learning and transparency. However, wider factors occasionally need to be considered on a case by case basis in respect of publication. The public interest aspect of publishing the report in full has to be balanced with any other competing interests, such as the right to confidentiality (which survives death) and the right to a private life under Article 8 of the Human

Rights Act 1998. This applies equally to both sets of affected families and service users as perpetrators.

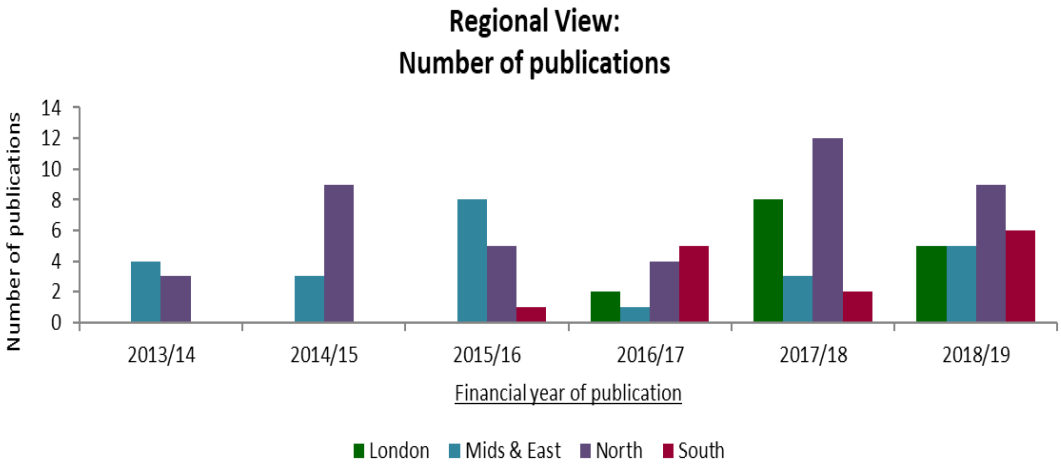
Publication of each case is determined individually, with publication options considered by regional Independent Investigation Review Groups (IIRGs) and discussed and agreed at pre-publication meetings, chaired by the relevant NHS England Director of Nursing or Medical Director with a representative from the communications team present.

If alternative publication formats and processes are required, the rationale will be presented to the IIRG in advance of the pre-publication meeting. This ensures that the decision-making debate and process is well evidenced, well-reasoned, clearly considering all relevant information. The minutes of these meetings where publication is determined serve as a record of such debate and formal decisions.

6.1 Published cases

Graph 5 highlights the position of regional publications by financial year.

Note that some earlier cases would have been published on the regional strategic health authorities' websites and therefore are not included in graph 6



Source: NHS England and Improvement analytic team

London: During 2018/19 financial year London published 5 reports:

- There were 4 male perpetrators and one female
- Incidents in all 5 cases occurred in either 2013 or 2014
- With two of the cases whereby the perpetrator killed themselves following the index offence, two were convicted of Manslaughter with defence of diminished responsibility and one convicted of murder.
- All victims were known to the perpetrators
- One case was subject to a Serious Case Review (SCR) and then a Mental Health Independent Investigation.

Midlands and East: The Midlands & East Region published six independent investigations, one of which was commissioned under the SIF and did not relate to a mental health investigation, and three Assurance Reviews.

- Of the five homicides all were male.
- Incidents in all cases occurred in either 2011, 2012 or 2015.
- In four cases the victim was known to the perpetrator
- In one case they had met on the day of the incident, prior association via internet dating.
- One case involved the passive smoking of psychiatric substances within a cell.

North: The North region published 10 independent reports including one Independent Assurance Review during this reporting period. Three of the independent investigations which were commissioned under Appendix 3 of the SIF and do not relate to Mental Health Homicide investigations. These cases are included in overall reporting total for completeness as case management was both resource intensive and challenging.

The sub set below refers only to Mental Health Homicide Investigations

- Of the six homicide investigations five perpetrators were male and one female.
- Published reports span several reporting years, with one incident occurring in 2011 (SHA Legacy case) and remaining cases the homicide occurring in 2015 and 2016.
- One perpetrator subsequently died of an unrelated medical condition following the homicide, one perpetrator was unfit to plead at trial and remains subject to an indefinite hospital order, two perpetrators were convicted of murder and two were convicted of manslaughter.
- In three of the incidents the victims were unknown to the perpetrator; one incident was a random attack and one as a result of sudden onset of symptoms
- One investigation was a joint DHR/Independent Investigation.
- One investigation included the commissioning of a Case Study which was published in lieu of the investigation report. The IIRG took this decision following consideration of serious and legitimate concerns raised for the health and safety of individuals and affected family members involved.

South: During 2018/19 financial year the South region published 6 reports:

- There were 5 male perpetrators and one female

- Two cases the perpetrator took their own lives during or immediately after the offence, three were convicted of Manslaughter with defence of diminished responsibility and one convicted of murder.
- In three cases the victims were not known to the perpetrator.
- Two cases were subject to SCR (one concurrent, one following completion of the independent investigation.

6.2 Themes from published Independent Mental Health Homicide Investigations 2017/18 and 2018/19 inclusive

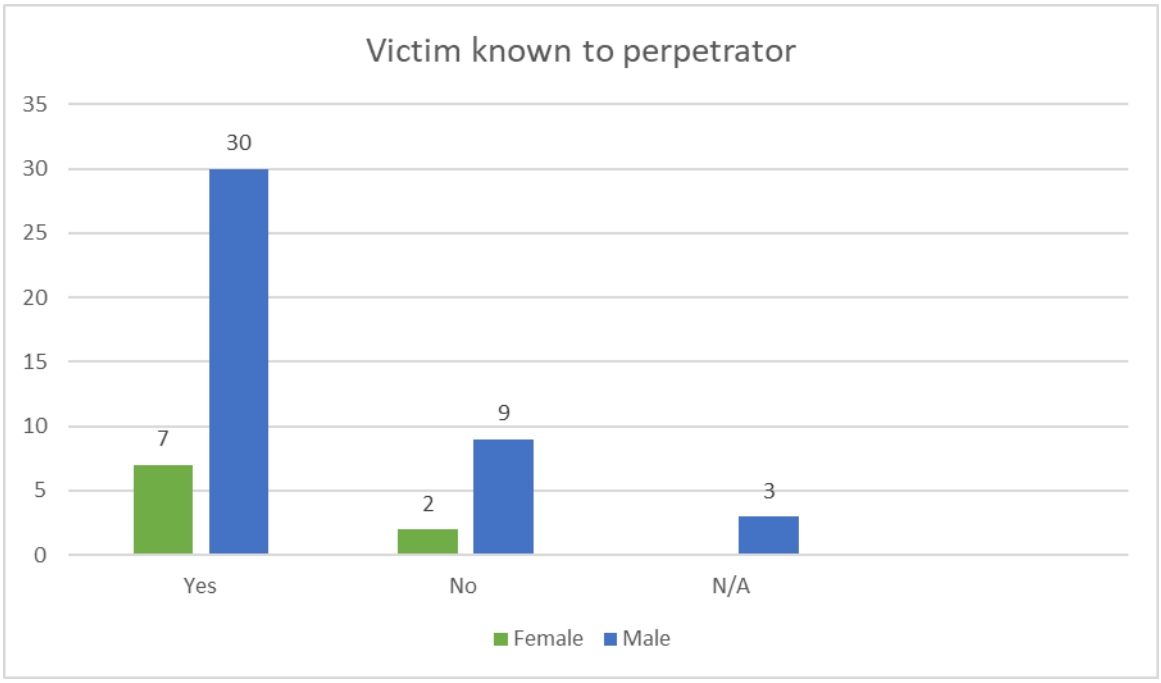
The data is from all four Independent Investigation Regional databases, it is inclusive of published reports in 2017/18 and 2018/19. These themes will be considered in our annual and regional workplans.

Table 3 highlights the perpetrator demographic collective data 2017/18 and 2018/19 of published reports. There was a total of 51 perpetrators.

Demographics	Female	Male
Age range/median	14-48 (34years)	16-71 (32.5 years)
Gender totals	9 (21%)	42 (79%)
BAME	2 (4%)	12 (24%)
White British/white other	7 (14%)	30 (59%)

The Office of National Statistics (ONS) 2018 reported that most homicides were committed by 16-25-year olds in both female and males. However, the median age reported as above is second highest in the ONS publication.

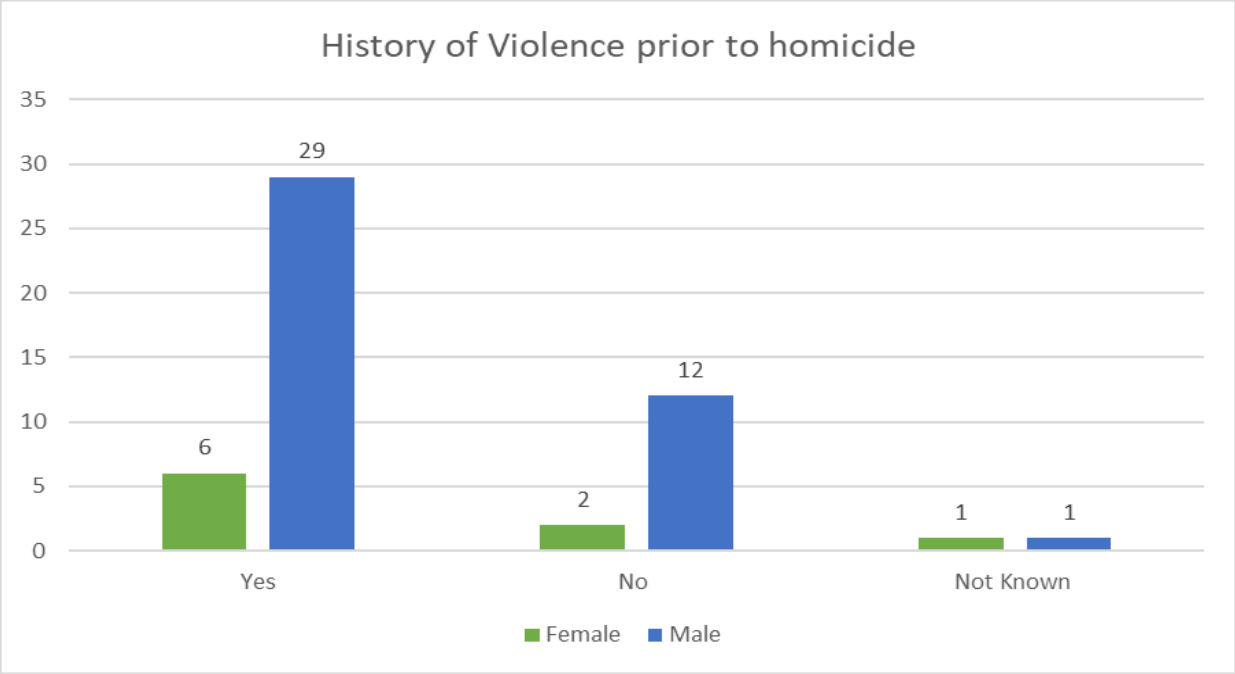
Graph 6 Indicates if the victim was known to the perpetrator prior to the homicide.



A total of 37 (72%) cases the perpetrator knew their victim prior to the fatality. Three cases were classed as not applicable as they were not classified as homicides.

The published data from the Office of National Statistics (ONS) 2018 highlights that '*victim acquainted with suspect'* is year on year lower than those where the *'victim not acquainted with suspect'.*

Graph 7 highlights cases where the perpetrator had a known history of violence prior to the homicide



A total of 35 (69%) perpetrators were known to have a history of violence prior to the homicide. In two cases it was unknown.

Table 4 highlights the range of services that the perpetrators were in prior to the homicides.

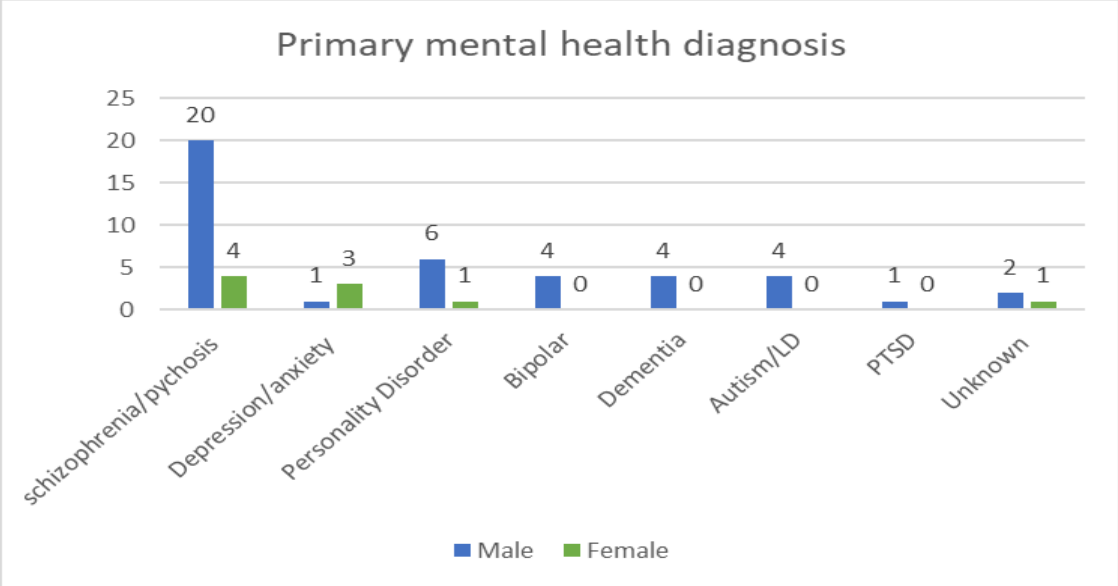
Service	Total
Community (varied)	28
CAMHS	12
Drug and Alcohol	11
Forensic services (varied)	7
Psychiatric Intensive Care Unit (PICU)	3
Inpatient (informal)	1
Lost to services post prison release	1
Memory service	1
LD residential	1

Community services have been grouped as one, they were however, inclusive of home treatment teams, recovery teams and Improving Access to Psychological Therapies (IAPT). Child and adolescent mental health services (CAMHS) were all inclusive of

community services. Most homicides occurred when perpetrators were receiving services within the community.

Those involved with drug and alcohol services were also involved with other services.

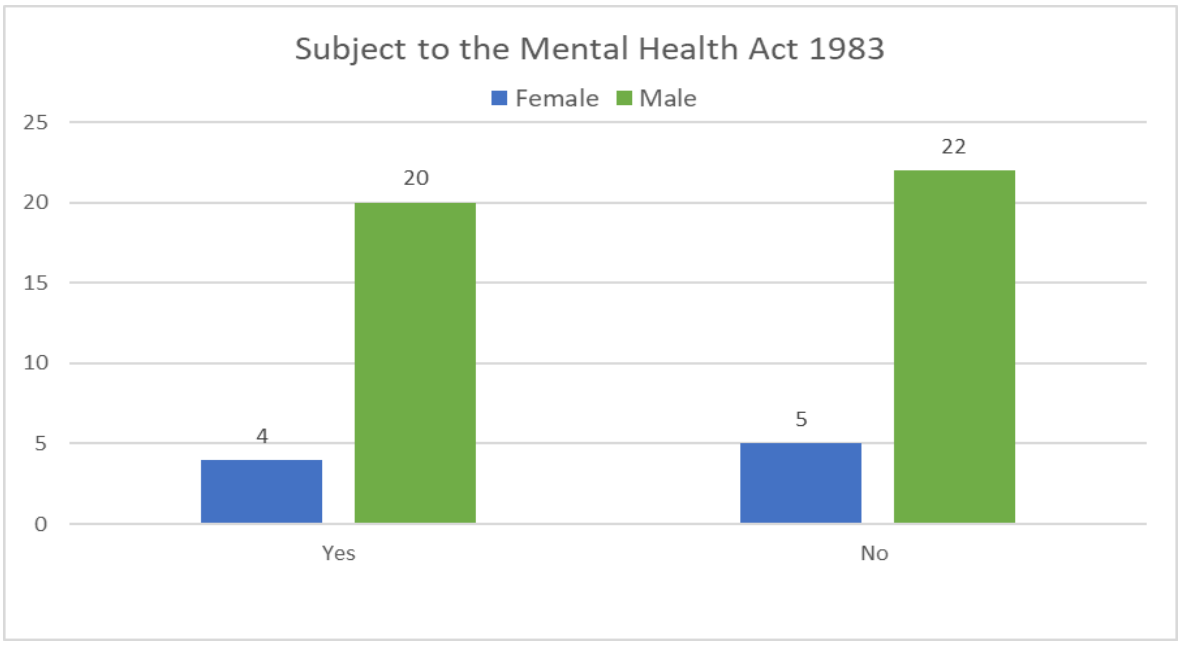
Graph 8 highlights primary mental health diagnosis of males and females in the published reports during 2017/18 and 2018/19.



The primary mental health diagnosis of paranoid schizophrenia, first onset psychosis and schizoaffective disorder were the most prominent in both male and females.

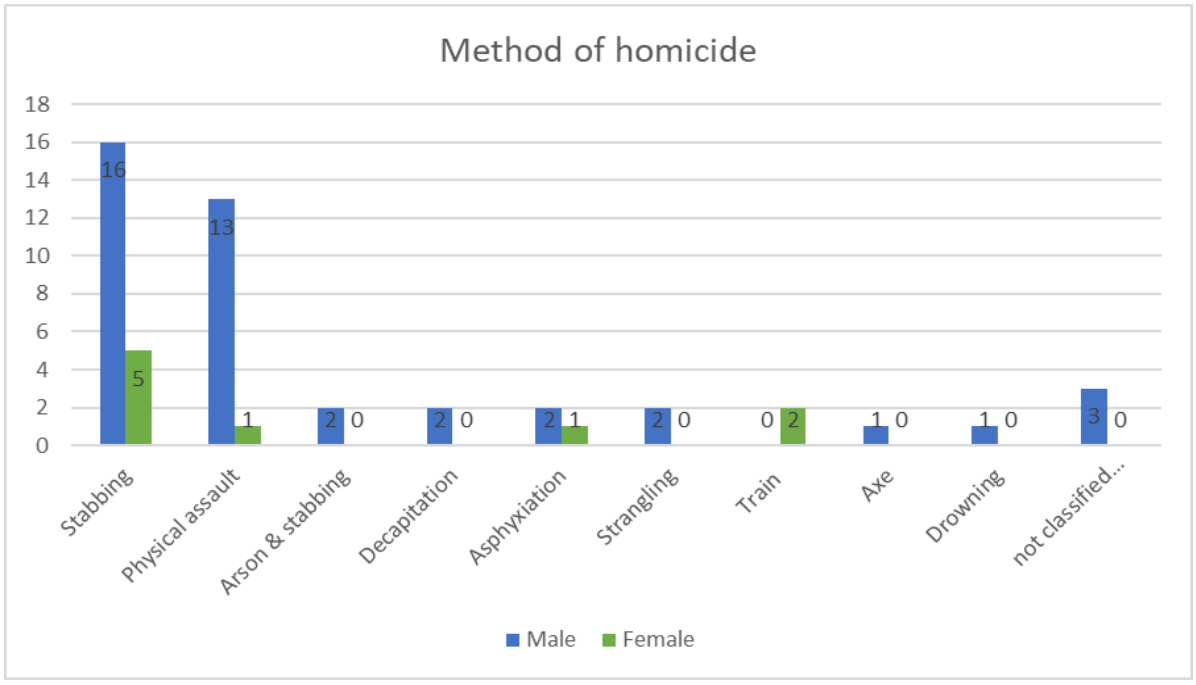
Whilst the numbers are low, depression and anxiety were higher in females than males.

Graph 9 identifies males and females who were subject to Mental Health Act 1983 (MHA) at the time of the homicide.



The data highlights that there is an even distribution of those perpetrators subject to the MHA and those who were not.

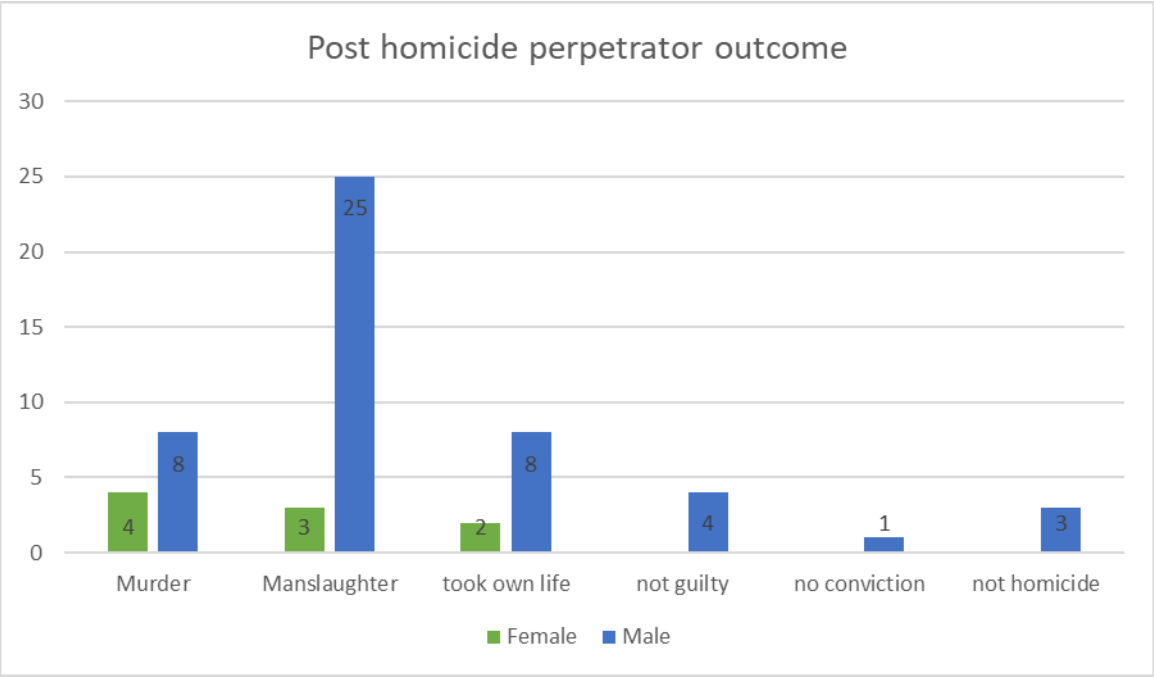
Graph 10 highlights the primary method of the homicide of the published reports during 2017/18 and 2018/19



Stabbing and physical assault are the predominant method of homicide with males. Stabbing is also the main method of homicide with women. This method is identified as being in line with the Office of National Statistics (ONS). In 2018, the ONS published that males who killed using sharp instrument was 222 and women were 63 incidents across England and Wales.

Please note that in the 2 train incidents, both the female perpetrators knew their victims, they both had a mental health diagnosis of depression/anxiety. They were both been seen by community services and neither were subject to the MHA. Both perpetrators took their own lives.

Graph 11 highlights the criminal justice outcome for the male/female perpetrator



The above highlights that males were, in the main, convicted of manslaughter by reason of diminished responsibility.

There were three Independent Investigations published by the North Region which were not homicides.

It is not possible to make direct comparisons with the Office of National Statistics and the Regional Independent Investigation Teams data, as the manslaughter data is inclusive of all three categories under section 2 of the Homicide Act 1957 [2].

[2] Manslaughter can be committed in one of three ways:
1.Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
2.Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and
3.Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

Table 5 provides information on some of the broad themes identified in 2018/19 published reports.

	Broad themes
Dual Diagnosis	• Challenges with patients with a dual diagnosis (co morbid Drug and Alcohol use) and complex needs accessing and engaging with treatment • The separation of mental health and substance misuse services resulting in; the respective services focusing only on one aspect of the patient's primary needs, misdiagnosis and/or receiving inappropriate treatment. • Issues resulting from the disconnect between mental and physical healthcare • CAMHS, substance misuse and youth offending services seen as distinct and separate services rather than essential components of a comprehensive service for young people • Lack of awareness of when to seek specialist advice within some CAMHS and delay in transfer to adult services
Care Planning /CPA/Risk	• Access issues to acute inpatient wards • Access issues for forensic assessments • Lack of awareness of when to seek specialist advice • Lack of a coordinated approach and continuity of care (specifically when individuals presenting with complex needs move between geographical, commissioning, or service boundaries on a regular basis) • Limited documentation in relation to strategies for securing engagement for complex patients • Lack of access to crisis intervention and planning including escalation arrangements • Lack of clarity and full understanding of role of the care coordinator and identifying their responsibilities for liaising with other involved services • Lack of primary care involvement in key decisions including discharge planning, variable care planning/intervention in relation to older people services • Minimal care planning information recorded, with little or no direction • Transfer to other services without appropriate assessment being undertaken • Transfer of Multi Agency Public Protection Arrangement (MAPPA) • Lack of consideration of MAPPA information featuring in risk assessment and care planning • information, failure to transfer complete history • Incomplete risk assessments for complex individual • Limited evidence of protocols for transitions between services • Variable standard of risk assessments and risk management plan • Historical risks not being considered/over reliance on self-reporting in relation to risk factors

	• Lack of proactive coordinated discharge planning, including consideration of social care needs
Safeguarding	• Lack of understanding/failure to acknowledge relevance of safeguarding information by some front-line staff • Variable application of safeguarding policy and guidance • Clinical supervision not inclusive of Safeguarding • Lack of coordinated approach across and within local authority boundaries, when adult/child safeguarding concerns and abuse are raised.
Communication	• Lack of appropriate transfer of risk and forensic information to partner agency and services • Incomplete handovers of care (incomplete exchange of information including care plans) • General lack and poor quality of communication between agencies despite risk being acknowledged
Drug and Alcohol	• Acknowledgement and acceptance of illicit drug taking by staff without robust risk assessment • Patients with complex needs and forensic and/or substance misuse histories and who are at high risk of disengagement from mental health services, not consistently receiving assertive and proactive care to prevent them being lost to services • Lack of effectiveness of Dual Diagnosis Policies
Family/Carers	• Think family not fully considered • Families' needs not always fully explored beyond routine contact with services • Families not recognised as carers, no carers assessment offered and not involved in care planning Family interventions and relationships by agencies and health not always well communicated or boundaries fully understood • Families concerns not being acted on in care planning/risk assessments • Lack of skills (staff) to deal with complex family dynamics • Staff not considering the importance of cultural diversities
Training and education	• The findings relating to risk training can be divided into distinct clear areas covering; risk assessment, its application, communication and consistent recording • Policy and guidance – CPA, Serious Incident management/investigation, Safeguarding, domestic abuse and Duty of Candour
Medication	• Lack of clear guidelines for risk assessment and care planning for the titration of clozapine in the community • Acceptance that the patient was taking prescribed medication as they picked up prescriptions
Commissioning	• Co-location of services (specifically out of hours) • Reduced access to drug and alcohol services • Limited provision of CAMHS psychiatrists/expertise available to GPs and other professionals

7 Regional Independent Investigation Teams activities 2018/19:

London

Over the last year the Regional Independent Investigation Teams have made a significant contribution to improving health services across London. Activities include:

- Bimonthly Provider patient safety forum to discuss and share the learning from independent investigations into Mental Health Homicides
- Overview of learning from independent investigations shared with all London providers of mental health, CCGs, other relevant stakeholders following each publication
- NHS England (London) mental health patient safety team commissioned a project to provide resources to families and staff following a mental health homicide. The project engaged families and multi-agency stakeholders in the co-design. The project has been endorsed by the Metropolitan Police Service and NHS Resolution. https://www.england.nhs.uk/london/our-work/mhsupport/
- NHS England (London) mental health patient safety team designed a series of key performance indicators to monitor performance and to support the wider system following a mental health homicide.
- Forthcoming multiagency improvement events for 2019/20:
    - Risk assessment and Risk management conference
    - Collaborative joint investigation workshop
    - Keeping young people safe in London

Midlands and East:

Midlands & East Region holds quarterly mental health provider network meetings to facilitate the sharing of learning and best practice.
Synopsis of the key learning issues from published investigations is shared with all providers within Midlands & East.
Learning resources developed for sharing across all provider organisations.

North:

Building on the positive evaluations and feedback received in relation to the planned programme of learning delivered across the region since 2015, in 2018 the region delivered three local 2-day Learning from Experience RCA Master Classes, tailored specifically for NHS provider staff who are expected to investigate moderate to high harming patient safety incidents. These events have culminated with a series of externally facilitated Action Learning Sets being delivered through to 2019/20.

South:

- Overview of learning from independent investigations shared with all South providers of mental health and commissioning bodies following each publication.
- Delivery of 4 Making Families Count Conference days across England

- Commissioned a quality assurance review of the previously published "Thematic Review into homicides involving patients known to Sussex Partnership NHS Foundation Trust"

8 Regional governance arrangements (Independent Investigations Review Group – IIRG)

The IIRG is the regional meeting which provides regional leadership, assurance, support and advice in the delivery and application of the Serious Incident Framework 2015 (specifically Appendices 1&3) and the Department of Health's guidance in relation to Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. All four regions host an Independent Investigations Review Group.

Terms of Reference and IIRG membership refinements have improved the effectiveness and governance of the IIRG. There is a focus on wider system learning, monitoring of regional themes and escalation of national actions arising from recommendations aimed at driving service improvements and influencing national work programmes.

The IIRG has a broad membership of internal and external partners; the composition of the membership provides an invaluable, unique, strong and independent perspective and challenge to both regional processes and the wider NHS system.

The IIRG Lay members ensure; that the needs of affected families are fully represented and remain central to the commissioning and investigation process, that there is greater assurance for families and members of the public by validating robust governance oversight and implementation of report recommendations, openness and transparency in how NHS England commissions independent investigations.

Table 6 Details of IIRG decisions

	Decision to commission - criteria met	Decision to commission - wider principles of SIF	Decision not to commission - criteria not met	Consideration of alternative publication options	Decision to publish partial aspect of the report
London	20	3	14	1	1
North	8	2	13	1	1
Midlands and East	9	0	20	0	0
South	8	1	6	1	1

London: Two cases were subject to both an internal trust report and Domestic Homicide Review, these reports were reviewed and the IIRG agreed to commission an independent investigation to review how their practices have changed in relation to the issues identified and also review the housing management/allocation, communication with Mental Health services and clarification of responsibilities. This decision was made in consultation with the families.

Two cases commissioned for Independent Investigation were not a mental health homicide:

- One was an attempted murder which left the victim with life changing injuries
- One was a complaint about care and treatment of a patient regarding Child and Adolescent Mental Health and Learning disability Services

Fourteen cases were considered at IIRG as not meeting the requirement of an Independent Investigation due to one of these reasons:

- The perpetrator had not been in receipt of mental health services.
- The incident did not meet the Serious Incident Framework (2015) and Article 2 of the European Convention on Human Rights. (Not subject to a CPA and no mental illness identified) criteria
- Minimal contact with mental health services. Issues identified and addressed appropriately via the provider internal investigation report.

The IIRG were informed of all publications. Options in two cases were tabled for discussion due to the complexity of these cases; significant media interest, and qualitative issues of a report. In one case a report was initially partially published to ensure learning was accessible to wider system, this decision was in agreement with the family. The full report was subsequently published with family and stakeholder agreement.

North: The numbers of decisions made at IIRG to commission/not to commission have remained relatively consistent across years, with a difference of 2 cases overall. Thirteen cases were considered at regional IIRG as not meeting the requirement of an Independent Investigation due to one of following reasons;

- The perpetrator had not been in receipt of mental health services.
- The incident did not meet the Serious Incident Framework (2015) criteria

In terms of publications, the IIRG considered and agreed to an alternative publication format for one specific case. The resultant published Case Study was considered a valuable learning tool which has been widely utilised by regional colleagues and local areas as part of the Safeguarding agenda. The success of this approach to publication and wider system dissemination of learning has been acknowledged and will inform the basis of a publication strategy to supplement the operating model for independent investigations.

Midlands & East: Nine cases were considered to meet the criteria, two of which were joint investigations, one with a Children's Serious Safeguarding Review and one with a DHR. Two cases will have targeted investigations commissioned due to the extensive internal investigation reports produced by the mental health trusts and investigations will be focussed on the wider system rather than the individual trust.
Twenty cases were considered as not meeting the requirement for an independent investigation.

All publications were considered by the IIRG and approved for full publication of the reports.

South: All publications were considered by the IIRG, one decision was taken to publish an investigation summary to reduce the impact of publication on surviving family members. The South IIRG also commissioned a Quality Assurance review following the 2016 Sussex Thematic Review, which is with the wider principles of the SIF, to ensure the embedding of learning across the organisation. Of the 8 cases commissioned 3 were quality Assurance reviews building on the work done either by Level 2 internal investigations or Domestic Homicide Reviews. One full investigation was commissioned outside of the frameworks criteria for inclusion (i.e. contact within 6 months of the index incident) as the absence of service led contact appeared critical to the incident.

9 National governance arrangements

The Independent Investigations Governance Committee (IIGC) undertakes a national oversight and assurance role for independent investigations. The IIGC provides a route to escalate and manage (through the Regional Directors of Nursing / Chief Nursing Officer's meeting and other appropriate committees such as the Quality Assurance Group) high profile cases and urgent issues arising from independent investigations.

The IIGC meets on a quarterly basis and reports into Executive Quality Group a sub-group of the board. The committee is jointly Chaired by Chief Nurse, (London) who is the Senior Responsible Officer for mental health homicides and a lay member.

The IIGC commissioned an independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day. The review was received and accepted by the IIGC in 2019. The purpose of this review was to provide NHS England with a credible, objective and impartial blueprint for change and service improvement; and to ensure themes and learning from investigation reports are subsequently transferred and utilised by relevant national Mental Health programmes. The review was inclusive of the needs and involvement of victims' families and perpetrator's families and explores the degree of support they receive. The report made 9 recommendations which are embedded into the national annual workplan.

10 Finance

The national Independent Investigations budget is held centrally within the Operations and Delivery directorate, with national oversight by the IIGC. The budget for this work programme has been revised since the original allocation of £3.2 million in 2013, due to both underspend and overspend in the subsequent financial periods.

The current budget allocated is £2.1m. Budget planning is based on an assumed average cost of £23,530 per investigation; this is calculated by monthly central financial review and consideration of the numbers of pending investigations to be commissioned.

Legal costs associated with each case are generally reflected within overall costs below, however occasionally legal costs may be significantly increased for individual complex cases, for example where Senior Partner or Barrister representation is required to represent the interests of NHS England in discharge of its Independent Investigation responsibility.

	North	Midlands & East	London	South
	2018/19	2018/19	2018/19	2018/19
Number of Commissioned Investigations	5	8*	10	7
Total agreed fee for investigations commissioned	£ 166,700.00	£ 154,419.00	£ 241,409.00	£ 139,785.00
Total legal fees paid	£ 13,136.00	£ 3,000.00	£ 4,500.00	£ 3,000.00
Total	£ 179,836.00	£ 157,419.00	£ 245,909.00	£ 142,785.00
Average fee agreed per investigation commissioned	£ 33,340.00	£ 19,677.37	£ 24,590.90	£ 19,969.28

11 Regional and national priorities

National work programme

The Independent Investigation Governance Committee commissioned an external review of regional processes, independent investigative outputs and findings from investigations. Actions arising from the recommendations are included in the national work plan for investigations and subsequently informs regional work programmes

Regional Independent Investigation Teams continue to work to regional programmes aligned to the national work programme deliverables and in response to Five Year Forward View and the NHS Long Term Plan.

In addition to the national work programme requirements, regional priorities to be delivered in year (2019/20) are to;

- Collaborate with national and regional improvement colleagues, inclusive of Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICS) to identify effective mechanisms to ensure that learning opportunities identified as a result of investigations are fully utilised.

- Support Providers to improve the level of insight and knowledge around investigatory processes (including robust investigative methodology and measurable action planning).

- Support Clinical Commissioning Groups to ensure they are equipped to support the improvement of the quality of Provider action plans and subsequent assurance of recommendation implementation.

- Continue to improve the experience of affected families and reduce the impact where possible of the investigation process.

- Lead the revision and implementation of the national procurement framework (2019/20) to ensure continued integrity and viability of framework (including required revisions to the investigative supplier list based on predominance where applicable).

- Measure the effectiveness of collaborative and joint investigations in terms of stakeholder, family satisfaction and added value.

- Consult on and develop operational principles of collaborative and joint investigations with regional NHS stakeholders.

- Consideration on how the Regional Independent Investigation Teams align with the National Patient Strategy and Patient Safety Incident Response Framework (due to be published in September 2019).

12 Risks and Mitigation

There were three risks on the national IIGC risk register. These risks are owned at a national level; they have actions to mitigate and are monitored via this governance committee on a quarterly basis. Actions to mitigate this risk are incorporated within the annual workplan of the IIGC.

The risks identified are:

- There is a risk that unwarranted variation will exist within national and regional governance processes leading to inconsistency of approach and inefficient national oversight, monitoring and timely intervention.
- There is a risk that future deaths will not be reduced due to ineffective learning from regional and national system, policy or practice issues or omissions and recurrent themes.
- There is a risk that we do not work effectively with key partners, internal or external of the NHS that enable timely responses to improve experience, safety and quality.

13 Summary

Published reports and their subsequent output should not be considered as the sole indicator of performance of the regional function and work programme in respect of independent investigations, as there are a number of completed investigations which are currently subject to external factors influencing the publication timescales. Additionally, complex and sensitive family dynamics and interrelated professional interests can often impact significantly on the pace of progress of individual cases.

The regional approaches to commissioning the investigation process are robust, transparent, effective and responsive to specific case considerations. Further work remains however to address the challenges posed with reducing the timeframe that it takes for the publication of independent investigation reports, interagency working and their respective variation in processes and to ensure dissemination of meaningful learning across the wider system.

14 Recommendations

NHS England Independent Investigation Governance Committee is requested to note the Independent Investigations Annual Report 2018/19 and to consider the national and regional independent investigation priorities for 2019/20 as detailed above.