An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day

Section two

Main report

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Contents

1. Introduction

Structure of the report

1.1 This review report has two sections: An Executive summary and the Main report, which includes Appendices. Section one is the Executive summary and contains the process, emerging themes, conclusions and recommendations of this report.

1.2 Section two is the Main report and contains:

I. Background information and the review process
II. Governance
III. Best practice (this provides a literature review pertinent to the terms of reference)
IV. IIMHH reports (this includes Quality of the reports, Recommendation themes and Perpetrator Characteristics)
V. Recommendations
VI. Appendices which include: Terms of reference, Resources used, References and Biographies of the reviewers

Background information

1.3 The NHS England Independent Investigation Governance Committee (IIGC) commissioned Professor Hilary McCallion and Paul Farrimond via NHS Interim Management and Support (IMAS) to undertake a review of the Independent Investigations for Mental Health Homicides (IIMHH) published and unpublished in England from 2013 to the present day. The consultation process of the review and the examination of the IIMHH reports took place between September 2017 and December 2017.

1.4 The Independent Investigations Governance Committee (IIGC) was established in 2015 and reports to the Quality Assurance Group (QAG), both in NHS England. The QAG provides oversight of key quality issues and risk and agrees actions for dissemination. The IIGC provides governance for Independent Investigations at a national level and considers national recommendations and associated actions.

1.5 Independent investigation for mental health care-related homicide (IIMHH) is based upon the Department of Health publication HSG (94)27. This offered guidance on the discharge of mentally disordered people and their continuing care in the community. Further amendment and guidance was implemented in 2005.

1.6 The National Patient Safety Agency (NPSA) published a Good Practice Guide in 2008 and in 2010 a National Framework for Reporting and Learning from Serious Incidents

Requiring Investigation. Tools to assist investigators undertaking Investigations using Root Cause Analysis were provided (NPSA 2008).

1.7 NHS England assumed the responsibility for the commissioning and oversight of independent investigations in 2013. The NHS England Serious Incident Framework (NHS England 2013) and DH Article 2 of the European Convention on Human Rights sets out the circumstances and criteria for when an independent investigation must be considered.

1.8 The NHS England Serious Incident framework (NHS England 2013) was updated in 2015 and includes Appendix 1: Regional Investigation Teams: Investigation of homicide by those in receipt of mental health care. Appendix 3: Independent Investigation (level 3) and Appendix 4: Domestic Homicide Reviews.

1.9 The Operating Policy for commissioning and managing Independent Investigations for the NHS in England (version 16 - unpublished) was provided in February 2017 for use by the regional leads and it explains the responsibilities and actions required for dealing with serious incidents that may require an Independent Investigation. These include investigations in Mental health, Domestic Homicides Reviews, Serious Case Reviews, Adult Safeguarding Reviews and Death in Custody Investigations. This policy describes the structures and responsibilities that should be in place across England to provide a robust approach to meeting the needs of Independent Investigations.

1.10 In each of the NHS England regions there is an Independent Investigation Regional Group (IIRG) in place. The membership of each group varies across the regions and may include family and NHS Improvement (NHSI) representatives. These groups provide support to the Regional Investigation Team (RIT) to determine which cases require Independent Investigations. The IIRG considers the scope and quality of a Trust internal investigation and determine the type and level of independent investigation required (unpublished NHS England 2017).

The Review

1.11 The purpose of this review is to assess the extent to which the NHS responds to and learns from Independent Investigations into mental health care-related homicide (IIMHH). The aim is 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 examines the needs and involvement of

victims' families and perpetrator's families and explores the degree of support they receive.

1.12 The review examined all Independent Investigation reports published (35) and unpublished (22) from 2013 to the present day (December 2017) and identified reoccurring trends, themes and the impact and effectiveness of service changes as a result of investigation report findings since the formation of NHS England.

1.13 Since April 2013, seventy-one reports were published on the NHS England website and thirty-six of these reports did not meet the criteria in that the event took place prior to 2013, and these reports are excluded from this review.

1.14 The fifty-seven IIMHH reports used included thirty-five published and twenty-two unpublished reports. These were scrutinised in detail, and were assessed against quality criteria published by the NPSA (2008). Eight of the published reports were scrutinised by both reviewers and these were compared to establish a consistent approach. The information from each of the reports was categorised into: Quality of the report: Themes of the Recommendations and Outline of the Perpetrator.

1.15 A consultation process took place across NHS organisations, individuals and families who had been or were involved in the IIMHH process. This included representatives from NHS England; NHS Improvement (NHSI); Healthcare Safety Investigation Branch (HSIB); Social care; NHS Trusts; Family Representatives; International leaders; Academics and Independent Investigation companies (Appendix B). The consultation process included 1:1 interviews, focus groups, telephone interviews; and surveys. The consultation process took place between September 2017 and January 2018.

1.16 Resources provided by NHSI, NHS England and Investigation companies, including documents; meeting minutes, risk registers and work plans, were scrutinised along with relevant literature and published reports. (*During the process of the review additional documentation and information was provided in January 2018).*

1.17 Alternative investigative processes were examined including Domestic Violence Reviews; Serious Case Reviews and National Guidance on Learning from Deaths. Investigation methodology including Root Cause Analysis; Human Factors and Complex Adaptive Systems were explored. Academic literature relating to Independent Investigations was considered and is provided in the Best practice section.

2 Governance

The reporting and monitoring structure in practice

2.1 The Independent Investigation Governance Committee (IIGC) meets quarterly. The committee membership includes NHSI and NHS England regional representation, lay and family representation and representation from Learning from Deaths and the HSIB.

2.2 The documentation of meetings and papers received by the IIGC provides evidence of it's evolution and delivery against the committee's terms of reference. The minutes of the committee demonstrate that progress has been made since the committee was set up, that actions are tracked and completed. Although papers accompany agenda items, there are a number of verbal items on the agenda. Some papers focus on similar topics and are regional, these vary in layout (paper 3, paper 5, August 2017). A template for papers would be helpful, and rather than receiving regional papers a collated report with England wide information would provide an improved overview and offer opportunity for comparison. An example of this approach was the finance paper (May 2017). A risk register is in place and updated.

2.3 A summary of the IIGC workshop (August 2017) demonstrated key achievements, strengths and core purpose. These were to:

- Reduce the risk of future deaths by maximising learning from any system, policy or practice errors to ensure they are not repeated across the system.
- Learn and share good practice across all regions.
- To strengthen and improve the governance infrastructure.
- Role in managing proposals for national policy change whether within NHS or beyond.

2.4 Outstanding issues are addressed in the 2017-2019 work-plan, and meet the strategic objectives of the committee. This work-plan (September 2017) focuses on consolidating the governance structures, increasing understanding on lesson learning and the improvement of shared learning. The strategic objectives are learning and prevention; national and regional governance and working with key stakeholders.

2.5 The IIGC work plan highlights the importance of engaging with external participants such as police; probation etc., Examples in the recommendations action tracker provided to the IIGC identifies the need to engage with other agencies to implement the recommendations.

2.6 The IIGC reports to the Quality Assurance Group, and the reviewers found that there is some alignment with other committees and organisations due to membership of the

committee, and this could be enhanced with other committees, which consider patient safety and investigations within NHS England or externally. An examination of the information as part of this review demonstrates that the IIGC has good governance arrangements in place, is monitoring actions and influencing national policy. The IIGC has systems and structures in place to oversee the process of the IIMHH.

2.7 Each NHS England region has a Regional lead, and reporting lines, structures, resources and practice differs across each region. The line management of the regional leads is provided from within their region and each regional lead attends the IIGC. The Regional leads meet on a regular basis and work together to deliver a work plan approved by the IIGC and to align processes. The regional Independent Investigation Review Groups (IIRG) meet monthly or bi-monthly as required and the membership and terms of reference of each IIRG differ across the regions, although all are working towards the same outcomes. The regional leads are pivotal to the successful delivery of the IIMHH process and this was evidenced during this review.

Commissioning and procurement

2.8 The National Procurement Framework is used by all regional leads for the commissioning of the IIMHH. This framework was implemented in 2013 and re-tendered in 2016. The commissioning process for IIMHH follows the guidance (unpublished NHS England 2017).

2.9 The National Procurement Framework has eleven Investigation companies, ten of these were interviewed for this review. When the decision to commission an IIMHH is made, the Investigation company has to tender for each individual investigation, although the reviewers were advised that a 'call off' approach directly with the investigation company can be taken.

2.10 Each investigation company varies in size, capacity, experience and geographical base and these factors determine which IIMHH they will tender for. During this consultation, it was confirmed by some Investigation companies that being on the National Procurement framework provides a professional credibility, and that they did not intend to tender or perform an IIMHH in the future. These factors reduce the number of available Investigation companies available for the IIMHH, and this is illuminated in a report to the IIGC (March 2017) where it is noted that of seventy-two tenders distributed, fifty-one percent of these were performed by one organisation. This reflected the findings of the reviewers of the IIMHH reports examined during this review.

2.11 The investigation companies work with the Regional leads and the NHS Trust to deliver the IIMHH. When appropriate the investigation companies liaise with other stakeholders, such as police or probation.

2.12 The complexity of working with the families and carers of the victim and the perpetrator was highlighted in the review and Investigation companies demonstrated that they engage with the families and carers.

2.13 This consultation and the review of the IIMHH reports identified that investigation companies had an individual approach to the layout and the methodology used in the IIMHH. These variations result in inconsistency and reduce the access and readability of the reports. This was compounded by a lack of consistent views on the purpose of the IIMHH.

Themes and Learning Lessons

2.14 The reviewers did not find an explicit link between the outcomes of the IIMHH and national policy such as the Five Year Forward View (NHS England 2016) and National Mental Health Strategy (No Health Without Mental Health). It was evidenced that these strategies include developments which are in line with the outcomes and recommendations of IIMHH such as: care packages in first episode psychosis, focusing on employment and physical and mental health care and the reviewers suggest that these are implicit links.

2.15 The regional leads and IIRG have commissioned thematic reviews in individual NHS Trusts and/or NHS England regions (Verita 2015) (Niche Health and Social Care Consulting 2016) and Caring Solutions (NHS England 2016). Hendy (2017) produced a thematic review of Independent Mental Health homicide investigations (hundredfamilies.org). This identified key themes which are consistently highlighted:

- Care planning
- Risk Management
- Engagement with Families/Carers
- Communication and Information Sharing
- Implementation of the CPA
- Record keeping
- Multi-agency working (Hendy 2017)

Thematic reviews can provide insight into a NHS Trust's systems and processes and the reviewers were advised that they can provide assurance of appropriate governance systems for CCGs, regional leads, and the host organisation.

2.16 The procurement and the terms of reference of the IIMHH includes the requirement to examine whether the recommendations of the internal investigation have been implemented. Since the last framework was implemented in 2016 the Investigation company who performed the IIMHH return to the Trust six months after completion of the report to assess whether the recommendations of the IIMHH have been embedded. The consultation process highlighted that the organisational size of the NHS Trust can create a challenge for the Investigation companies to provide full assurance of the embedding the learning across the NHS Trust in the time they have allocated to achieve this, as part of the IIMHH process.

2.17 Niche Health and Social Care Consulting's (2017) report concludes that real assurance of implementation of internal investigation recommendations is lacking and supports the Sussex report findings (NHS England 2016) in that recommendations should be sustainable with a focus on outcomes. Niche Health and Social Care Consulting (2017) highlight their main concern as the standard and nature of risk assessments, and the lack of consideration of protective factors, especially when consistently there is evidence of a lack of family inclusion. They provide some helpful questions for individuals, teams and senior leaders in NHS Trusts for consideration.

2.18 The outcome of the themed reviews (NHS England 2016; Niche Health and Social Care Consulting 2017) concur with the themes of the recommendations in this review. During this consultation, it was suggested that recurring recommendations equated to little change, which the reviewers found to not be correct, although as identified this is not always explicit. One example of where this was evident was the independent inquiry into the care and treatment of Michael Stone (SCIE 2006) which impacted on service changes. The present system of governance within NHS England through the IIGC provides a structured framework which should be able to demonstrate these improvements explicitly.

2.19 The IIMHH reports are published on the NHS England website. These are published on one site by region rather than England-wide. The reviewers found that not all of the information was found to be present on publication, which can reduce access to the relevant information for learning lessons and service improvement.

Timeliness

2.20 Timeliness was identified as a key issue by all involved in the IIMHH. It relates to the time lapse between the event taking place and the publication of a report which can take a number of years. There is no evidence that the delay in the report provision impacts upon the implementation of actions in response to the event. However, the

delay in process does have an impact on all parts of the system and the following was raised during the review.

- NHS Trusts identified repetitive interviewing of staff and the impact of a second investigation long after the event creates stress for staff. There is a duplication of costs in internal and external investigations, which is not cost-effectiveness. Recommendations may be out of date, due to service changes and operational need.
- The investigation companies identified that access to staff was more difficult as they had often moved organisations. They highlighted that once the report is completed, the legal review and sign off for publication can take time and on occasions it may be necessary to return to the investigation report and debate amendments.
- Families questioned the relevance of the report to the present-day services, and delay in changes taking place. Often the services may have changed due to operational or commissioning requirements. Revisiting the event for families may cause further distress and delay the grieving process. The expectations of the family and carers may not be met by the outcomes of the IIMHH.
- Regional leads identified that there are delays in being advised of the event taking place and waiting for the Internal Investigation report via the CCG can delay the decision as to whether an IIMHH is required.
- Additional constraints include Her Majesty's Coroner; the police and meaningful family engagement.

Families

2.21 All those involved in the Investigation process highlighted the importance of engaging with families and that this became more complex due to the time between the event taking place and the commencement of the IIMHH. There may be the patient's family and the victim's family and in some cases the patient's family are also the victim.

2.22 It was reported during the consultation that families do not always see the information provided to Her Majesty's Coroner or courts and can be left with further questions and an open and transparent investigation is important to mitigate this.

2.23 The IIMHH may be a traumatic experience for families although it was described as cathartic by some. Independent advocacy support for families was identified as helpful in supporting families through the process and as a communication link if involved in the investigation.

2.24 The investigation organisations identified the working relationship with the families as requiring extensive time by the Investigation panel, and the differing expectations of families of victims and perpetrators was highlighted during this review. The purpose of the IIMHH should be identified and consistently communicated to families, so there is no misunderstanding of the purpose of the IIMHH.

2.25 On publication of the IIMHH report, the information relating to the perpetrator and staff remains anonymous. This was highlighted by the families as being difficult as there is often a public record through the court case, or in the media. Reasons for anonymity, may include the protection of families of the perpetrator, the victim's family and staff and should be made clear to the families and carers.

Predictable and preventable

2.26 All IIMHH reports are expected to identify whether the homicide was predictable and/or preventable. The reviewers established that each of the investigation organisations use different definitions for predictability and preventability and the application of this requirement was not consistent. Hendy (Hundred Families, March 2017) analysed the definitions for predictability and preventability used by three Investigation companies and concluded that the definitions were narrow.

2.27 The intention of the IIMHH is to learn lessons and prevent further incidents, so the application of predictability and preventability should be about identifying the lessons to be learned from any deficiencies in the care provided. The definition of predictable and preventable should be standardised for the IIMHH or alternatively the removal of this from the IIMHH process should be considered.

Multi-agency approaches

2.28 The IIGC has an action as part of it's work plan to develop working arrangements with other statutory agencies, such as police and probation. A Memorandum of Understanding with the police is in place in London region. Multi-agency alignment would assist in implementing cross-agency recommendations.

2.29 The process for Domestic Homicide Reviews (DHR) and Safeguarding Children and Safeguarding Adult Reviews (SCR) are multi-agency reviews. Although these have different statutory arrangements to the IIMHH, the principles could be considered as an alternative approach for IIMHH. This would be a single collaborative approach at the interface with other investigations (NHS England 2015)

2.30 On reviewing the reports the reviewers found evidence of the commissioning of an IIMHH alongside a Domestic Homicide Review and Safeguarding Children Review.

Each of the statutory agencies involved in the delivery of a service to the perpetrator, victim and/or child contribute their information. The review panel has an independent chair, who is not directly associated with the agencies involved. The approach is collaborative and provides learning across the services involved.

Conclusions

2.31 Since the introduction of the IIMHH process (HSG (94) 27) there have been various iterations and changes to this approach. The IIGC has been developing since 2015, it has systems and structures are in place to oversee the process of the IIMHH. An examination of the information as part of this review demonstrates that the IIGC has good governance arrangements in place, is monitoring actions and can influence national policy. The committee membership includes NHSI and NHS England regional representation, lay and family representation and representation from Learning from Deaths and the HSIB.

2.32 The regional leads through the regional IIRG deliver the process and commissioning overview of IIMHH. Each Region reports into the IIGC and the Chair of the IIRG's provide a written report. An examination of the information provided shows that the regional leads are developing coherent systems to provide consistency in practice and delivery across the regions whilst retaining an individual local approach. The information provided to the IIGC would benefit from being collated as an England-wide process rather than regionally as this would enhance information sharing at the strategic level.

2.33 The National Procurement Framework requirement for individual tenders to be submitted for each IIMHH has limitations due to the time and costs of submitting the individual tenders. The reviewers were advised that direct awards were possible under the framework and it may be beneficial to consider a 'call-off' approach where each investigation company takes it's turn. Each of the investigation companies on the National Procurement Framework vary in size and capacity, and during this consultation more than one investigation company indicated that they have no intention to tender, and use the framework for professional credibility. This has resulted in a reduction in the number of Investigation companies actively tendering for IIMHHs.

2.34 The publication of the IIMHH reports on the NHS England website requires improvement to enable access to the relevant information. Publication standards and a single repository should be developed.

2.35 This review highlighted a number of delays which exist in the process of commissioning and delivering an IIMHH, from the homicide taking place to the publication on the NHS

England website. Improvements to this process would be beneficial and could consider: the provision of an Independent Chair of the NHS Trust investigation or a Multi-Agency review (similar to DHR/SCR) commencing when the event takes place and with an Independent Chair.

2.36 The reviewers recognised the importance and value of the regional leads meeting with the families to introduce the independent investigators, explain the process, provide clarity about the expectations and assist families to identify questions that they would like the investigation to answer. It would be beneficial for all Investigation panels to have family support/advocate present on behalf of the families. The reviewers were advised that the engagement with family representative organisations have improved the standards of support for families in the regions.

2.37 The reviewers concluded that if it is a requirement to consider predictability and preventability then this should be against a nationally standardised definition that everyone uses. Alternatively, the removal of the requirement for predictability and preventability from the core terms of reference for IIMHH should be considered.

2.38 To improve multi-agency involvement such as: police, probation, prison and local authorities to enable policy and recommendation implementation at the IIGC level, a formal strategic approach to working alongside statutory agencies could be implemented.

3. Best Practice

Independent Investigations of Mental Health Homicides

3.1 After the introduction of the IIMHH HSG (94) 27 in 1994, there followed a number of publications which questioned this approach including the costs of the investigations, the development of defensive clinical practice and the generating of a blame culture (Szmukler 2000, Eastman 1996). 'Inquiries after Homicide' (Peay 1996) provided the commentary on current practice at that time and stated:

'*they are bound to fail: recent inquiries have, at times, lacked sufficient clarity in their purpose and scope; they cost too much; services under the spotlight are put under huge and perhaps unreasonable strain; the number and length of inquiry reports is overwhelming; and the important lessons which need to be learnt are being obscured by peripheral issues and are not communicated to those who would benefit from them'.*

3.2 McGrath and Oyebode (2005) commented that Independent inquiries into homicides in their present form have a limited future, although their use as data for sociological and historical studies will be useful retrospectively.

3.3 Goldberg (2005) raised the question whether the complexity of everyday life and delivery of mental health services can be captured in a single coherent narrative as provided in an Independent Investigation report.

3.4 Eastman (1996) suggests that treating homicides in the mentally ill uniquely with mandatory investigations whilst other events such as suicide are not treated in the same way is not acceptable and he advocates the use of mandatory audit processes to achieve a consistent understanding of psychiatric violence across England.

Purpose of Independent Investigations in Mental Health Homicides

3.5 The Operating Policy for commissioning and managing independent investigations for the NHS in England (2017) states:

'Independent Investigations are intended to examine the care and treatment of service users, establish whether or not a homicide/incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the chances of reoccurrence of a similar incident'

3.6 Blom-Cooper (1996) recommends that the purpose of the IIMHH is to establish the truth of what happened, how it happened and establish responsibility for what has taken place. Eldergill's (1999) view is that it is to inform the relatives of the victim and the killer; to give reassurance of the accountability of public services; highlight the need for improvement; and identify negligence. In 2001, he elaborated by advising:

'the function of an independent inquiry is thoroughly and objectively to review the patient's care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies'.

3.7 Crichton (2011) suggests that all individuals involved in an IIMHH will have different expectations, and recommends that the National Confidential Inquiry in Suicide and Homicide (NCISH) is superior in case identification. He further states that it is unlikely to satisfy relatives wanting the details of how the death has taken place.

3.8 The importance of the inquiry for the families of the victim and perpetrator were not always recognised until families exercised their rights to be engaged in the process in *Edwards and Another v United Kingdom* 46477 [2002] ECHR 303, as prior to this date it was not automatically guaranteed.

Learning Lessons

3.9 Petch and Bradley (1997) reviewed 'Learning the Lessons' (Sheppard 1996) and concluded that many inquiries and reports into homicides by psychiatric patients imply that these could be prevented by mental health services. The assumption is made that if the highest standard of care is provided then homicides would be reduced, and services can reduce the likelihood of homicides through embedding and learning lessons, although there is little evidence or certainty to demonstrate this. Szmukler (2000) confirmed this view when he stated that:

'*an assumption reigns among the media and politicians at least, that all such homicides are preventable, despite the fact that every country has, and has always had them'.*

He questions how individuals, teams and mental health organisations can be responsible for the behaviour of others, and that the patient has a mind of their own.

3.10 Eastman (1996) questioned whether Independent Inquiries are the mechanism for achieving the embedding and learning of lessons. It is suggested by Petch and Bradley (1997) that there is there is little evidence that recommendations if implemented reduce the risk of further homicides by patients.

3.11 Sheppard (1996) questioned whether recommendations were implemented and whether lessons learned. Reasons for this have been mooted as the lack of central repository (Reith 1998), the quality and style and delays between the incident, completion of the report and publication of the report (Prins 1998) resulting in irrelevant recommendations as they may be out of date (Crichton and Sheppard 1996).

International perspective

3.12 The reviewers found limited published information on the process of IIMHH in other countries. In addition, to examining the literature, the reviewers contacted the International Institute for Mental Health Leadership, who consulted with their eight-member countries. Information was provided from USA, Australia and New Zealand.

3.13 The Health Quality and Safety Commission in New Zealand has a National Adverse Events Policy which sets out the requirements for reporting and includes links to different approaches to support investigations (Simpson et al 2004). These include Root Cause Analysis (RCA), Yorkshire Contributory Factors Framework and Systems Analysis of Clinical Incidents: The London Protocol. (HQSC 2018, Lawton 2012; NPSF 2015)

3.14 In August 2017, NHS Scotland consulted on a 'Review of homicides by people with recent contact with NHS Scotland mental health and learning disabilities services'. Examination of the published responses highlighted issues of the involvement of families and information available due to confidentiality requirements, and a debate of using independent investigations similar to the English model (Consult.gov.scot, 2018).

Reviews and Recommendations

3.15 The Sussex Partnership NHS Foundation Trust Review (NHS England 2016) identified themes in the eleven investigations reports examined. These included delays between referrals and assessment; poor risk assessment and risk management; Mental Health Act (MHA) powers not comprehended; and non-adherence to policy. The Sussex Partnership NHS Foundation Trust Review recommended that future recommendations and action plans from investigations should focus on outcomes (changing practice) and impact (on stakeholders – service users, staff and carers) rather than the process (developing policy and training).

3.16 Niche Health and Social Care Consulting provided a thematic learning review of investigations (Niche 2017) when they examined twenty-three Independent Investigations their organisation had undertaken between June 2010 and December 2016. The report focuses on terms of reference, recommendations, contributory factors, notable practice and predictability and preventability. They observed that a noticeable change in the process towards outcome focused, measurable and sustainable recommendations as a key requirement. The report concludes that real assurance of implementation of internal investigation recommendations is lacking and supports the Sussex report findings (NHS England 2016) in that recommendations

should be sustainable with a focus on outcomes.

3.17 In 2008 the National Confidential Inquiry into Suicide and Homicide by people with mental illness published a report that examined homicides and independent inquiries between 2002 and 2005. They noted that 15 of the 50 homicides with enhanced CPA in this period were not subject to an Independent Investigation. They considered the recommendations from the Independent Investigations and themed them into fifteen recommendations which include: CPA policy; risk assessment; dual diagnosis services; domestic violence; families and carers involvement; and information sharing.

3.18 Mellsop (2016) considered five homicides that took place over a 15-month period in New Zealand. The recommendations identified were: communications, clinical records, accommodation, team working and staff training on use of compulsory detention.

3.19 Niche Health and Social Care Consulting (2017) examined predictability and preventability and suggest:

'legalistically we are asked to consider the predictability based on 'that person on that day' and preventability on 'would that action have prevented the homicide?' it is perhaps not surprising then that homicides are rarely found predictable or preventable if we stick to such a tight definition' and comment that:

'What is clear is that strict legal definitions of predictability and preventability is not satisfying families, and that sticking to a legalistic framework can be unhelpful'.

Investigations and review methodology/Safe healthcare

3.20 Challenges to the provision of safe healthcare was examined by Hignett et al (2016) who identified with 330 NHS staff that there were 760 challenges to delivering effective, high quality and safe care. A number of the issues identified were not new and had been present for over twenty-five years and included staff shortages, finance and patient complexity. Other challenges that were raised included organisational culture, *'stifling bureaucracy*', '*firefighting daily'* and '*perpetual crisis mode'*. Although good practice in healthcare safety has been identified (Xie and Carayon 2015), according to Hignett et al 2016) (Wears 2015) there is little progress in embedding safer practice, technology and changing culture.

3.21 The NPSA was established in 2001 to monitor patient safety incidents, including medication and prescribing error reporting in the NHS. From April 2005, it was responsible for safety aspects of hospital design and cleanliness as well as food. It was responsible for the: National Confidential Enquiry into Patient Outcome and Death;

Confidential Enquiry into Maternal Deaths in the UK and National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

3.22 The NPSA highlighted the need to learn lessons from incidents and advocated the use of Root Cause Analysis (RCA), a process imported from aviation and initially applied to healthcare in the USA (Baglan et al 2002). Training in RCA investigation was provided across the NHS, along with investigation resources which are available on the NPSA National Reporting and Learning service nrls.npsa.nhs.uk. Guidance for investigations and templates for reports were provided (NPSA 2008)

3.23 Root Cause Analysis (RCA) is a method of structured risk identification and management following an adverse event, and rather than a single technique it provides a range of approaches and tools drawn from areas such as safety science and human factors. Peerally et al (2016) suggest that RCA in healthcare has not been adequately customised for use in healthcare and not achieved it's potential. They criticise the quality of the RCA investigations as they are conducted by local teams and lack of expert investigators, which result in poor practice in the analysis of the incident.

3.24 Peerally et al (2016) advocate the use of professional incident investigators with specialist expertise in underlying theories such as ergonomics, human factors and experience of analytic methods. They recommend the use of aggregated analyses at different organisational and national levels to generate collaborative redesign of services.

3.25 Prospective Hazard Analysis (PHA) approaches were identified by Ward et al (2010) as a new way to consider risk assessment and safety. They describe this approach as involving a range of tools and systematic and structured methods.
'It is both proactive and predictive and demands a different mind-set and organisational culture relating to risk'

3.26 A project commissioned by the Department of Health (Ward et al 2010), tested a toolkit in a number of case studies and provided a risk assessment framework and guidance. They found that PHA knowledge within healthcare was limited and this was potentially a barrier to it's implementation in healthcare. The potential of using PHA to reduce retrospective and reactive risk management is in its systematic, comprehensive and thorough approach to risk prioritisation and decision making in risk mitigation. Ward et al (2010) suggest it has the potential to change organisational culture in risk management resulting in improvements in patient safety.

3.27 Potts et al (2014) compared two Prospective Hazard Techniques – Healthcare Failure Modes and Effects Analysis (HFMEA) and Structured What If Technique (SWIFT) in

clinical practice. They questioned the reliability of these techniques despite their application in healthcare having benefits. They used a clinical setting to test the techniques and the different techniques identified that using two different methods less than half of the hazards were identified by the other method. They concluded that although there was limited overlap both methods raised important hazards and that it provided an opportunity for the team to examine the risk perspective within their setting, although these methods cannot be relied upon in isolation and recommends multiple sources to provide a comprehensive view.

3.28 An alternative model of investigation is complex adaptive system. Kuziemsky (2016) suggests that complexity of providing care across multiple providers and settings results in a different approach to how healthcare is structured and managed. These changes can end in unforeseen outcomes such as patient safety events. Kuziemsky (2016) advocates that this is because the focus is on the service transformation rather the wider system of healthcare *delivery.*

'Many healthcare problems are an effect of the interactive and multi-dimensional nature of the system and rarely can be reduced to one root cause or a single factor'

3.29 In a literature review to develop theoretical models of quality improvement Ellis and Herbert (2011) identified that complex adaptive system tools are valuable to make sense of natural phenomena and it usefully describes evolving processes and *'provided insight into how the origins of quality assurance were predicated on the rational reductionism and linearity'.*

3.30 Benham-Hutchins and Clancy (2010) suggest that using tools to analyse social network will enable understanding of complex communication patterns and reduce errors. They recognise that embedded complex adaptive systems are hierarchical and that it is these nonlinear processes that characterise the provision of patient care from multiple professions.

3.31 According to Human Factors in Healthcare (A Concordat from the National Quality Board 2013)

'the NHS has already started to harness Human Factors approaches through the successful adoption of patient safety and quality improvement science, and in the ergonomic design of medical devices and workplaces.'

This concordat commits to ensuring that there is a wider understanding of Human Factors across the NHS to ensure that the NHS

'does the right thing first time every-time'.

3.32 This commitment brought together different national organisations with a responsibility for quality in the NHS, with patient representatives to support the embedding of Human Factors principles and practices at all levels of the healthcare system (NHS England 2013). Rosenorn-Lanng (2014) introduces a user-friendly approach to human factors in healthcare by building a framework, the 'SHEEP' model. The SHEEP model guides the individual to look at systems, human *'safety positive behaviour'*.

3.33 A clinical human factors group commenced by the Health Foundation in 2007, provided tools, guidance and support to the NHS. They define Clinical Human Factors as *'Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings'*

Catchpole (2017)

3.34 On 1st April 2017, the Health Safety Investigation Bureau was created, made up of a team of experienced safety investigators. The team has a range of expertise with a background in the NHS, aviation and military, human factors specialists and investigator expertise. One of the principles of the HSIB is to *'use findings of the investigations to deliver practical solutions, address causes and contributory factors and provide support to increase the capability within local NHS systems'*.

The setting up of this service signals a new direction in the investigation and learning from serious incidents in the NHS, plus provides the opportunity for support, training and modelling for an alternative approach to Independent Investigations.

Conclusions

3.35 The present process for IIMHH commenced in 1994, and there have been questions raised about this approach since 1996. There are few academic studies which have evaluated the costs; process and impact of the IIMHH. The consultation process of this review suggested that the present IIMHH system did not deliver a timely process; duplicated the internal investigation process; impacted on all those involved and it was not evidenced that it reduced the recurrence of events of this type.

3.36 Alternative approaches to investigations such as the Learning from Deaths (NHS England 2017) structured investigation processes and the introduction of the HSIB could inform future developments with regards to IIMHH processes.

3.37 The principles of multi-agency reviews such as DHR and SCR could be used to provide an alternative approach for IIMHH as a multi-agency and collaborative approach to investigation. In these cases, an external independent chair could oversee the process,

and this could reduce the length of time the IIMHH takes, provide objectivity and have a wider impact due to it's inclusive nature.

3.38 The international information examined on independent investigations in mental health related homicides did not identify or establish any alternative or different approaches to those being used in England.

3.39 The reviewers asked throughout this consultation process 'What is the purpose of the IIMHH? Many different responses were received. The variety of views can impact on the different expectations and outcomes for all involved in the IIMHH.

3.40 There are a number of different investigation methodologies that can be used for an IIMHH. In the NHS, the approach standardised by the NPSA from 2001 was the need to learn lessons from incidents and the use of RCA Investigation as a methodology to deliver this was advocated. RCA methodology continues to be the dominant investigation approach in the NHS and is recognised as the standard system for conducting investigations (NHS England 2015) The use of Human Factors in investigations is becoming more evident (HSIB 2017, NHS England 2013 and Health Foundation 2007). It would be helpful to have an agreed methodology for the production of the IIMHH, as this would enable quality monitoring processes and ease of access to the reader of the salient points and important information in the reports.

3.41 During this consultation, the reviewers found little evidence that the use of predictability and preventability in it's present form contributes to the IIMHH process. The definitions used are variable, and according to Hendy (2017) are narrow. As the intention is to learn lessons and avoid further incidents the application of predictability and preventability should be defined to provide a framework in which lessons can be learned and deficiencies in care identified. Alternatively, the removal of the requirement for predictability and preventability from the core terms of reference for IIMHH should be considered in any future review of the Serious Incident Framework

4. IIMHH reports – Quality of Reports

4.1 Thirty-five published (35) and twenty-two unpublished (22) IIMHH reports were scrutinised. Each report was examined using criteria identified by the NPSA (2008) for investigations using root cause analysis (RCA) and the Serious Incident Framework (NHS England 2015). To ensure a consistent approach by the two reviewers, eight of the published reports were examined by both reviewers and compared.

4.2 Three categories for the examination of the reports were identified, these were the assessment of the quality of the report; the theming of the recommendations using criteria identified by Niche Health and Social Care Consulting (2017) and an outline of the perpetrator of each homicide.

Assessment of reports

4.3 The minimum standards for the quality of Independent Investigation Reports is identified in the Serious Incident Framework (NHS England 2015) and the NPSA (2008) guide to Investigation Report Writing. Fundamentally the purpose of the IIMHH report is to provide:

'a formal record of the investigation process and a means of sharing the learning'. It should be clear and logical and demonstrate that an open and fair approach has been taken'.

NPSA (2008)

4.4 According to the NPSA (2008) a good quality investigation allows organisations to identify:

'*the problems (the what) including lapses in care/acts/omissions that may have contributed towards the incident; and*

the contributory factors that led to the problems (the how?) taking into account the environment and human factors; and

the fundamental issues/root cause (the why?) that need to be addressed; and enables the development of solutions which effectively address problems to reduce the likelihood of recurrence'

4.5 Each report was examined and the following areas were assessed: Clarity of writing: Report length: Clear layout: Executive Summary; Terms of reference: Contributory Factors: Recommendations relevant to the Findings: Use of RCA methodology: Investigator profile and biographies: Each report was rated as good, satisfactory or poor using criteria from Serious Incident Framework (NHS England 2015) and the NPSA (2008).

4.6 On examination of the reports for clarity and quality of writing, the reviewers considered whether there was evidence of typographical errors, subjectivity, a lack of thoroughness and whether the report was readable. Eighty percent were rated as good and satisfactory, and the remaining twenty percent were poor with comments of 'descriptive and convoluted'.

4.7 The length of the reports varied between 17 and 200 pages. As there is no template or guidance on this aspect, it is difficult to establish whether the reports are of a reasonable length or not. A longer report may be required where an investigation is complex and involves other statutory agencies.

4.8 Templates for the layout of the reports are identified by the NPSA (2008). The reviewers found that there was no common template to the IIMHH's examined. Eighty-four percent of the reports were rated as good and satisfactory, and sixteen percent as poor.

4.9 Five percent of the executive summaries were not available and when checked with Investigation companies, it was confirmed that these had been provided, so it was concluded they had not been published on the NHS England website with the full report. Eighty-three percent were rated good and satisfactory, with the remaining twelve percent as poor.

4.10 In each of the IIMHH reports the reviewers examined the terms of reference, and found these were not available in all of the IIMHH published reports. In the terms of reference reviewed seventy-five were identified as core or common and repeated in a number of IIMHH, and the remainder were found to be specific to the homicide. In the fifty-seven reports there were found to be between five and twenty-three terms of reference and the median was eleven.

4.11 The NPSA (2008) provided the Contributory Factors Classification which represents the main areas which explore the influencing factors contributing to the identified issue of the problem. Each report was scrutinised to identify whether contributory factors were present; and if so were they clear, evident and related to findings. Sixty-six percent of the reports had contributory factors which were good or satisfactory. Eight percent of the reports had contributory factors which were poor, and the remaining reports did not have any contributory factors identified.

4.12 Eighty-six percent of the reports had recommendations which were related to the findings, although not all of the reports had contributory factors. A report should be able to demonstrate the linkage between the contributory factors, findings and recommendations.

4.13 Forty-four percent of the reports were found to identify the use of root cause analysis (RCA) methodology, although elements of RCA methodology such as chronology was found in seventy percent of the reports, half of these were rated as poor. Forty-three percent of those reports with a chronology also used the fishbone analysis to determine contributory factors.

4.14 Seventy-four percent of the reports examined had full biographies of the investigation team, including the peer reviewer if used. It is important for the credibility of the IIMHH for a detailed biography of each of the panel to be included.

4.15 On examination of the IIMHH reports, the reviewers found that the majority of the fifty-seven examined included reviews of the NHS Trust internal investigation. As this was an unexpected finding, it was not quantified. Appendix 3: Independent investigation (level 3) (NHS England 2015) does not allow for this approach although the Operating Policy for commissioning and managing independent investigations for the NHS in England (NHS England 2017) provides guidance on '*external verification and quality assurance review of the internal investigation with limited further investigation'.* In this review, this approach was found to be the most common in the IIMHH reports examined.

Conclusions

4.16 The examination of fifty-seven, published and unpublished IIMHH reports has demonstrated that the most of the reports are of a good or satisfactory standard against the standards used. A template for the IIMHH used by all Investigation companies would be beneficial and would improve access and readability of the IIMHH report. Publication standards would ensure that the full IIMHH report is published on the NHS England website and a single repository would enable access.

4.17 The review of the IIMHH reports demonstrated that few of the Investigation companies use RCA in full. Any investigation method should be used appropriately to provide the structure and framework for the investigation. An agreed methodological approach should be determined and used.

4.18 All IIMHH reports should include full biographies of the Investigation panel and include a lay person/advocate on behalf of the family and carers.

4.19 Changes in the independent investigation policy from Appendix 3: Independent investigation (level 3) (NHS England 2015) to Operating Policy for commissioning and managing independent investigations for the NHS in England (NHS England 2017 - unpublished) allow for the provision to use the NHS Trust internal investigation as the basis for the independent investigation. This review found that the majority of the

IIMHH reports reviewed had used this approach. The consultation process of this review highlighted the duplication of this process, the lack of additional learning and the impact on costs, length of time and all those involved. In this review, the NHS Trust internal investigations were not provided, although the IIMHH reports noted the recommendations from these investigations and they were examined by the reviewers. The benefits of the second investigation could not be established in all of the IIMHH reports reviewed. The reviewers suggest that a combination of the internal investigation with an external Independent Chair commissioned as soon after the event has taken place would potentially reduce costs; duplication and deliver a timely report, which could benefit all those involved.

5. IIMHH reports – Recommendations

5.1 Each of the fifty-seven IIMHH reports examined by the reviewers had recommendations. A number of the recommendations were found to be vague and unfocused; uncomprehensive and provided a commentary rather than a recommendation. The reviewers cross-checked these recommendations for parity and omitted them from the final analysis. Five hundred and one recommendations were reviewed for categorisation.

5.2 The NPSA (2008) defined Specific; Measurable, Achievable, Realistic, Timely (SMART) criteria and the 501 recommendations were scrutinised using this approach. The reviewers found that of the 501 recommendations, thirty-three percent were specific; twenty-one percent were achievable; five percent were timely and five percent were measurable and two percent realistic. The two percent of recommendations that were realistic were developed in tandem with the NHS Trust in response to the findings. This was highlighted to the reviewers in this consultation that the approach assisted in ensuring the recommendations could be implemented as the NHS Trust was involved.

5.3 The delivery of the recommendations was explored by examining the action plans available. These were reported in the body of the reports although not all were published with the IIMHH on the NHS England website. Due to this, it was not possible for the reviewers to confirm whether the actions and recommendations had been implemented and embedded. The IIMHH includes a six month follow up by the Investigation company to assess for the implementation of recommendations and the outcomes of this follow up was not available to the reviewers.

5.4 In eighty-two percent of the fifty-seven IIMHH reports reviewed the Investigation panel had assessed the learning from the NHS Trust internal investigation. Of these it was found that thirty-nine percent had fully implemented the recommendations and learning; twenty-one percent had implemented some of the recommendations; and for the remaining it was too early to assess or there was no evidence of learning. The investigation panel in all of the IIMHH reports made additional recommendations to the internal investigation, the reviewers could not establish the ‘added value’ of these recommendations as the NHS Trust internal investigation reports were not available.

5.5 Action plans developed by the NHS trust in response to the recommendations are monitored through the CCGs. To provide assurance to the IIGC a systematic link to the CCG through the IIRG could be enhanced and quarterly updates on recommendation

implementation progress provided, and the reviewers were advised this is taking place in some regions.

Recommendation themes

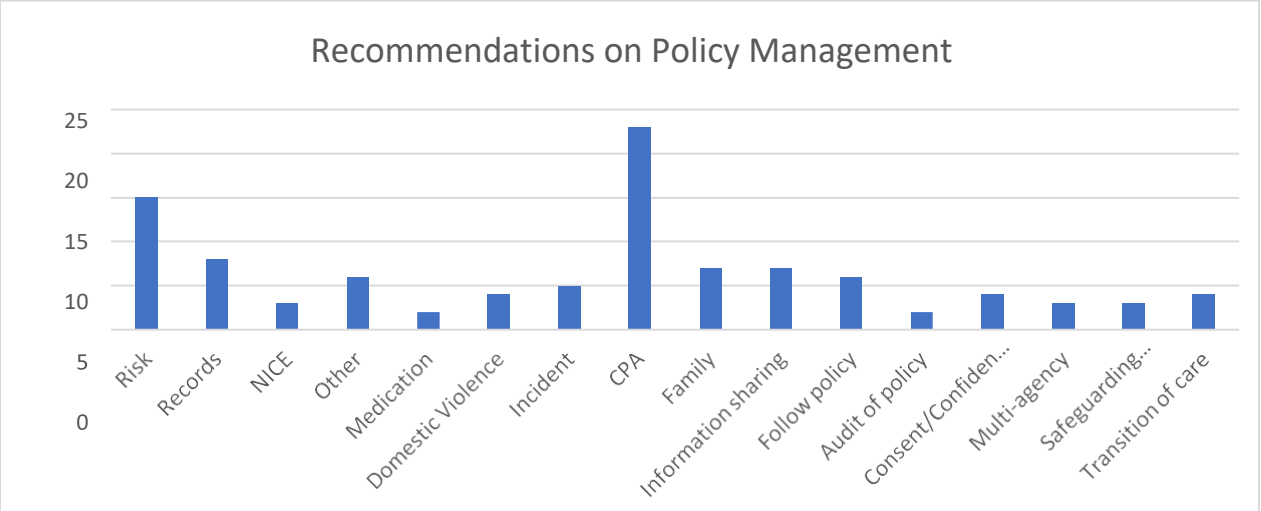
5.6 The recommendations are categorised using a framework first described by Niche Health and Social Care Consulting (2015) and used by Caring Solutions (UK) Ltd in the thematic review of service users who committed a homicide and to a victim of homicide at Sussex Partnership NHS Foundation Trust (NHS England 2016).

5.7 The categories identified by Niche Health and Social Care Consulting (2015) are: Communication; Policy Management; Practice/Risk; Training; Organisational learning; Contact with families; Pathway development and Miscellaneous. The 501 recommendations were themed into the individual categories and then collated in specific areas of each category.

5.8 Recommendations on communication accounted for twelve percent of the 501 recommendations. These were subdivided into: communication, multi-agency communication and information sharing. Communication recommendations accounted for 51 percent of the total and related to communication with families: GPs and between teams. Thirty-one percent of the recommendations were themed as multi-agency communication and these focused on improving communication between agencies to develop a consistent approach to care; developing multi agency guidance and working with schools, prison and probation. The remaining eighteen percent of communication recommendations related to information sharing and the development

of information sharing protocols, and appropriate information provided to clinicians and families.

5.9 Recommendations on policy management accounted for twenty percent of the total recommendations. These recommendations are spread across a number of different areas, with the highest relating to CPA policy, and second highest relating to risk.



5.10 The recommendations relating to practice/risk account for twenty-one percent of the 501 recommendations. Fifty-eight percent of these recommendations relate to risk and of these seventy-six percent focus on the risk assessment completion, quality, implementation, information, consistency, update and formulation. The remaining recommendations focus on practice and include documentation, care planning and interventions.

5.11 Recommendations for training account for eight percent of the 501 recommendations analysed. These covered: medication; CPA; Safeguarding; Diagnosis/personality disorder; Forensic/MAPPA; Risk; Confidentiality; Carers/Families; Culture; New policies/Policy adherence. Domestic violence training accounted for the highest number of recommendations in this category.

5.12 Twelve percent of the 501 recommendations were categorised as Organisational learning, and were sub-divided into seven areas. Serious incident management and implementation accounted for thirty-five percent and focus on learning and embedding of learning from investigations and adhering to the Serious incident process. The remaining recommendations focus on quality and performance, including audit; guidance and information to staff; new service provision, multi-agency working, families and governance.

5.13 Contact with families accounted for nine percent of the 501 recommendations. Other categories include recommendations related to families, and the reviewers categorised them in the most appropriate theme due to the essence of the recommendation, for example communication with families is within communication. The recommendations in this category focus on three specific areas: strategy and guidance; contact, engagement and support; and involvement of the family during the NHS Trust internal investigation process.

5.14 Eight percent of the 501 recommendations relate to pathway development. The highest number focus on adult service pathways, followed by transfer of care and prison pathways. The remainder range from Early Intervention services; Perinatal services; Women and non-specific NICE guidance pathways.

5.15 The miscellaneous recommendations are those that did not fit into any of the other categories, and account for nine percent of the 501 recommendations. They were subdivided into CCG, System improvement, Safeguarding, Environment, Independent Investigations/Serious Incidents; and Culture.

Conclusions

5.16 The recommendations are developed by the Investigation panels and discussed with NHS trusts. This retains the independence of the panel though does not ensure that the NHS trust engage in the recommendation development process. Some investigation companies develop the recommendations with the NHS Trust, ensuring that the recommendations are achievable and realistic and is good practice. This approach may be effective in enhancing the embedding of recommendations in NHS Trusts.

5.17 Not all of the IIMHH report information is published on the NHS England website. Each publication is by region rather than England-wide. One repository with clear standards of publication would be beneficial and deliver an open and transparent process which would enable access and ultimately uphold public confidence.

5.18 The 501 recommendations were categorised using a framework first described by Niche Health and Social Care Consulting (2015) and used by Caring Solutions (UK) Ltd (NHS England 2016). The examination of these recommendations concurred with those consistently found since HSG (27) 94 was introduced. These themes are in line with findings in other thematic reviews of recommendations (Hendy 2017); Niche Consulting (2017) and NHS England (2016) and the National Confidential Inquiry into Suicide and Homicide by people with mental illness (2008).

5.19 The recommendations in the IIMHH reports were examined against the SMART (NPSA 2008) criteria and it was found that few met this standard. The recommendations focused on the local context including the NHS provider trust; the CCG, the health community and related agencies such as the police or probation. No recommendations were assessed to be nationally strategic or related to national policy change. On scrutinising the terms of reference, the reviewers found that local, regional and national recommendations were not required or identified. This demarcation of the recommendations would assist with the implementation and embedding at the regional and national level.

5.20 This review has highlighted the constancy of similar recommendations from IIMHH reports over a number of years. It has been suggested by Niche Health and Social Care Consulting (2017) and Caring Solutions (NHS England 2016) that the recommendations of an IIMHH should focus on outcomes rather than process and on changes of behaviour through different approaches. This should be considered in further reviews of the serious incident processes.

6. IIMHH reports - Outline of Perpetrator

6.1 The characteristics of the perpetrator of homicide was analysed in each of the fifty-seven published (35) and unpublished (22) IIMHH reports used in this review. The individualised layouts of the IIMHH provided challenges to obtaining the information required.

6.2 The commissioning and distribution of the reports reflected each of the regions of NHS England, and there were twenty-nine percent of the reports from the North and twenty-nine percent from the South; twenty-three percent from London and twenty percent from Midlands and East. It was not possible to determine whether incidents took place in an urban or rural environment due to a lack of detail in the reports.

6.3 On examining the reports, it was found that in eighty percent of the homicides the perpetrator was male. The age of the perpetrator was not recorded in six of the reports, and in the remaining 51 reports, the perpetrator age range is 70 years, with a mean of 37 years and median 36 years.

6.4 Ethnicity was not recorded in sixty-six percent of the reports and of the remainder all but one of the perpetrators was identified as coming from BME backgrounds.

6.5 In ninety-three percent of the homicides, the perpetrator was informal under the Mental Health Act. The remaining individuals were recorded as Section 3, Community Treatment Orders or Section 37/41.

6.6 In eighty-three percent of the reports reviewed the perpetrator had known the victim, and of these, thirty-three percent were a friend or acquaintance; thirty-three percent their partner; twenty-two percent were a parent and in twelve percent were a child. Of the remaining seventeen percent, 9% were present in the same care environment or prison.

6.7 The IIMHH reports identified a variety of methods used by the perpetrator including the use of more than one method. These methods included the use of fire; suffocation, drowning and jumping in front of a train. In fifty-eight percent of cases the use of a knife and /or stabbing was the cause and in twenty-two percent assault was used.

6.8 Each perpetrator in the IIMHH reports had at least one diagnosis, and seventy-six percent had more than one. Eleven percent of the perpetrators had more than four diagnoses. Substance misuse, paranoid schizophrenia, personality disorder and anxiety and depression were diagnosed in sixty-four percent of the perpetrators.

6.9 In the review of the IIMHH reports it was found that seventy-five percent of the perpetrators used illegal and/or legal substances, although only twenty-one percent had a formal diagnosis of substance misuse.

6.10 The reviewers checked whether the perpetrators had a forensic history and found that this was unknown in seven percent of the reports; fifty-seven percent were identified as having a forensic history and twenty percent had no history. A history of violence and aggression without a formal forensic history was recorded in sixteen percent of the perpetrators and some of these had been seen by police but not charged.

6.11 The reviewers found that the IIMHH report recorded that the perpetrators had a risk assessment present in seventy-nine percent of the reports. Of the remainder, thirteen percent did not have a risk assessment and in nine percent it was unknown. In the seventy-nine percent who had a risk assessment; twenty-seven percent of these were not updated with new information and in twenty-nine percent the assessment was not evaluated as comprehensive by the investigation panel.

6.12 At the time of the homicide taking place, ninety-five percent of the perpetrators were in the community and the remainder in a care or prison environment. Two of the perpetrators were homeless.

6.13 The reviewers found that the IIMHH reports highlighted that ninety-six percent of the perpetrators were engaged with multiple agencies at the time of the homicide. The number of agencies ranged from zero to seven agencies involved and forty percent of the perpetrators were in contact with more than three agencies. The different agencies identified include: contact with probation; police; courts; GP, voluntary and third sector agencies; housing and hostels; family and social services. GPs were involved in twenty-six percent of cases, police contact in nineteen percent and probation in twelve percent.

Conclusions

6.14 The reviewers found that not all of the IIMHH reports identified the full characteristics of the perpetrator, and specifically regarding ethnicity. The emerging perpetrator outline demonstrates that the majority were male (80%), in the community (95%), had a median age of 36 years, known to their victims (83%), not held under the MHA (93%), had used legal or illegal substances (85%) and had a forensic history (58%) or a history of violence (16%) and may have more than one diagnosis including: substance misuse; paranoid schizophrenia, anxiety and depression and personality disorder (64%). The reviewers found that this analysis of the perpetrator profile was consistent with previous

studies, nationally and internationally. It could not be established in this review whether the perpetrator outline had informed the commissioning of mental health services.

6.15 A comparative study from the Treatment Advocacy Centre in 2016 (USA) suggests that individuals with schizophrenia and bipolar disorders are responsible for approximately 10% of all homicides in the USA. (Treatment Advocacy Centre, 2016). Comparison studies with other countries noted that:

- Sweden – 11% of homicides had schizophrenia or bipolar disorder. Substance misuse and medication compliance were significant risk factors.
- Singapore – 9% of homicides had psychotic disorders.
- Germany – 10% of homicides had schizophrenia.
- Finland – didn't report the % of homicides related to mental health, but did report that schizophrenia with coexisting alcoholism increased the risk of homicide ratio by 17 times.
- Denmark – 15% of homicides were diagnosed with psychosis related to schizophrenia or affective disorder.
- Iceland – 15% of homicides had schizophrenia. (Treatment Advocacy Centre, 2016).

In New Zealand, Frances (2006; 2007) identified that sixty-eight percent of perpetrators were male, with a mean age of thirty-four years, fifty-nine percent had a schizophrenia or another psychotic diagnosis. This confirms offender characteristics found in Australia where seventy percent were male, with a mean age of 35 years, eighty-five percent had a psychosis and a sharp instrument was the method used in forty-three percent of cases (Mouzos 1999). In this review, it is observed that the perpetrator profile is consistent with these and other studies such as McGrath and Oyebode (2005) and Petch and Bradley (1997) and mental health services should consider how the patients with these profiles have support and engagement in the community.

6.16 The reviewers found that a substantial number of the perpetrators had used substances prior to the homicide taking place. Not all of these perpetrators had a diagnosis of substance misuse and it could not be established whether the use of substances had been part of the risk assessment.

6.17 The number of agencies who were in contact with the perpetrator would suggest that a multi-agency review process would be beneficial to provide outcomes and policy improvements.

7 Overall Conclusions

7.1 The reviewers have undertaken an assessment of the current governance systems and processes which are in place for the management and the monitoring of IIMHH process and outcomes in NHS England. This assessment has been based on the information provided and the consultation process, and it is concluded that assurance can be provided that governance systems and processes are in place. The IIGC provides the strategic overview and each NHS England region has structures to deliver IIMHH process in their respective areas through an Independent Investigation Regional Group (IIRG) and Regional Investigation Teams (RIT). Each region has a regional lead who report into and deliver a work plan approved by the IIGC. These regional leads are pivotal to the process and delivery of the IIMHH.

7.2 The IIGC should continue to function as the strategic governance group for IIMHH and have the overview for England, whilst further developing alignments with other committees and organisations such as, mental health; quality and patient safety. An examination of the information as part of this review demonstrates that the IIGC has good governance arrangements in place, is monitoring actions and influencing national policy. The committee membership includes NHSI and NHS England regional representation, lay and family representation and representation from Learning from Deaths and the HSIB.

7.3 To enhance the IIGC, the reviewers believe it would be beneficial to identify the co-dependencies with agencies engaged and in contact with mental health service users and services. This reflects at the strategic level the involvement of different agencies in ninety-six percent of the IIMHH reports reviewed.

7.4 The reviewers examined the commissioning arrangements for IIMHH and can advise that these are in line with Operating Policy for commissioning and managing Independent Investigations for the NHS in England (NHS England 2017; unpublished) and the Serious Incident policy (NHS England 2015).

7.5 This review has highlighted the length of time (a number of years) an IIMHH takes between the homicide taking place and the publication of the report. The consultation process recognised that this length of time had an impact on all of those involved. Improvements to this process would be beneficial and alternative approaches used in Domestic Homicide Reviews and Safeguarding Reviews could be considered, when there is multi-agency involvement. The introduction of an Independent Chair for the

NHS Trust Internal Investigation could reduce the time taken and be more cost-effective.

7.6 The reviewers found that the IIMHH reports published were accessible through the NHS England website on a regional basis. Some of the reports were not published in full, and few had published action plans. To improve access to the relevant information the use of a single repository and a standardised approach to the information published should be in place.

7.7 This consultation highlighted the complexity of supporting families and carers through the IIMHH process and the need for clarity about expectations. In order to support families, the reviewers believe that the introduction of a family support person/advocate for independent support be present on the Investigation panels as this would assist with the process.

7.8 The review of the fifty-seven published (35) and unpublished (22) reports demonstrated to the reviewers that the IIMHH reports were variable in quality and did not in all cases meet the standards that may be expected. The diverse approaches of the investigation organisations to methodology and layout, contributed to the different levels of quality and report production. The reviewers conclude that a standardised template and agreed methodology for IIMHH should be in place to ease access and enhance readability. The provision of a synopsis by the investigation companies of all IIMHH reports would also contribute to the accessibility of these reports.

7.9 The reviewers found that the IIMHH reports considered the NHS Trust internal investigation and assessed whether recommendations had been implemented and the learning embedded from this process. The value of performing two investigations was considered and it can provide assurance, insight and outcomes. The reviewers did not have access to the internal investigations to confirm this. It is known, that the provision of two investigations extends the time taken, and this was raised as an issue by all those consulted in this review. The reviewers were unable to establish the additional value of two investigations in all cases, and would observe that additional recommendations to the internal investigation were provided in all IIMHH reports.

7.10 This consultation did not enable the reviewers to establish whether the recommendations of the IIMHH reports had been implemented, and if changes to policy and embedding of learning had taken place at the NHS Trust (local level), this was due to the omission of information, for example: action plans. To achieve this an in-depth review of individual NHS Trusts would need to take place, though the reviewers believe

that this could be achieved through CCG monitoring and the CQC through their regulatory visits to NHS organisations.

7.11 The IIMHH reports examined as part of this review provided recommendations which focused on the NHS Trust and local health economy. The reviewers did not identify any recommendations which had a regional or national focus. Caring Solutions (NHS 2016) recommended that IIMHH should *'aim to produce not more than three high-impact key recommendations'*. This review would support that this would be helpful in establishing the priority areas of focus and would suggest that identifying recommendations as local, regional and national would further enhance the focus of the investigation panels.

7.12 This consultation determined that there is an implicit effect on developments in national policy through the outcomes of the IIMHH, and evidence to demonstrate the consideration of recommendations at the IIGC and IIRG levels. The relationship between the recommendations of the IIMHH reports and the changes in policy are not explicit and would be strengthened with the connection being demonstrated. The reviewers could not establish whether the recommendations identified in the published IIMHH reports guide the commissioning of future independent investigations, and lead to sustainable changes in practice.

7.13 The reviewers were unable to establish that the outcomes of the IIMHH reports inform the commissioning landscape of NHS England including Specialist Commissioning and Health and Justice. The reviewers suggest the themes emerging in this review such as the perpetrator profile, the recommendations and the outcomes of IIMHH reports are disseminated to inform the commissioning of mental health services, and service improvements.

7.14 The reviewers concluded that if it remains a requirement to consider predictability and preventability then this should be against a nationally standardised definition that everyone uses. Alternatively, the removal of the requirement for predictability and preventability from the core terms of reference for IIMHH should be considered in any review of the Serious Incident Framework.

7.15 The reviewers considered different methodological approaches in the investigation of Serious incidents and concluded that the present focus within the NHS (Serious Incident Framework 2015) and HSIB, the methods being advocated are Human Factors and Root Cause Analysis. Any review of the future of independent investigations should determine the most appropriate method for these investigations and ensure that Investigation companies and NHS Trusts are competent in their use.

7.16 The reviewers have considered all of the emerging themes from the examination of the IIMHH reports and the consultation process. They believe that the present IIMHH process would benefit from review to deliver the most cost-effective and productive process which provides evidence for future improvements in services and contributes to the reduction of the recurrence of homicide events.

8 Recommendations

1. It is recommended that the process for Independent Investigations in Mental Health Homicides is reviewed in line with the review of the Serious Incident Framework. This process review should consider the proposals for:
    I. a single approach to the quality of reports; including standardised template and agreed investigation methodology
    II. the provision of a synopsis of the IIMHH by the investigation panels for publication and sharing
    III. improvement in the timeliness of the report and reduce delays
    IV. provision of an independent chair of Trust internal investigations and/or provision of multi-agency reviews with an independent chair
    V. the support to families and carers of advocate and who would be present on the investigation panel
    VI. to provide standard and event specific terms of reference which focus on outcomes and identify local, regional and national recommendations.
    VII. provide a recommendation workshop with the NHS Trust and other agencies involved
    VIII. monitor embedding of learning and lessons learned through the CCG quality monitoring and the CQC.
2. It is recommended that a national repository is provided to deliver a single access point for IIMHH reports, and that publication standards are developed to provide complete publication of the IIMHH, the synopsis and the recommendations for public access
3. It is recommended that the requirement for consideration of predictability and preventability in IIMHH investigations is either removed or a national standard definition provided and used by all Investigation panels and included in the revision and the principles of the Serious Incident Framework.
4. It is recommended that the IIGC continues to function as the strategic governance group for Independent Investigations into mental healthcare related homicides, and makes the necessary linkages with other national programmes of work i.e. mental health and quality and safety.
5. It is recommended that the IIGC identifies the strategic co-dependencies with agencies such as police, probation, prison engaged with mental health services to optimize the learning and improvement and to provide a platform for joint working at the strategic level.

6 It is recommended that the IIGC should alert the National Quality Board and the Quality Assurance Group of the complexities and challenges of sharing learning and implementing improvement across the wider systems and with those partners identified by recommendation four.

7 It is recommended that the IIGC should develop additional metrics and key performance indicators to provide assurance of regional adherence to quality as well as process requirements of Independent Investigations and the Serious Incident Framework.

8 It is recommended that the IIGC should develop measures to demonstrate the impact and outcomes of the Independent Investigation process, with particular regard to; learning, service improvement, policy development and the experience of all affected families and carers.

9 It is recommended that the outcomes of the perpetrator characteristics and profile identified in this review be shared with the appropriate commissioners and service providers for the future commissioning of services.

APPENDIX A: Terms of reference

Governance

1. It is expected that the reviewers will undertake an assessment of the current governance systems and processes in place, specifically they will consider;
2. Whether independent reports have been commissioned in line with NHS policy;
3. Whether the standards of those reports meet the expectations of such NHS policy and specifically provide evidence to demonstrate lessons have been learned from published reports, identifying where changes to practice, policy and strategy has been embedded;
4. Whether the reports sufficiently address areas such as patient safety factors, quality standards, family and carer engagement and future commissioning outcomes of better experience, outcomes and use of resources;
5. Whether recommendations guide the commissioning of future independent investigations and the development of quality standards;
6. How themes and learning from investigation reports are disseminated and inform national mental health policy and programmes and recommend a 'blueprint' for any required improvement;
7. Whether and how recommendations and lessons learnt can be agreed and implemented across four regions;
8. Key measures for development of an assurance system to ensure changes are made to practice and sustained within the commissioning landscape of NHS England and the wider system as relevant;
9. How national learning can be strengthened including considering how the IIGC can be provided with greater assurance on implementation of national recommendations;
10. How the outcomes of the published reports influence change in practice locally, regionally, nationally and strategically;

Best Practice Review

The reviewers will ensure they ascertain international best practice in patient safety and learning from serious incidents. They will consider the following key areas:

1. Any existing best evidence which can be developed to improve the learning from independent investigations. This should consider such learning from safety sciences such as 'Human factors' and 'Prospective Hazard' analysis;
2. Guidance on minimum standards for the quality of Independent Reports, including addressing the recommendations from the Sussex thematic review;

3. Best practice for supporting victims and families during the investigatory process;
4. The impact of the outcomes of the reports on the commissioning landscape of NHS England including Specialist Commissioning and Health and Justice;
5. Any changes to practice which have been made and sustained, within providers, commissioning organisations and National Policy as a result of the published reports since April 2013;
6. If the relevant families have belief in the process from commissioning to the implementation of the recommendations;
7. If the independent investigation companies undertake the investigation in partnership with the mental health provider key parties and commissioners (CCG/specialised commissioning/external bodies);
8. If there have been changes to the profile of perpetrators, to enable an understanding of the commissioning of current services;

APPENDIX B: Resources

Paper resources

Published Independent Inquiry Reports – 2013 – present day Unpublished Independent Inquiry Reports – 2013 – present day

Synopsis and Precis of Independent Inquiry Reports (Midlands and East and London 2013 – present day)

Draft Annual Reports – North and London

Minutes of IIRG

Consultation, Interviews and Meetings

Independent Investigation Group Committee members

Max McClean, Chair of IIGC

Chief Executive Group – North East and Yorkshire and Humber

Mental Health and Learning Disability Director of Nursing Forum (thirty-eight interviews, group and personal responses)

HSIB - Keith Conradi, Chief Executive

HSIB - Tracey Herlihey – National Investigator, HSIB -

Paul Davis – National Investigator, HSIB

NHS England -Angela Middleton – Patient Safety Lead, London

NHS England - Karen Conway – Patient Safety Lead, North

NHS Improvement - Mette Vognesen – Head of Independent Investigations Midlands and East.

NHS England - Lucien Champion – Head of Investigations, South

NHS England - Alena Buttivant, Patient Safety Manager

NHS England - London NHS England - Martin Machray, Director of Nursing, North West London.

NHS England – Catherine Wardle, Independent Investigation Lead

NHS England – Joanne McDonnell, Senior Nurse for Mental Health

Ivan Wintringham – Children's Social Care Innovation, Practice and Reform, Department of Education

Sam Hudson - Uberology

Julian Hendy – One Hundred Families

Ernst Klunder – Dimence Group, Netherlands

Grant Sara – New South Wales, Australia

Frank Mullane, Centre of Excellence for Reviews after Domestic Homicide and for Specialist Peer Support - AAFDA

Dan Curran – Senior Policy Manager – Gov.Scot

Dr David Horton, University of Liverpool

Dr Mark Potter, Medical Director, South West London and St. George's NHS Trust

John Short, Chief Executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Independent Investigation providers

HASCAS - Androulla Johnston
Mazars LLP – Kathryn Hyde-Bales
Niche Health and Social Care Consulting Limited -Nick Moor
Psychological Approaches CIC – Jackie Craissati
Ann Richardson Consulting Limited - Anne Richardson
Caring Solutions Limited - Colin Dale
Iodem Health - Janet Hawthorne
Clarity and Partnership Ltd - John Woodhouse
Consequence UK - Maria Dineen

Interim reports and Presentations

31st October 2017 – Interim report on themes and findings from Independent Investigations
31st October 2017 – Independent Investigation Group Committee
28th October 2017 – Patient Safety Leads Group
16th November 2017 – Mental Health and Learning Disability Director of Nursing Forum
30th August 2018 - Independent Investigation Group Committee

Key

Investigation organisation – Those companies which are on the procurement framework for the provision of Independent Investigations.
NHS Trusts – NHS Trusts which provide mental health services.
CCG – Clinical Commissioning Groups
NHSI –NHS Improvement
Regional leads – Individuals employed by NHS England/NHSI to oversee Independent Investigation process in NHS England/NHSI Regions.
IIRG – Independent Investigation Regional Group
IIGC – Independent Investigation Governance Committee
HSIB – Healthcare Safety Investigation Bureau

APPENDIX C: References and Bibliography

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APPENDIX D: Biographies

PROFESSOR HILARY MCCALLION CBE

RN(MH), RN (G), MSc, BA Hons, Dip NS, Cert Counselling

Hilary McCallion was Director of Nursing and Education at the South London and Maudsley NHS Foundation Trust from 1999 to 2013 when she retired and developed a healthcare consultancy service. This service has provided services to the NHS, Hospices, Charities and Higher Education Institutions delivering service reviews, redesign, investigation and transformation processes to support organisations and its people to achieve and succeed. She has been delivering a National Leadership programme for Ward Manager/Team Leaders since 1999, and continues to provide this and an Aspiring and Emerging Healthcare Leaders programme. She provides Executive Coaching and has proudly supported a number of nurses to Executive roles in the UK. She is a Non-Executive Director and Senior Independent Director at Ashford and St. Peter's Hospital NHS Foundation Trust and chairs the Quality of Care committee.

As an Executive Nurse, she was responsible for clinical quality standards, patient safety, hotel services and education and training along with the professional leadership of nurses and nursing ensuring standards were set and maintained.

Hilary has worked across England and Wales in education and clinical practice and has both general and psychiatric nursing experience. She has been a recipient of the Florence Nightingale Award for the examination of people with AIDS related brain impairment. She is an Independent governor on the Board of Governors at London South Bank University, and has been a trustee for the Maudsley Charity, Dementia UK and Bethlem Museum of the Mind. She is visiting professor at London South Bank University and former Chair of the Mental Health and Learning Disabilities, Director of Nursing and Lead Nurses National forum. Hilary was awarded the Commander of the British Empire for services to Nursing in 2012 in the Queen's Birthday Honours.

PAUL FARRIMOND

SRN RMN MBA DipHSM HND

Paul Farrimond trained at the London Hospital as a General and Mental Health Nurse in the 1970's and worked in London before moving into General Management in 1987. He then worked in Community, Mental Health and Acute services before becoming a Director in a PCT in 2000, with responsibility for Primary Care, Mental Health and Community services. Paul retired in 2007 and has since then undertaken mainly interim Director roles in the NHS. This included being interim Director of CSIP and NIMHE for the North East and Yorkshire & Humber regions. Following the closure of CSIP/NIMHE he has continued to facilitate the meetings of the nine mental health Trusts in these two regions. He has also had experiences as an officer in the RAMC(V) and trustee for a mental health charity. Paul was a Non-Executive Director at Barnet Enfield and Haringey Mental Health NHS Trust, chairing the Quality and Safety and Mental Health Law Committees between April 2013 and July 2018. He is also Specialist Advisor to NHS Providers on Mental Health issues and is a member of several External Advisory Groups for CQC and DoH. Paul is widowed with two adult children and lives in Somerset.