An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day

Section one

Executive Summary

Prepared by:
Professor Hilary McCallion CBE
Paul Farrimond
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Prepared by:	Professor Hilary McCallion CBE (Independent Healthcare Consultant) Paul Farrimond (Independent Healthcare Consultant)

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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(IMAS) to undertake a review of the Independent Investigations for Mental Health Homicides (IIMHH) published and unpublished in England from 2013 to the present day.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 process

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 (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 new 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 Emerging themes

Governance

2.1 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.

2.2 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.

2.3 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.

2.4 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.

2.5 The publication of the IIMHH reports on the NHS England website requires improvement to enable access to the relevant information. 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.

2.6 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.

2.7 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.

IIMHH process

2.8 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.

2.9 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.

2.10 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.

2.11 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.

2.12 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.

2.13 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.

2.14 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.

IIMHH Reports

2.15 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.

2.16 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 (NPSA 2008). A template for the IIMHH used by all Investigation companies would be beneficial and would improve access and readability of the IIMHH report.

2.17 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.

2.18 The 501 recommendations in the IIMHH reports examined 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).

2.19 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.

2.20 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.

2.21 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.

2.22 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.

2.23 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.

3 Overall Conclusions

3.1 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.

3.2 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.

3.3 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.

3.4 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).

3.5 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 overall time taken and be more cost-effective.

3.6 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.

3.7 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.

3.8 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.

3.9 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.

3.10 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.

3.11 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.

3.12 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.

3.13 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.

3.14 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.

3.15 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.

3.16 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.

4 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.