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Independent Investigations

2019/21 Annual Report

December 2021

Contents

1. Foreword

The 2019/2021 Annual Report provides an overview of independent investigations commissioned by regional independent investigation teams, which primarily relate to homicides committed by those in receipt of mental health services. NHS England and NHS Improvement Independent Investigation Governance Committee (IIGC) are responsible for the commissioning of the Annual Report. The IIGC made the decision not to publish an Annual Report of 2019/20 in 2020 due to the pressures on the NHS during the COVID-19 pandemic. However, when pressures eased the IIGC made the decision to conduct an Annual Report which was inclusive of both financial years 2019/20 and 2020/21.

The report details the key findings from the investigations and the performance of the commissioning arrangements.

Mental health homicides are tragic incidents that can have a devastating impact on families of both victims and perpetrators and on those staff and services providing care and treatment to the patient. The safety of patients receiving healthcare is paramount and responding appropriately when things go wrong is a key part of how the NHS can continually improve the safety of the services. Independent investigations are commissioned under the Serious Incident Framework (2015), to ensure that mental healthcare-related homicides are investigated in such a way that effective learning can be identified, and changes implemented to minimise the risk of recurrence.

As a result of the COVID-19 pandemic and required response, the NHS experienced unprecedented pressure and challenges to enable services to manage the significant demands. NHS services and support functions were required to reconfigure, step down and redeploy staff at very short notice. During this time, NHS England and NHS Improvement's national and regional teams were redeployed in various roles to support COVID-19 response activities. Reduced regional capacity resulted in limited and some suspension of Independent Investigation activity, however affected families of those mental healthcare related homicide cases under investigation and relevant staff were notified.

The 2019/2021 Annual Report highlights that while regional teams were redeployed some Independent Investigation and commissioning activity continued and was undertaken with the caveat that this should not add to the additional pressures

facing NHS organisations. During 2020 there were four regional independent investigation teams operating across seven regions in the NHS in England. During the report's timeframe, organisational change has occurred and there are currently five regional investigation teams covering seven regions. Therefore over this period, some reporting was disaggregated to reflect seven regions.

Regional team members have now all returned to their respective teams and are resuming the full range of investigation and commissioning activities. We are assured that regional approaches to commissioning the independent investigations are robust, transparent, effective and responsive to specific case considerations. However, we recognise that there will be a period of recovery to ensure that the learning from independent investigations is not compromised further and that meaningful learning is disseminated across the system in a timely fashion.

The outputs set out in this Annual Report have been accomplished by the regional independent investigation teams with multiple partners all of whom are committed to improving care for patients.

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

Dr Maxwell Mclean
Lay member and Co-Chair,
Independent Investigations
Governance Committee

Martin Machray
Regional Chief Nurse, London
Co-Chair, Independent Investigations
Governance Committee

2. Purpose

This document provides an annual report and update on the work undertaken by our (NHS England and NHS Improvement's) regional independent investigation teams (RIITs). During the period covered by the report, there were four RIITs covering seven regions within the national NHS in England geography. The portfolio, remit and capacity of each team differs slightly; however they are responsible for managing and overseeing the independent investigation function on behalf of our organisation. Regional teams commission a number of patient safety system wide investigations, including non-mental health homicide investigations.

This report details information on 2019/2021 activity (two years) and status of independent investigations, predominately mental health homicides, both completed and commissioned across all four teams/five regions. It includes the themes of learning identified, governance arrangements and financial information. Data volumes are often small, therefore analyses and assumptions should be considered with caution.

The report provides detail on development activity in all regions and plans for 2021/2022 to strengthen governance arrangements and improve the quality and spread of learning.

3. Introduction

Homicides committed by those in receipt of mental health services are at the utmost end of the spectrum of safety concerns. These incidents have a devastating impact on families of both victim(s) and perpetrator/s and on those staff and services providing care and treatment to the patient.

Resultant independent investigations carried out under the Serious Incident Framework (2015) [SIF],[1] ensure that mental healthcare related homicides are investigated in such a way so that learning leading to positive changes in practice can be identified and widely and effectively shared to minimise recurrence.

[1] https://www.england.nhs.uk/patient-safety/serious-incident-framework/

Regional ambitions are to:

- ensure the mandatory responsibilities placed on NHS England and NHS Improvement are fulfilled
- promote meaningful and compassionate family engagement
- commission high quality independent investigations that lead to influencing and supporting system-wide development, with the aim to minimise recurrence.

The NHS SIF (2015) and Article 2 of the European Convention on Human Rights, set out the circumstances and criteria when an independent investigation should be considered. An overview of the criteria is detailed below:

At the time of compiling the annual report, the criteria within the NHS SIF (2015) for considering the commissioning of an independent investigation was as follows –

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

When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death or where the victim sustains life-threatening injuries, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.

In accordance with the NHS SIF (2015), all providers of mental health services are required to report all "apparent/actual/suspected homicide meeting [serious incident] criteria" on the Strategic Executive Information System (StEIS).[2]

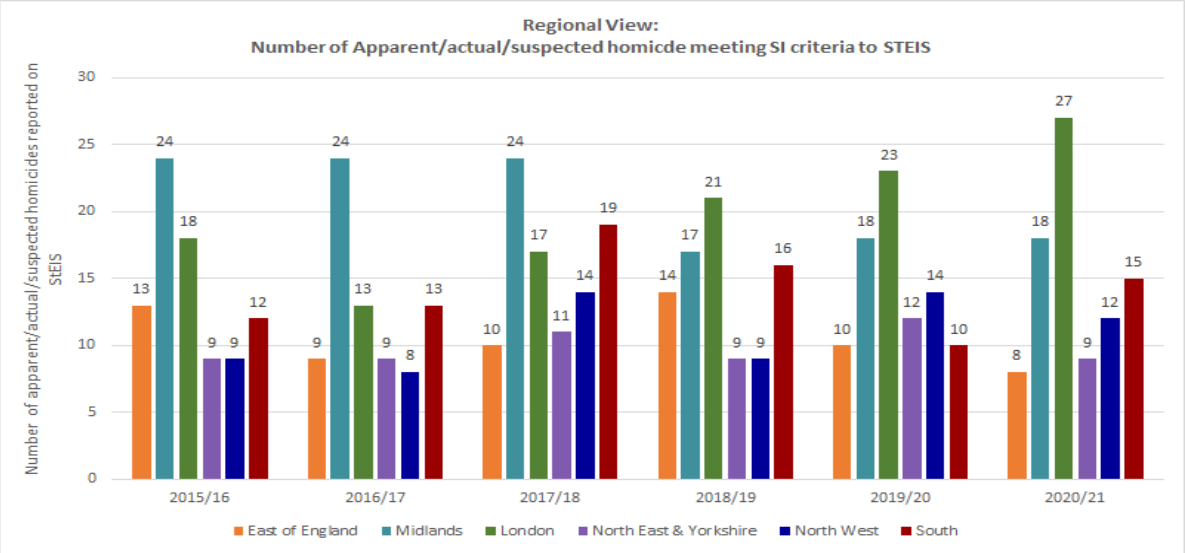
[2]NHS England and NHS Improvement is replacing the CPA framework *https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf* and making changes as to how the NHS respond to patient safety incidents https://www.england.nhs.uk/patient-safety/incident-response-framework/ Future Independent Investigation annual reports will reflect these framework revisions.

4. StEIS reported incidents

4.1 Number of actual and suspected homicides

Figure 1 below highlights the StEIS category of apparent/actual/suspected homicides from April 2015 to March 2021, across the five regions. Please note that not all the reported incidents will meet the criteria for an independent investigation as outlined above; therefore, the figures reported on StEIS will be higher than those commissioned as independent investigations.

Figure 1: Regional view – number of apparent/actual/suspected homicides meeting serious incident criteria to StEIS



Source: StEIS, NHS England and NHS Improvement analytic team. To note that for reporting during this period, the South maintained a pan-regional function.

StEIS is an electronic incident management database that enables NHS providers and clinical commissioning groups (CCGs) to record, track and monitor the progress of individual serious incidents. Our regional teams have access to view the database, but do not have editorial permission to amend an entry once it has been logged.

StEIS does not provide trend analysis or monitor prevalence of specific incident types. The system which has been in operation for more than 15 years, has been changed and developed to reflect the changes in the NHS landscape (both structural and contractual).

The quality and accuracy of serious incident information recording on StEIS by NHS providers is variable. Due to several factors, inaccurate categories may be selected in the absence of timely contextual information and/or by human error. There are additional limitations in reviewing StEIS data as not all search fields are completed in every case, with some incident details not being updated promptly. Therefore, StEIS interrogation provides regional teams with a point in time view of incident types, which are inclusive of the reporting of alleged homicides by those individuals in receipt of mental healthcare.

Inaccurate category selection within StEIS should be routinely rectified through the usual oversight arrangements by CCGs, with further scrutiny of incident type by regional teams.

During this reporting period, several serious incidents (SIs) were initially declared and categorised as homicides, which on further regional examination did not subsequently meet the mental health homicide criteria as set out in the Serious Incidents Framework.

Examples of inaccurate categorisations noted by regional teams include:

- Death of prisoner – not homicide
- Death of mental health patient, not by homicide, eg suicide
- Victim of homicide was a mental health patient and not a perpetrator
- Victim of homicide, with no mental health involvement (reported by CCG)
- Death/homicide of child, no mental health involvement (reported by CCG due to serious case review (SCR) being completed)
- Attempted homicide – perpetrator was in receipt of mental health services.

Notification data:

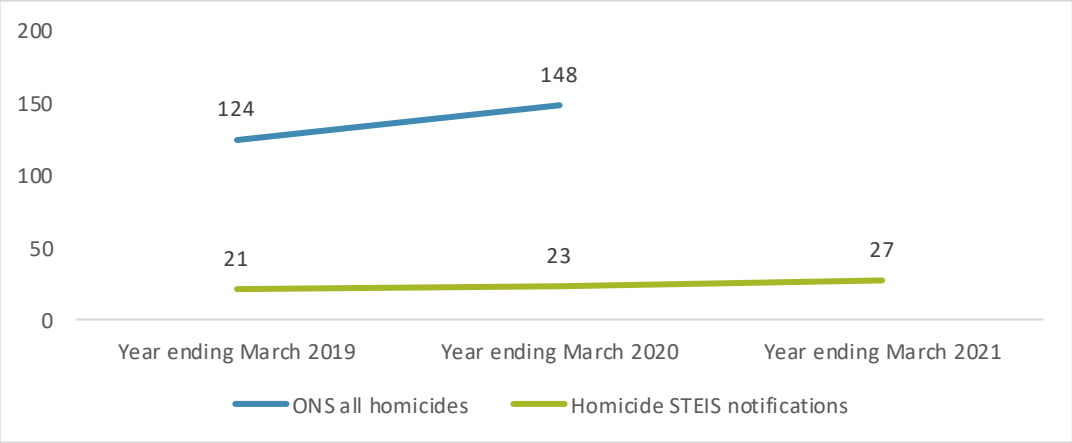
In the year ending March 2019, The Office of National Statistics (ONS) published that there had been a reduction in all homicides. At the end of March 2015, there was a reduction in the homicide rate to a low point of 8.8 per million population. The rate then increased until the year ending March 2018 (11.9 per million population), before a reduction in the following year 2019 (11.0 per million population).

For the year ending March 2020 (in England and Wales), ONS[3] published that there were 695 victims of homicide, 7% more than the previous year; this figure includes the Grays (Essex) lorry incident with 39 homicide victims – if this incident is excluded, homicide showed a 1% increase overall (11.7 per million population).

The ONS published the latest homicide data in England and Wales for year ending March 2020, on the 25/02/2021. Data for the financial year 2020/2021 was not available at the time of report writing and therefore not included in the numbers below.

4.1.1 London

Figure 2: London homicide data



	2019	2020	2021
ONS all homicide data - Number of victims	124	148	No data available
ONS all homicide data per 100,000 population	1.4	1.7	No data available
Homicide committed by those in receipt of mental health services (STEIS notifications)	21	23	27
Homicide committed by those in receipt of mental health services (per 100,000)	0.2	0.25	0.3

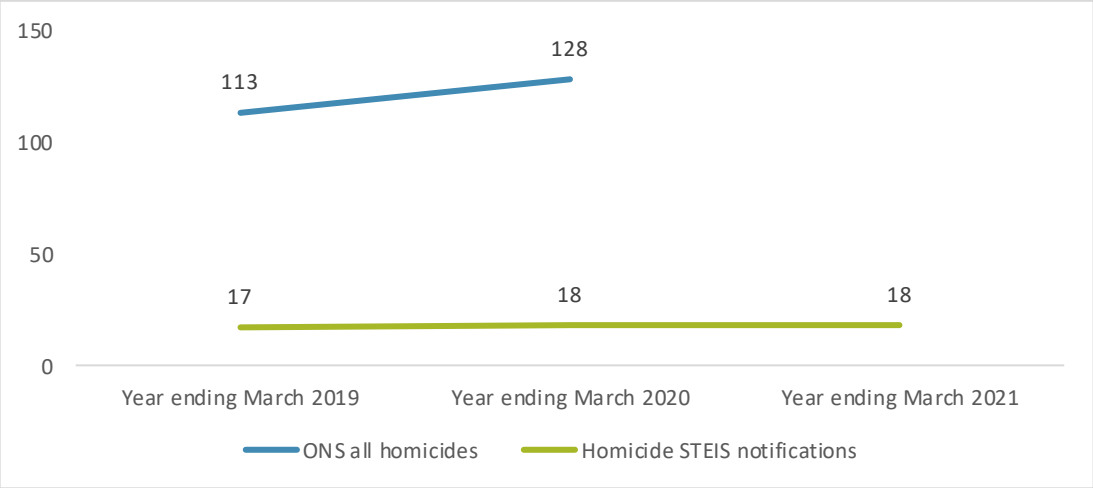
[3] All references related to the ONS can be located via the following link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/appendixtableshomicideinenglandandwales

Apparent/actual/suspected homicides notifications on StEIS:

- In the year ending March 2019 there were 21 apparent/actual/suspected homicide SI notifications (0.2 per 100,000).
- In the year ending March 2020 there were 23 apparent/actual/suspected homicide SI notifications, representing 0.25 per 100,000 of the population.
- In the year ending March 2021 there were 27 apparent/actual/suspected homicide SI notifications, representing 0.3 per 100,000 of the population.

4.1.2 Midlands

Figure 3: Midlands homicide data



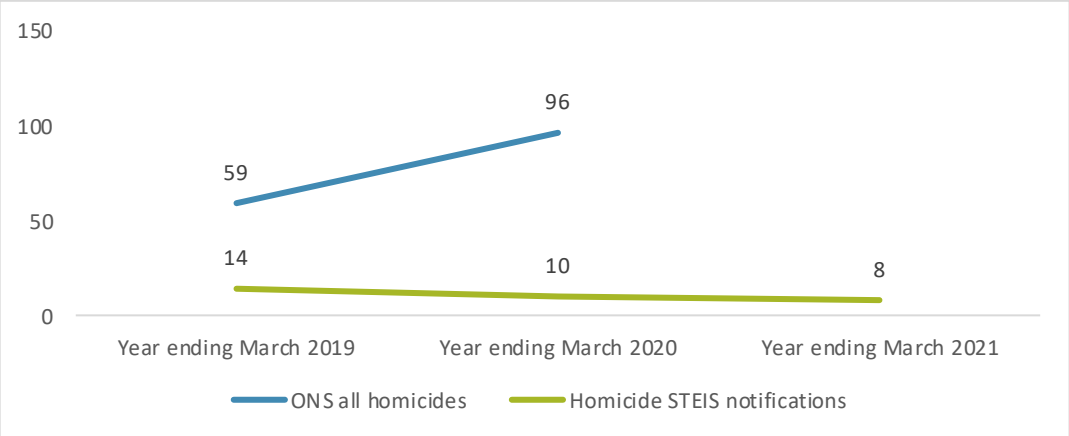
	2019		2020		2021	
	West Midlands	**East Midlands**	**West Midlands**	**East Midlands**	**West Midlands**	**East Midlands**
ONS all homicide data - Number of victims	70	43	77	51	No data available	No data available
ONS all homicide data per 100,000 population	1.2	0.9	1.3	1.1	No data available	No data available
	Midlands		**Midlands**		**Midlands**	
Homicide committed by those in receipt of mental health services (STEIS notifications)	17		18		18	
Homicide committed by those in receipt of mental health services (per 100,000)	0.2		0.2		0.2	

Apparent/actual/suspected homicides notifications on StEIS:

- In the year ending March 2019 there were 17 apparent/actual/suspected homicide SI notifications (0.2 per 100,000).
- In the year ending March 2020 there were 18 apparent/actual/suspected homicide SI notifications, representing 0.2 per 100,000 of the population.
- In the year ending March 2021 there were 18 apparent/actual/suspected homicide SI notifications, the same number as 2020 (0.2 per 100,000).

4.1.3 East of England

Figure 4: East of England homicide data



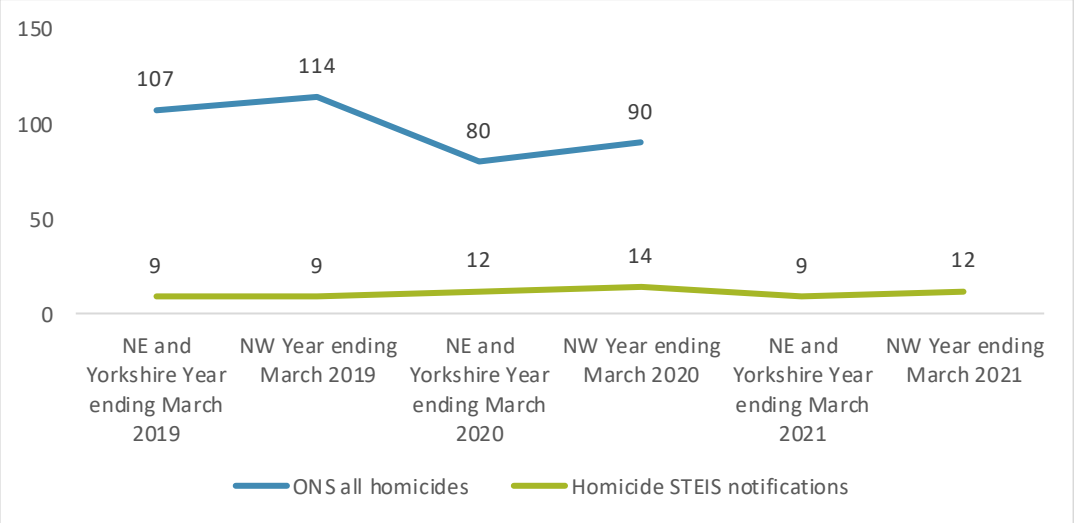
	2019	2020	2021
ONS all homicide data - Number of victims	59	96	No data available
ONS all homicide data per 100,000 population	0.95	1.5	No data available
Homicide committed by those in receipt of mental health services (STEIS notifications)	14	10	8
Homicide committed by those in receipt of mental health services (per 100,000)	0.4	0.2	0.1

Apparent/actual/suspected homicides notifications on StEIS:

- In the year ending March 2019 there were 14 apparent/actual/suspected homicide SI notifications (0.4 per 100,000).
- In the year ending March 2020 there were 10 apparent/actual/suspected homicide SI notifications, representing 0.2 per 100,000 of the population.
- In the year ending March 2021 there were eight apparent/actual/suspected homicide SI notifications, representing 0.1 per 100,000 of the population.

4.1.4 North

Figure 5: North homicide data



	2019		2020		2021	
	NE and Yorkshire	NW	NE and Yorkshire	NW	NE and Yorkshire	NW
ONS all homicide data - Number of victims	107	114	80	90	No data available	No data available
ONS all homicide data per 100,000 population	1.3	1.5	1.0	1.2	No data available	No data available
Homicide committed by those in receipt of mental health services (STEIS notifications)	9	9	12	14	9	12
Homicide committed by those in receipt of mental health services (per 100,000)	0.1	0.1	0.15	0.2	0.1	0.2

Apparent/actual/suspected homicides notifications on StEIS:

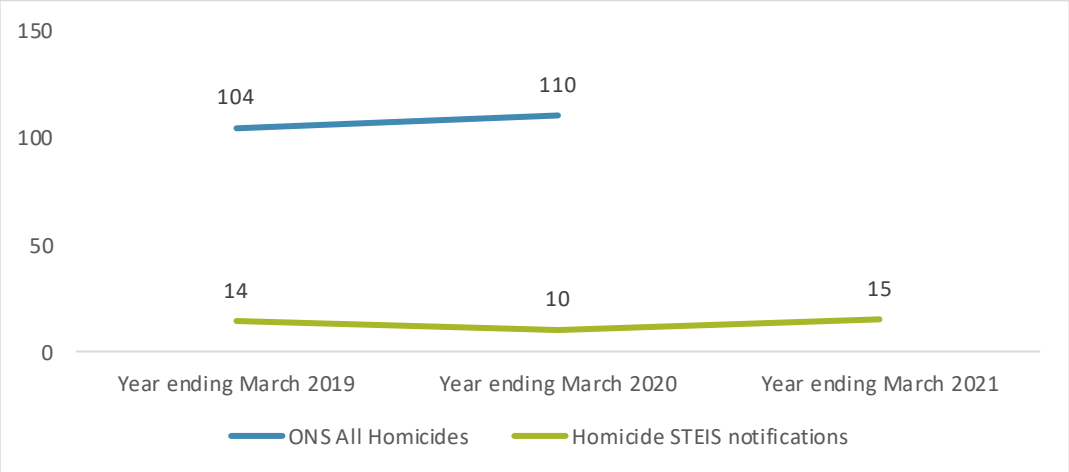
- In the year ending March 2019 in North East and Yorkshire there were nine apparent/actual/suspected homicide SI notifications (0.1 per 100,000). In the North West there were nine (0.1 per 100,000).

- In the year ending March 2020 in North East and Yorkshire there were 12 apparent/actual/suspected Homicide SI notifications (0.15 per 100,000). In the North West there were 14, 0.2 per 100,000).

- In the year ending March 2021 in North East and Yorkshire there were nine apparent/actual/suspected Homicide SI notifications, and the same as 2019 (0.1 per 100,000). In the North West there were 12, representing 0.2 per 100,000 of the population.

4.1.5 South

Figure 6: South homicide data



	2019		2020		2021	
	SE	SW	SE	SW	SE	SW
ONS all homicide data - Number of victims	63	41	76	34	No data available	No data available
ONS all homicide data per 100,000 population	0.7	0.7	0.8	0.6	No data available	No data available
	South		South		South	
Homicide committed by those in receipt of mental health services (STEIS notifications)	16		10		15	
Homicide committed by those in receipt of mental health services (per 100,000)	0.1		0.07		0.1	

Apparent/actual/suspected homicides notifications on StEIS:

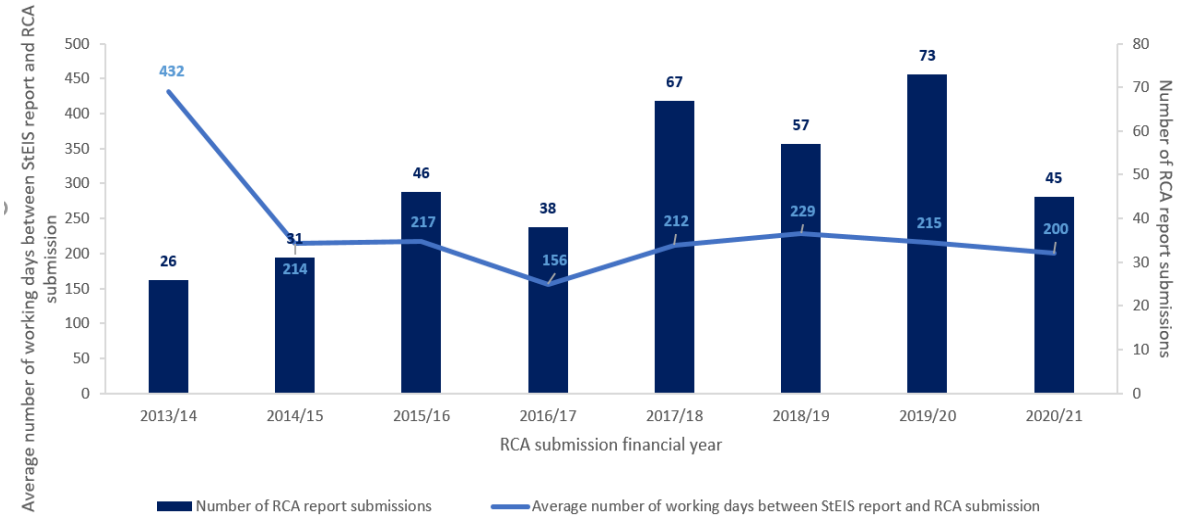
- In year ending March 2019 there were 16 apparent/actual/suspected homicide SI notifications (0.1 per 100,000).
- In year ending March 2020 there were 10 apparent/actual/suspected homicide SI notifications, representing 0.07 per 100,000 of the population.

- In year ending March 2021 there were 15 apparent/actual/suspected homicide SI notifications, representing 0.1 per 100,000of the population.

4.2 Average time between StEIS report date and RCA report submission

Figure 7 highlights the total number of Mental Health Provider Serious Incident Level 2 reports submitted, the average time taken to submit the report and whether they were submitted within the target of 60 working days from the report date.

Figure 7: Average time between StEIS report date and submission of the mental health provider level 2 report (RCA report)



Source: NHS England and NHS Improvement analytic team

Financial year 2019/2020:

Regions continued to experience challenges and delays in the completion and submission of Trust internal investigations. Delays have been noted to but not inclusive of:

- The criminal justice process which may affect trusts completing Root Cause Analysis Investigations. The police on occasion request that providers delay investigations until conclusion of the criminal justice process. The regional teams continue to work collaboratively with regional Police Services. To support the system with timely submission of Level 2 serious incident reports, one RIIT meets with providers of mental health services on a bi-monthly basis, to share learning and identify any challenges with the management of mental health homicide investigations.

- The capacity of both CCGs and providers and the impact of legal and/or coronial proceedings. Many mental health homicides are intra-familial and are therefore subject to other statutory reviews. These are often commissioned within a shorter time frame and engaging with the relevant commissioning organisations in a timely manner, to determine the scope of any joint approach, remains a challenge.

- Trusts supplying their internal investigation reports to commissioners for sign-off.

- Extensions agreed with trusts by CCGs, ongoing criminal or coronial processes and delays in the report being shared with NHS England and NHS Improvement by CCGs.

- Delays in the report being shared with local sub-regional teams by CCGs and the occasional delay in the sub regional team sharing with the regional team.

Financial year 2020/2021:

- The SIF promotes identification and reporting of Serious Incidents based on the potential for learning, future risk reduction and the consequences of any recurrence of the incident. At the onset of the COVID-19 pandemic and the required NHS response, it was acknowledged staff shortages may have made it more difficult for organisations to undertake timely internal investigations and the 60-day timeframe for investigations was suspended during this period. However, organisations were encouraged to be pragmatic about the sign-off and closure of internal investigations, which included internal investigations following a mental healthcare-related homicide.

- External influences affecting report submission timescales, such as ongoing criminal or coronial processes, are known factors which can delay the conclusion of investigations. The required response by the NHS to the COVID-19 pandemic significantly affected provider and CCG capacity to prioritise Level 2 reporting, both in terms of availability to author reports and process them through governance structures.

5. Published cases

In line with the SIF, there is an expectation that independent reports and their associated action plans will be published and made public in the interests of learning and transparency.[4] However, wider factors occasionally need to be considered on a case-by-case basis in respect of publication. The public interest aspect of publishing the report in full must be balanced with any other competing interests, such as the right to confidentiality (which survives death) and the right to a private life under Article 8 of the Human Rights Act 1998. This applies equally to both sets of affected families and service users as perpetrators.

Publication of each case is determined individually, with publication options considered by regional independent investigation review groups (IIRGs) and discussed and agreed at pre-publication meetings, chaired by the relevant NHS England and NHS Improvement Director of Nursing or Medical Director with a representative of the Communications team present. In the North, Midlands and East of England regions, while the IIRG is chaired by the regional chief nurse, the pre-publication meetings are not.

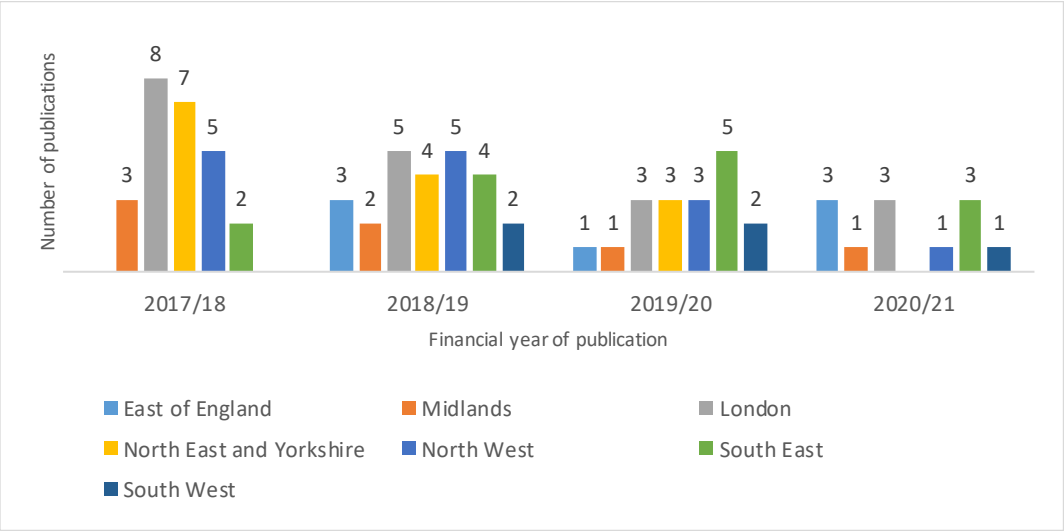
If alternative publication formats and processes are required, the rationale will be presented to the IIRG in advance of the pre-publication meeting. This ensures that the decision-making debate and process is well evidenced, well-reasoned, clearly considering all relevant information.

5.1 Published cases: key features

Figure 8 below highlights the position of regional publications by financial year. Note that some earlier cases would have been published on the regional strategic health authorities' websites and therefore are not included.

[4] https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports

Figure 8: Number of publications by financial year



Source: NHS England and NHS Improvement Analytic team

Financial year 2019/2020:

5.1.1 London

During 2019/2020, London published three reports.

- There were two male perpetrators and one female.
- Incidents occurred in 2014, 2015 and 2016.
- Two perpetrators have been convicted of manslaughter, and one of murder.
- All victims were known to the perpetrators.
- One case was subject to a joint SCR and mental health investigation.
- Two deaths were attributed to stabbing and one to strangulation.

5.1.2 Midlands

The Midlands region published an independent investigation into a near miss that did not result in harm, but there was significant learning for the system.

- The perpetrator was male.
- The incident occurred in 2016.

5.1.3 East of England

East of England region published one independent investigation.

- The perpetrator was male.

- The incident occurred in 2013.
- The perpetrator was convicted of murder.
- The victim was known to the perpetrator.
- The death was attributed to stabbing.

5.1.4 North

The North region published 10 independent reports during this reporting period.

- Of the 10 homicide investigations, nine of the perpetrators were male and one female.
- Published reports span several reporting years, with one incident occurring in 2013 and remaining cases occurring in 2015 and 2017.
- In six of the 10 incidents, the victim was known to the perpetrator; the perpetrator did not know the victim in three; one report does not state this information.
- Five perpetrators were convicted of manslaughter; three of murder; and two reports did not state post-homicide outcome for the perpetrator.
- Five deaths were attributed to stabbing; one to strangulation; one to burning; one to pushing and subsequent death of victim; two reports did not detail the mode of homicide.

5.1.5 South

During the 2019/2020 financial year, the South region published seven reports:

- There were six male perpetrators and one female.
- In two cases, the perpetrators took their own lives during, or immediately after the offence; three were convicted of murder; one of attempted murder; and one of manslaughter with defence of diminished responsibility. In all seven cases, the victims were known to the perpetrator.
- Two deaths were attributed to stabbing; one following attack with a hammer; one by drowning; one by physical assault; one report does not state the method of homicide. The attempted murder was by stabbing.

Financial year 2020/2021:

5.1.6 London

During 2020/2021, London published four reports: three were investigation reports and one an assurance review.

- All perpetrators were male.
- Three incidents occurred in 2015, one in 2016.
- Two perpetrators have been convicted of manslaughter diminished responsibility, and two of murder.
- All victims were known to the perpetrators.
- One case was subject to a joint Safeguarding Adult Review (SAR) and one a Domestic Homicide Review (DHR).
- One death was attributed to severe head trauma; three reports gave no indication of method of homicide.

5.1.7 Midlands

The Midlands Region published one independent investigation.

- The perpetrator was male.
- The incident occurred in 2014.
- The perpetrator was convicted of murder.
- The victim was known to the perpetrator.
- The death was attributed to drowning.

5.1.8 East of England

East of England published three reports.

- Two perpetrators were male and one female.
- Incidents occurred in 2015, 2017 and 2018.
- One perpetrator was convicted of murder, one was unfit to plea and given a hospital order under section 37 of the MHA (1083) with a section 41 restriction on discharge. There is no detail of the post-perpetrator outcome in one of the reports.
- The victims were known to the perpetrators.

- One death was attributed to stabbing; two reports do not detail the method of homicide.

5.1.9 North

The pan-North regional team published two independent reports during this reporting period. One report was in relation to a suicide and not a homicide. The homicide report identifies two perpetrators.

- Both perpetrators of the homicide were male.
- Both the homicide and the suicide occurred in 2016.
- The victim of the homicide was known to the perpetrators.
- In the homicide report one of the perpetrators was convicted of murder and one of manslaughter.
- The homicide was attributed to stabbing.

5.1.10 South

During the 2020/2021 financial year, the South region published four reports:

- All perpetrators were male.
- One perpetrator was convicted of murder and two of manslaughter with defence of diminished responsibility. One report does not state perpetrator outcome.
- In all four cases, the victims were known to the perpetrator.
- Two deaths were attributed to head trauma and one by stabbing. One report does not state the method of homicide.

6. Open mental health homicide cases

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

6.1 Status of independent investigations (March 2020)

Table 1 provides a high-level position of the seven regions, as at the end of March 2020.

Table 1: Regional status of independent investigations as at March 2020

Regional cases	Potential cases	Awaiting commissioning	Underway investigation/ awaiting publication	Total
London	33	5	12	**50**
Midlands	22	6	8	**36**
East of England	10	2	9	**21**
North East	4	6	10	**20**
North West	2	5	9	**16**
South East	7	0	8	**15**
South West	5	0	10	**15**
Total	**83**	**24**	**66**	**173**

6.1.1 London

The London region had oversight of 50 cases, a slight increase from 2018/2019, when there were 47. Of these 50, 33 were potential cases.

These cases were pending the outcome of the criminal justice process, waiting for other statutory investigations such as SCR/DHR, or waiting for the mental health provider to complete their internal serious incident investigation. They were also inclusive of incidents whereby victims sustained serious assaults.

6.1.2 Midlands

The Midlands region had oversight of 36 cases, 22 of the cases were potential where a definitive decision had not been taken on whether an independent investigation was required. Six were awaiting the commissioning process and there were 8 investigations in either the investigation phase or awaiting publication.

6.1.3 East of England

The East of England region had oversight of 21 cases, 10 of the cases were potential where a definitive decision had not been taken on whether an independent investigation was required. Two cases were awaiting the commissioning process and there were nine investigations in either the investigation phase or awaiting publication.

6.1.4 North

The figures above for both North East and Yorkshire, and North West regions include all levels and types of investigations which include mental health experts commissioned to support DHRs and SCRs; non-homicide system-wide investigations; and a public inquiry. The figures do not include post-publication assurance reviews that were ongoing, of which (for completeness) there were three.

The timeframe from the decision being made to commission an investigation to its commencement, continues to be affected by the timeliness of provider internal investigations and submission of Level 2 reports. While an early decision to commission may be reached, internal reports are required to inform the development of appropriate and comprehensive investigative terms of reference.

6.1.5 South

The South region had oversight of 30 cases. The South East had seven potential cases, with a further eight investigations underway or awaiting publication.

The South West had five potential cases, with a further 10 investigations either underway or awaiting publication.

6.2 Status of independent investigations (March 2021)

Table 2 provides a high-level position of the seven regions; the cases listed below consist of reported homicide/serious assault cases as at the end of March 2021. Some of the cases represented in the table below are ongoing cases that have spanned two financial years.

Table 2: Regional status of independent investigations as at March 2021

Regional cases	Potential cases	Awaiting commissioning	Underway investigation/ awaiting publication	Total
London	41	4	11	**56**
Midlands	23	7	8	**38**
East of England	7	6	7	**20**
North East and Yorkshire	4	4	14	**22**
North West	6	6	11	**23**
South East	16	0	8	**24**
South West	9	0	11	**20**
Total	**106**	**27**	**70**	**203**

6.2.1 London

The London region had oversight of 56 cases, a slight increase from 2019/20 when there were 50. Of these, 41 were potential cases.

These cases were pending the outcome of the criminal justice process, waiting for other statutory investigations such as SCR/DHR, or waiting for the mental health provider to complete their internal serious incident investigation. They were also inclusive of incidents whereby victims sustained serious assaults.

6.2.2 Midlands

The Midlands region had oversight of 38 cases – a slight increase from 2019/20 when there were 36. Of these, 23 were potential, where a definitive decision had not been taken on whether an independent investigation was required. Seven cases were awaiting the commissioning process and there were eight investigations in either the investigation phase or awaiting publication.

6.2.3 East of England

The East of England region had oversight of 20 cases; a slight reduction from 2019/20 when there were 21. Seven of the cases were potential, where a definitive decision had not been taken on whether an independent investigation was required. Six cases were awaiting the commissioning process and there were seven investigations in either the investigation phase or awaiting publication.

6.2.4 North

The North East and Yorkshire and North West regions had oversight of 45 cases, a slight increase from 2020 when there were 36. There were four potential cases in the North East and Yorkshire and six in the North West, and 10 cases awaiting commissioning across the two areas. There were 14 cases either underway or awaiting publication in the North East and Yorkshire and 11 in the North West, two of which were system wide investigations.

6.2.5 South

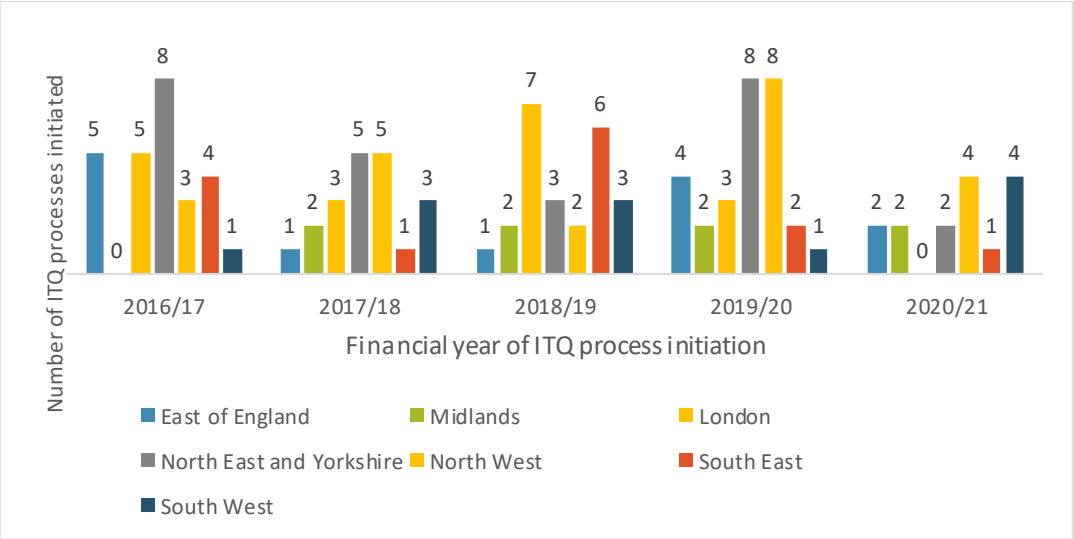
The South region had oversight of 44 cases, an increase from 2019/2020 when there were 30. The South East had 16 potential cases, with a further eight investigations underway or awaiting publication.

The South West had nine potential cases, with a further 11 investigations either underway or awaiting publication.

6.3 Commissioning timescales and completion dates

Figure 9 highlights the number of Invitations to Quote (ITQ) issued within each financial year by region. The ITQ follows the commissioning decision, it is the tendering process. ITQs include both mini-competition (MCs) and direct contract awards (DAs).

Figure 9: Number of ITQ processes initiated per financial year



Source: NHS England and NHS Improvement Analytic team

All regional teams have experienced significant challenges in obtaining a varied breadth of companies to tender for investigative commissions. This has a direct impact on the number of investigations which can proceed in a timely manner and within a given time period. These challenges have been raised via regional IIRGs, Independent Investigations Governance Committee (IIGC) and risk register reporting.

The following provides examples of some of the ITQ challenges presented to the regions during 2019/2021:

- In the London region for 2020/21 there were no ITQs due to the regional team supporting the region's response to the COVID-19 pandemic.

- Across the North East and Yorkshire and North West regions for 2019/2020, of the 15 investigations commissioned, 12 were DAs and two were commissioned via an MC with an ITQ circulated to investigative suppliers within the relevant framework Lot.[5] One investigation is an off-framework investigation and is not included within the submission above as this is a different commissioning process. In terms of the average timeframe to complete the commissioning process (from approach if DA or circulation of ITQ if MC), the average number of working days to complete was 13.78 days. The longest timeframe being 36 working days; the shortest, one working day.

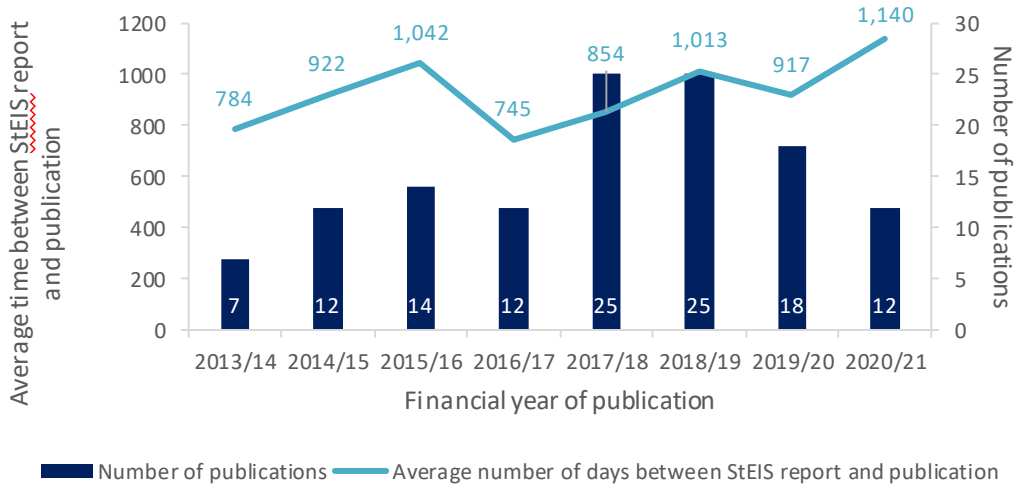
- For both the Midlands and the East of England, the new framework came into effect November 2019 the issuing of ITQ was held back until it was in place.

Challenges and constraints:

Figure 10 highlights the total number of investigation reports published per financial year and the average time (days) taken to publish from the date reported on StEIS, by the financial year of publication. This data is aggregated across all seven regions.

[5] The NHS has identified that several different types of investigation may be required. These types of investigation have been broken down as follows: Individual Experts Investigations (Lot 1); Partnership Investigations (Lot 2); Local Care System Investigations (Lot 3); Health and Social Care and Partners Investigations (Lot 4); Systematic Independent Investigations (Lot 5).

Figure 10: National view – average time between StEIS report and publication



Source: NHS England and NHS Improvement Analytic team

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

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

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

Financial year 2019/2020:

6.3.1 London

During 2019/2020, London published three reports. Two publications were due to be published in February and March 2020; one was postponed initially due to the surviving victim coming forward later in the process to participate in the review.

Both were further postponed due to the NHS response to the COVID-19 pandemic.

Other cases were delayed due to the following;

- Family bereavement.
- Staff from provider and commissioning organisations were re-deployed to support the pandemic, this also applied to the NHS England and NHS Improvement RIIT.
- Legal challenges.
- Family challenges with the report.

6.3.2 Midlands

The Midlands region published one report in January 2020, but due to the impact of the pandemic some publications had to be postponed or cancelled at short notice.

6.3.3 East of England

The East of England Region published one report in September 2019. Due to the impact of the pandemic some publications had to be postponed or cancelled at short notice.

6.3.4 North

The North East and Yorkshire and North West regions did not experience any delays in publications due to COVID-19 in the period January to March 2020.

On behalf of both regions, the pan-North investigations team published six independent investigation reports during 2019/20. The average time between StEIS reporting and publication of the investigation was 708.6 working days. The shortest timeframe being 633 working days and the longest 778 working days.

Challenges in the timeliness of completion of investigations (through to publication) that were experienced, include:

- Additional time and resource required to support families with well-being and safety in their community prior to publication.
- Delays in receiving trust internal RCA reports prior to commissioning independent investigations.

In 2019/2020 The North East and Yorkshire region completed one independent investigation, the report of which was not published. Non-publication in this instance was due to serious safeguarding concerns relating to the service user and affected family members. This investigation took 1,059 working days to complete due to the complexities of the multi-agency aspects of the investigation.

The pan-North regional team also published four post-publication assurance reviews.

6.3.5 South

During 2019/2020 financial year, the South region published seven reports. The region did not experience an impact from the onset of the COVID-19 pandemic in Q4.

Delays experienced in this region were issues in accessing records (particularly primary care), engaging with families as part of the publication process and legal reviews and challenges.

Financial year 2020/21

6.3.6 London

Between March 2020 and April 2021, the London regional independent investigations team were redeployed, either part-time or full-time at various periods to provide additional support to the NHS system.

The IIRG was suspended until Sept 2020 with a meeting by exception held in July 2020 to consider a pragmatic approach to recently commissioned cases.

All families and stakeholders were notified accordingly. Invitations to quote were put on hold and publications were limited during 2020. All meetings including those with families, were held via MS Teams calls or conference calls.

Delays occurred with the administration of reports being sent to families due to limited access to offices.

6.3.7 Midlands

The Midlands region continued to work on publications up until the end of March 2021. Due to the impact of the pandemic, redeployment of the team and the capacity, both internally and within providers, to prioritise publications of reports

some publications were postponed or cancelled at short notice. All families and stakeholders were kept informed.

6.3.8 East of England

The East of England region continued to work on publications until the end of March 2021. Due to the impact of the pandemic, redeployment of the team and the capacity, both internally and within providers, to prioritise publications of reports some publications were postponed or cancelled at short notice. All families and stakeholders were kept informed.

During the easing of the restrictions the East of England region managed to publish three independent investigations.

6.3.9 North

A number of investigations and completed reports have remained open and or unpublished across both North East and Yorkshire and North West Regions due to external factors and constraints, such as:

- Providers being prevented from producing a comprehensive internal report (at Police request)
- Affected family, perpetrator and HM Coroner considerations
- Family bereavement and illness
- The combined effect of the complex requirements of stakeholder scrutiny
- Redeployment of RIIT to support COVID-19 response related activities

The RIITs continue to take a proactive approach to mitigate where possible these delays, escalating issues where required and managing family and stakeholder expectations.

6.3.10 South

The NHS response to the COVID-19 pandemic significantly affected our capacity to prioritise publication of independent investigations, particularly in terms of the Communications team capacity. Providers and commissioning agencies were unavailable to participate in the process. The South IIRG was ‘stood down’ temporarily at the beginning of the pandemic (March 2020) and attendance at subsequent meetings was limited due to reprioritisation of work across the membership. Three publications that were scheduled for March and April were

cancelled and rearranged for later in the year. Framework suppliers were also subject to compromised capacity during the pandemic.

6.4 Collaborative and joint investigations

A key element of the SIF is the requirement to elicit lessons to inform systematic learning and improvement, acknowledging the investigative interfaces with other organisations, particularly those with a statutory responsibility to investigate specific types of incidents. SIF advocates a collaborative approach to investigations and recognises that a variety of investigation frameworks may be applied.[5]

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

Joint investigations continue to be considered across the seven regions. Benefits of commissioning joint reviews include:

- Families are included in the decision-making of a single investigation or fewer review processes.
- Reduced risk of duplicating processes for NHS providers and other stakeholders involved.
- Enabling learning from these types of investigations to be disseminated across the widest audience possible. However, in considering any joint investigation the mental health aspect must be explicit within the resultant terms of reference.
- Enabling learning across multiple systems.
- Improved understanding of the independent investigation process with external stakeholders (local authorities, safeguarding boards/partnerships and community safety partnerships).
- Collaborative system learning.

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

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

The effectiveness of this approach does however need to be formally measured, both in terms of family and stakeholder satisfaction and added value. An agreed set of principles governing the approach across the regions has been a key deliverable and work priority of the 2020/2021 work programme.

Table 3 highlights regions' collective summary of joint investigations in 2019/2020. The data is inclusive of commissioned and published cases.

Table 3: Regions' joint investigations 2019/20

Regional cases	Joint DHR	Joint SAR	Joint SCR	Other
London	1	1	0	0
Midlands	3	0	0	0
East of England	4	1	0	0
North East	6	0	0	0
North West	2	1	1	0
South East	0	0	1	0
South West	0	0	0	0
Total	**16**	**3**	**2**	**0**

London region

Commissioned one joint mental health homicide independent investigation and SAR, and one joint mental health homicide and DHR. The London RIIT supports DHRs across London. This is inclusive of the team being full panel members, supporting the community safety partnerships with chair selection and supporting the DHR chairs with navigating health and social care.

Midlands region

At the end of March 2020 there were three joint independent investigations/DHRs in partnership with three different community safety partnerships.

East of England region

At the end of March 2020 there were four joint independent investigations/DHRs and one joint SAR in partnership with three community safety partnerships and on safeguarding board.

North region

The number of ongoing joint processes across both North East and Yorkshire and North West Regions at 31 March 2020 has been included. The numbers above include independent investigations fully combined with other statutory investigations, investigations aligned with other statutory processes (and where one report will be appended to the other to make one overarching document), and where mental health experts have been commissioned to support other statutory processes.

South region

There was one concurrent SCR undertaken.

Table 4 (below) highlights regions' collective summary of joint investigations in 2020/2021. The data is inclusive of commissioned and published cases.

Table 4: Regions' joint investigations 2020/21

Regional Cases	Joint DHR	Joint SAR	Joint SCR	Joint SCR/DHR	Other
London	1	0	0	0	0
Midlands	3	0	0	0	5
East of England	2	0	1	1	3
North East and Yorkshire	9	0	0	0	0
North West	2	1	0	0	0
South East	0	0	0	0	0
South West	0	0	0	0	0
Total	**17**	**1**	**1**	**1**	**8**

London region

The IIRG supported the decision to commission an independent mental health specialist to provide independent scrutiny to a DHR panel.

Midlands region

At the end of March 2021 there were three joint independent investigations/DHRs and five other investigations underway during this time period.

East of England region

At the end of March 2021 there were two joint independent investigations/DHRs, one joint independent investigation/SCR and one joint independent investigation/SCR/DHR underway during this time period. There were three other investigations also underway.

North region

In the North East and Yorkshire there were nine joint DHRs; two investigations commissioned mental health experts only, to assist with DHR (rather than full joint investigations). In the North West this also applied to two investigations. There was one joint SAR for the North West where a mental health expert was commissioned to assist with SAR (rather than full joint investigation).

South region

There were no reported incidents that met the criteria or threshold for joint investigations during 2020/2021 in either the South West or South East.

6.5 Themes from published independent mental health homicide investigations

(2019/2020 and 2020/2021 inclusive of collaborative and joint investigations)

The data is from all five independent investigation regional databases, it is inclusive of published reports in 2019/2021. These themes will be considered in annual and regional work plans.

Table 5 highlights the perpetrator demographic collective data 2019/2020 of published reports. There was a total of 21 perpetrators.

Table 5: Collective perpetrator demographic data, financial year 2019/20

Demographics	Female	Male
Age range (median)	40-54 (52 years)	19-85 (38 years)
Gender totals	3 (14%)	18 (86%)
BAME	1 (5%)	1 (5%)
White British/White Other	2 (10%)	17 (80%)

Table 6 highlights the perpetrator demographic collective data 2020/2021 of published reports. There was a total of 13 perpetrators.

Table 6: Collective perpetrator demographic data, financial year 2020/21

Demographics	Female	Male
Age Range/Median	37	22 – 74 (44 years)
Gender Totals	1 (8%)	12 (92%)
BAME	Not indicated in reports	Not indicated in reports
White British/White Other	Not indicated in reports	Not indicated in reports

ONS data reports that for the three-year period covering financial year 2017/18 up to financial year 2019/20, the vast majority of suspects convicted of homicide were male (93%). Four in 10 convicted male suspects were aged 16 to 24-years-old (40%), with 25% being 25 to 34-years-old, and 16% being 35 to 44-years-old.

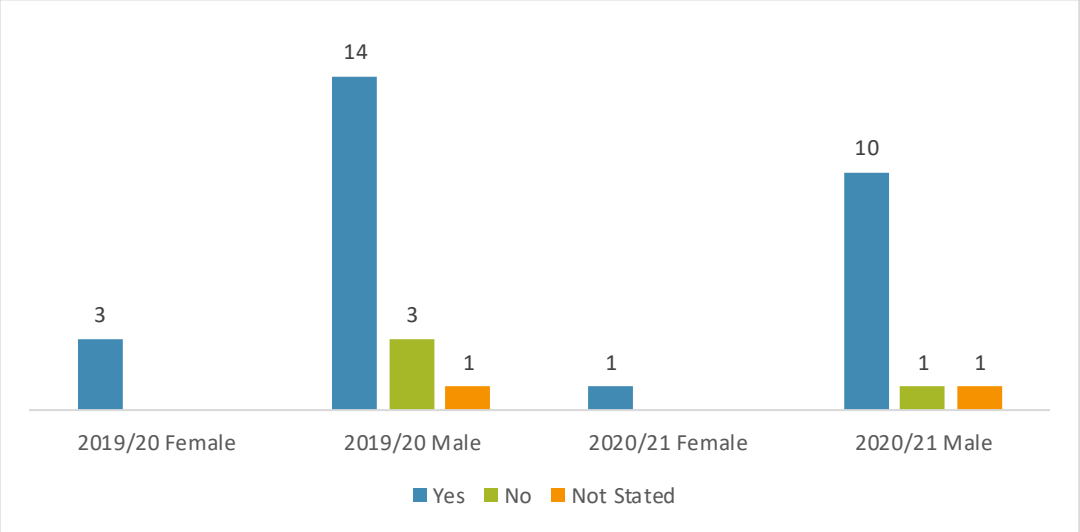
Theme 1: Victim known to perpetrator

Figure 11 Indicates if the victim was known to the perpetrator prior to the homicide.

In 2019/2020 a total of 16/21 (76%) of cases, the perpetrator knew their victim prior to the fatality. This detail was not included in one report.

In 2020/2021 a total of 11/13 (85%) of cases, the perpetrator knew their victim prior to the fatality. This detail was not included in one report and one victim was not known to the perpetrator (8%).

Figure 11: Victim known to perpetrator



ONS data for all homicides for England and Wales indicates that in the year ending March 2020, female victims were more commonly killed by a partner or ex-partner or a family member, while for males the suspected killer was more commonly a friend or acquaintance, stranger or other known person.

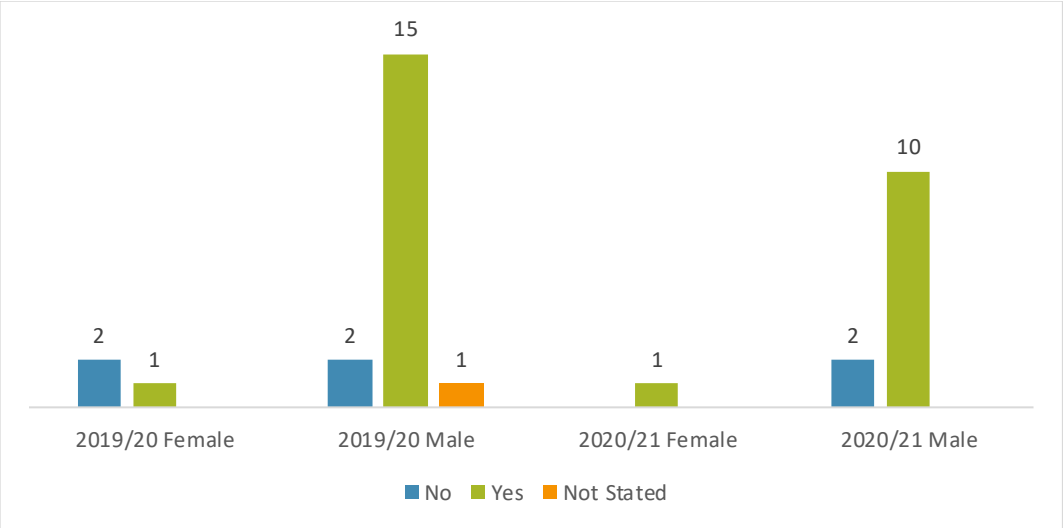
Nationally there were 45 victims of all homicides aged under 16 years in the year ending March 2020, the lowest number for four years. As in previous years, for just over a quarter of child victims, the suspect was a parent or stepparent (27%, 12 offences).

It is uncommon for under 16-year-olds to be killed by a stranger, with seven such offences in the last year, similar to previous years.

Theme 2: Known history of violence

Figure 12 highlights cases where the perpetrator had a known history of violence prior to the homicide.

Figure 12: History of violence prior to homicide



In 2019/20 a total of 16/21 (76%) perpetrators were known to have a history of violence prior to the homicide. In four cases, there had been no previously reported violence and in one case, this was not indicated.

In 2020/21 a total of 11/13 (85%) perpetrators were known to have a history of violence prior to the homicide. In two cases, there had been no previously reported violence and in one case, this was not indicated.

Theme 3: Services

Table 7 below highlights the range of services that the perpetrators were in, prior to the homicides 2019/2021:

Table 7

Service	Total
Community (Varied)	22
CAMHS	2
Drug and Alcohol	2
Forensic Services	4
Inpatient	4

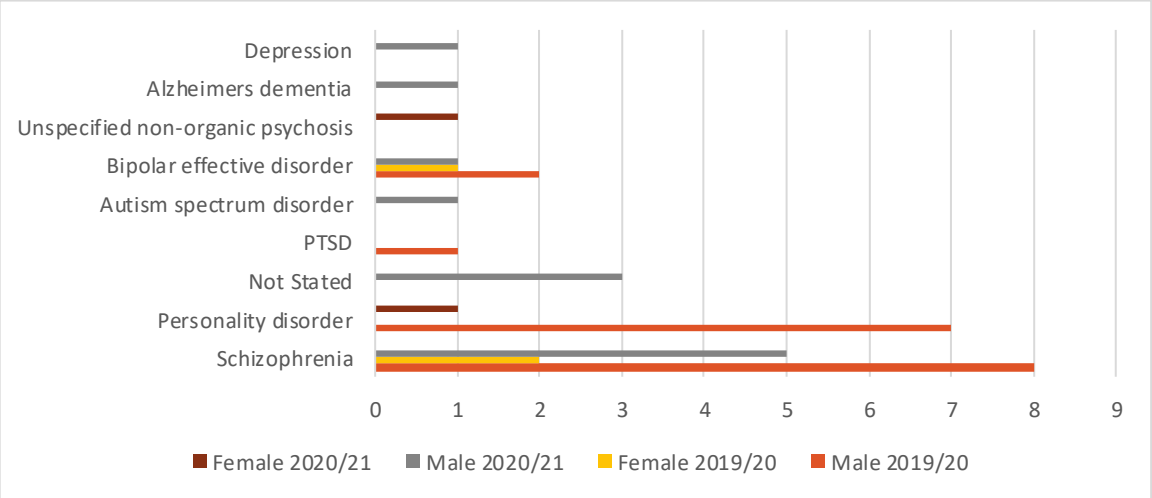
Community Services have been grouped as one; however, they are inclusive of home treatment teams (HTTs), recovery teams and improving access to psychological therapy (IAPT) teams. Child and Adolescent Mental Health Services (CAMHS) were all inclusive of community services. Most homicides occurred when perpetrators were receiving services within the community.

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

Theme 4: Primary mental health diagnosis

Graph 13 highlights the primary mental health diagnosis of males and females in the published reports during 2019/2021.

Figure 13: Primary mental health diagnosis



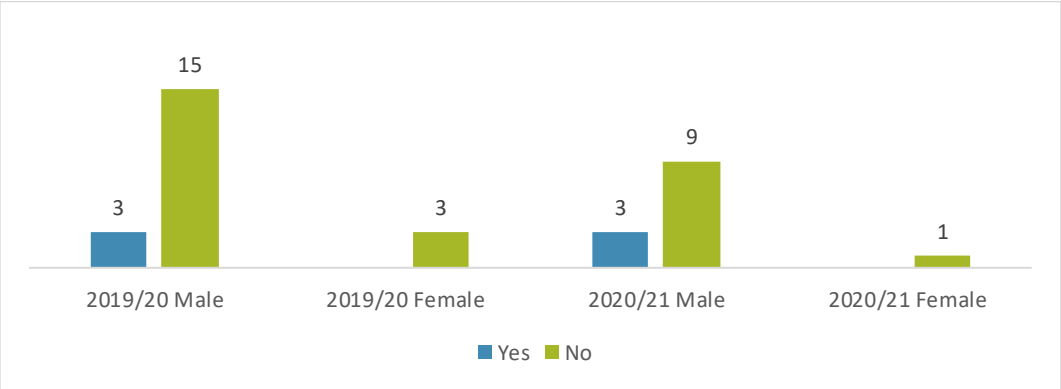
There were 30 male and four female perpetrators. The primary mental health diagnosis of paranoid schizophrenia was the most prominent in males, closely followed by personality disorder. A primary mental health diagnosis was not stated in three reports. bipolar and schizoaffective disorder were the next most prevalent diagnoses. All other diagnoses were identified only once.

Of the female perpetrators, each presented with a different primary health diagnosis of schizoaffective disorder, bipolar, unspecified non-organic psychosis and schizophrenia/psychosis.

Theme 5: Subject to Mental Health Act

Figure 14 identifies males and females who were subject to Mental Health Act 1983 (MHA) at the time of the homicide.

Figure 14: Subject to the Mental Health Act 1983

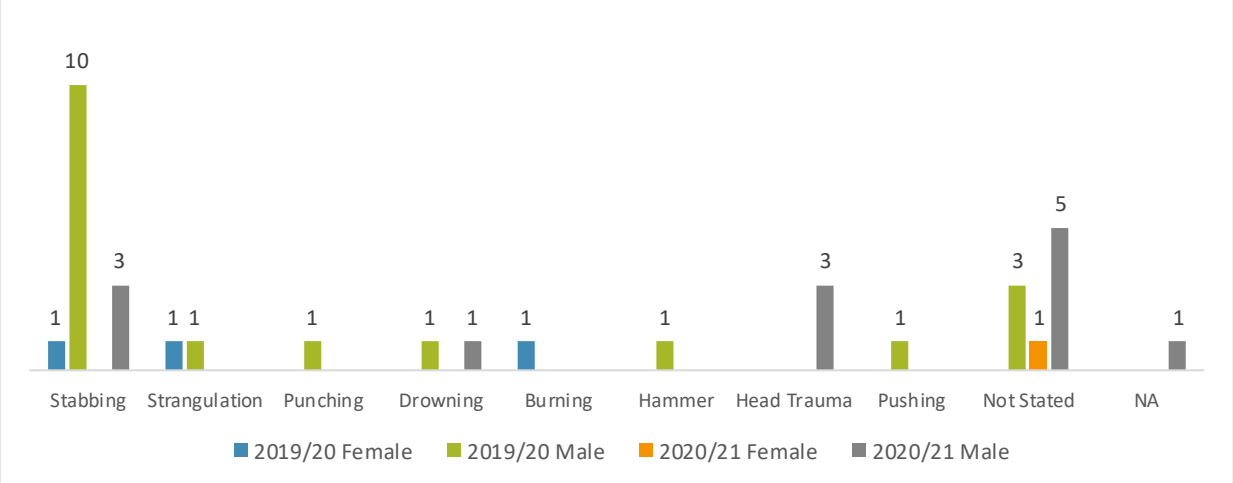


The data highlights that there were a larger proportion of perpetrators not subject to the Mental Health Act at the time of the homicide.

Theme 6: Primary method of homicide

Figure 15 highlights the primary method of the homicide of the published reports during 2019/2021.

Figure 15: Method of homicide



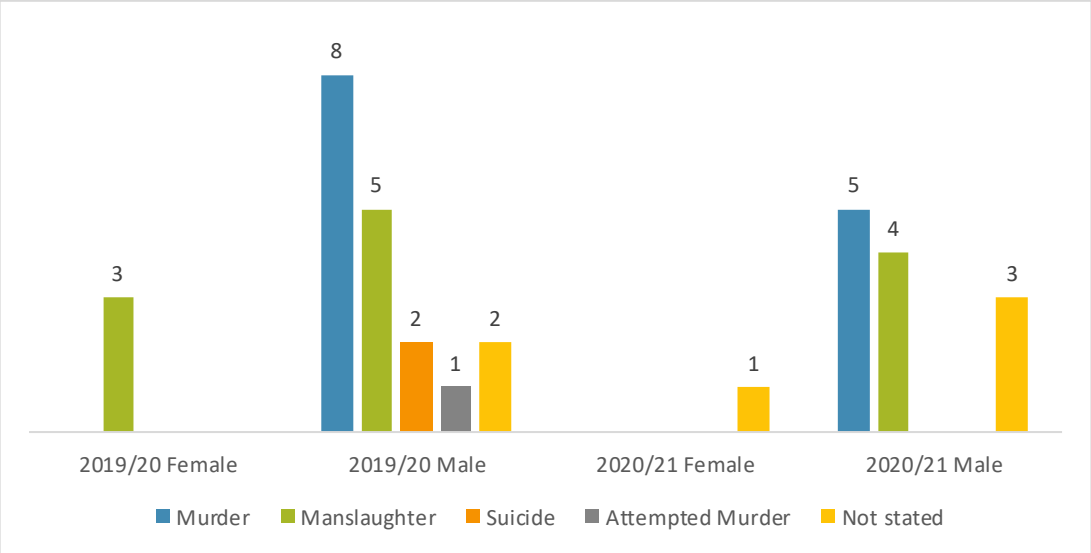
ONS data across England and Wales to year ending March 2020, identifies that the most common method of all killings continued to be by a sharp instrument. There were 275 homicides committed using a knife or other sharp instrument recorded in the year ending March 2020, an increase of 6% compared with the previous year. This was the second highest annual total seen since the Homicide Index began in 1946, and six fewer than the peak in year ending March 2018.

The data in this report corroborates with ONS data, where 14 out of the 35 homicide reports, detail stabbing as the method of homicide (40%).

Theme 7: Criminal justice outcome

Graph 16 highlights the criminal justice outcome for the male/female perpetrator

Figure 16: Post-homicide perpetrator outcome



In 2019/2020 the above highlights that male perpetrators were, in the main, convicted of murder. All three females were found guilty of manslaughter by diminished responsibility.[6]

In 2020/2021 the majority of male perpetrators were convicted of murder (5/13), with (4/13) being convicted of manslaughter by reason of diminished responsibility. There was no perpetrator outcome provided in 4/13 reports.

It is not possible to make direct comparisons with the ONS and the RIITs data, as the manslaughter data is inclusive of all three categories under section 2 of the Homicide Act 1957.

[6] Manslaughter can be committed in one of three ways:

- Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
- Conduct that was grossly negligent given the risk of death, and did kill ('gross negligence manslaughter').
- Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ('unlawful and dangerous act manslaughter').

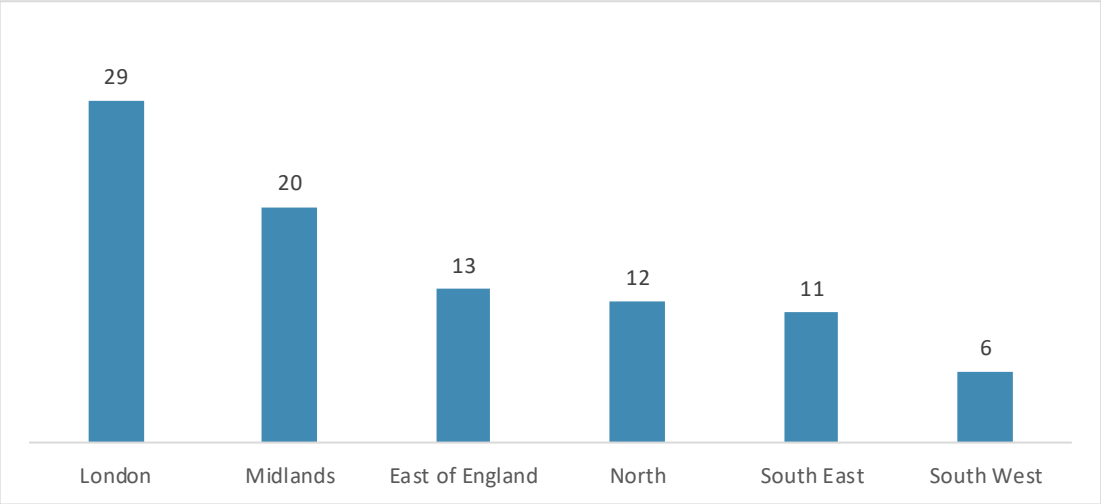
6.6 StEIS notification data April 2020 – March 2021

The following data provides an overview of StEIS notifications categorised as apparent/actual/suspected homicide, during the period 1 April 2020 to the 31 March 2021.

6.6.1 Reporting region

At the point of data extraction there were a total of 91 SI apparent/actual/suspected homicide notifications made on StEIS, between April 2020 and March 2021. London reported more notifications than the other regions, this in line with previous reporting.

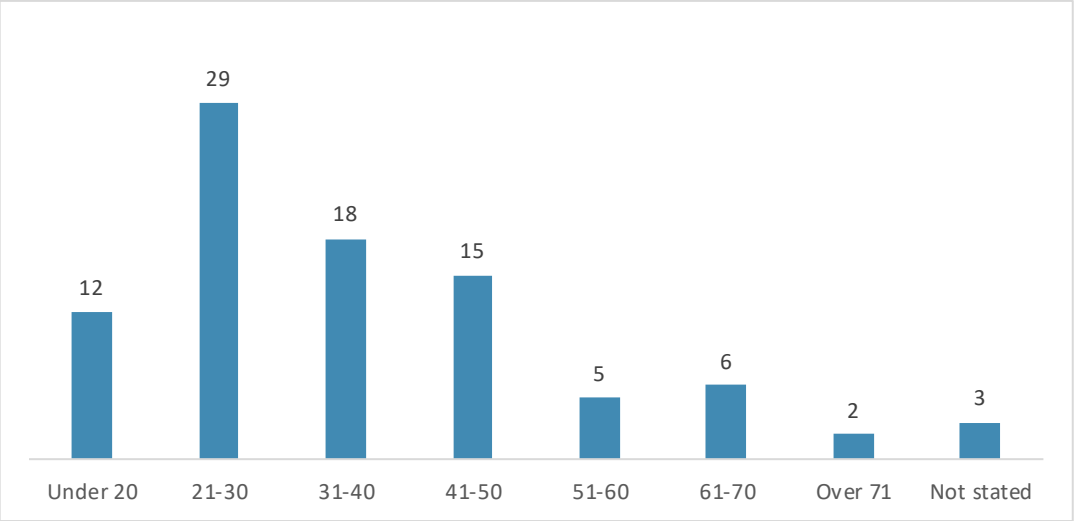
Figure 17: Reporting region 2020/2021



6.6.2 Age of perpetrator

The most prevalent age of perpetrator notified, was age range 21-30.

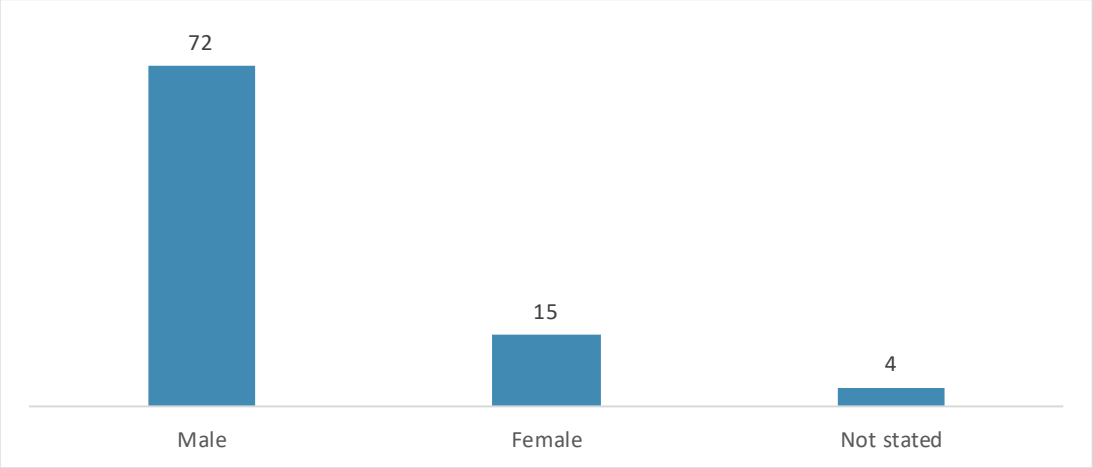
Figure 18: Perpetrator age 2020/2021



6.6.3 Gender

79% of all perpetrators were male, with 16% female and 4% not stated.

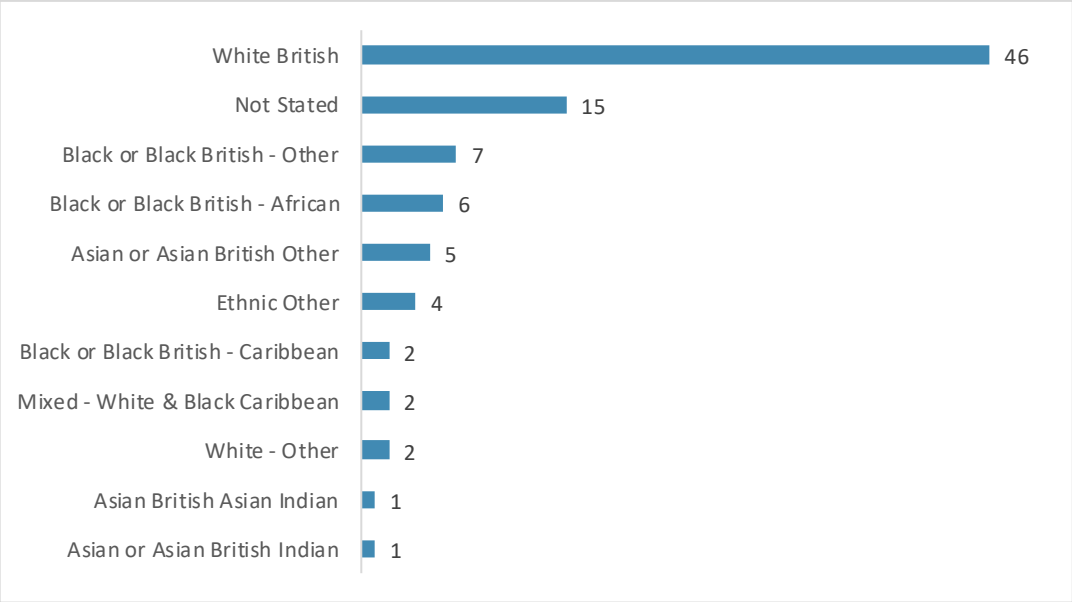
Figure 19: Perpetrator gender 2020/21



6.6.4 Ethnicity

StEIS data indicates that 50% of all perpetrators were classified as White British.

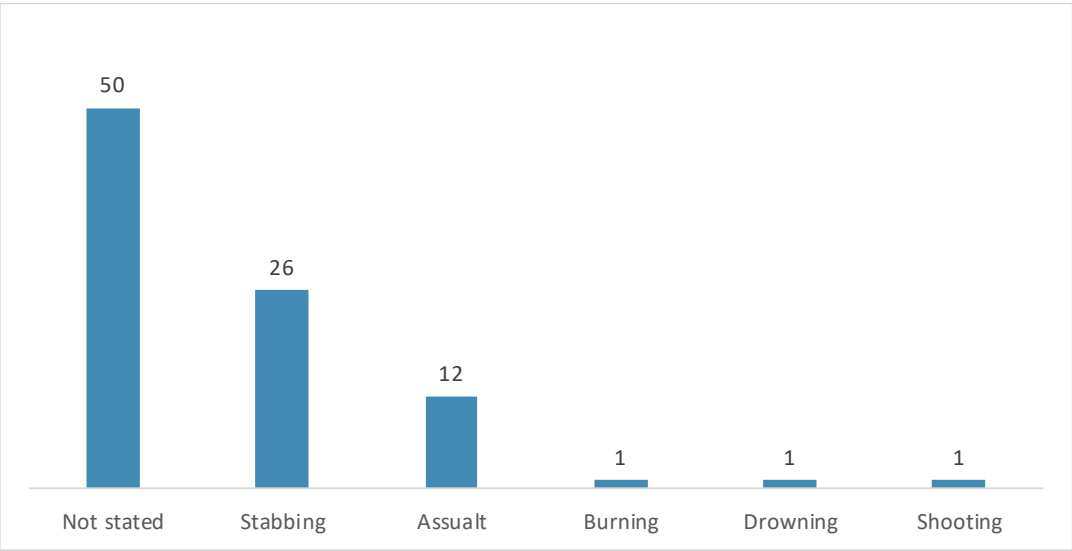
Figure 20: Perpetrator ethnic group 2020/2021



6.6.5 Method of homicide

In 55% of notifications, the method of homicide is not reported. In 29% of homicides the method is recorded as stabbing and in 13% recorded as assault.

Figure 21: Method of homicide 2020/2021



6.7 Themes and trends

Methods

The following section provides an overview of the methods used to analyse the homicide investigations.

6.7.1 Homicide investigations

There were 19 (2019/2020) and nine (2020/2021) published homicide reports included in this analysis. There were also two (2019/2020) and five (2020/2021) post-publication assurance reviews published during this timeframe, that were not included within this analysis. Quality assurance reviews (QARs) are to provide assurance that action plans have been acted upon and change to practice has been embedded within organisations.

6.7.2 Analysis methods

A qualitative and quantitative thematic analysis approach was taken to identify factors that might have contributed to the occurrence of homicides. In keeping with the NHS England Concordat on Human Factors in Healthcare, thematic analysis was undertaken using the Human Factors Analysis and Classification System (HFACS).[7]

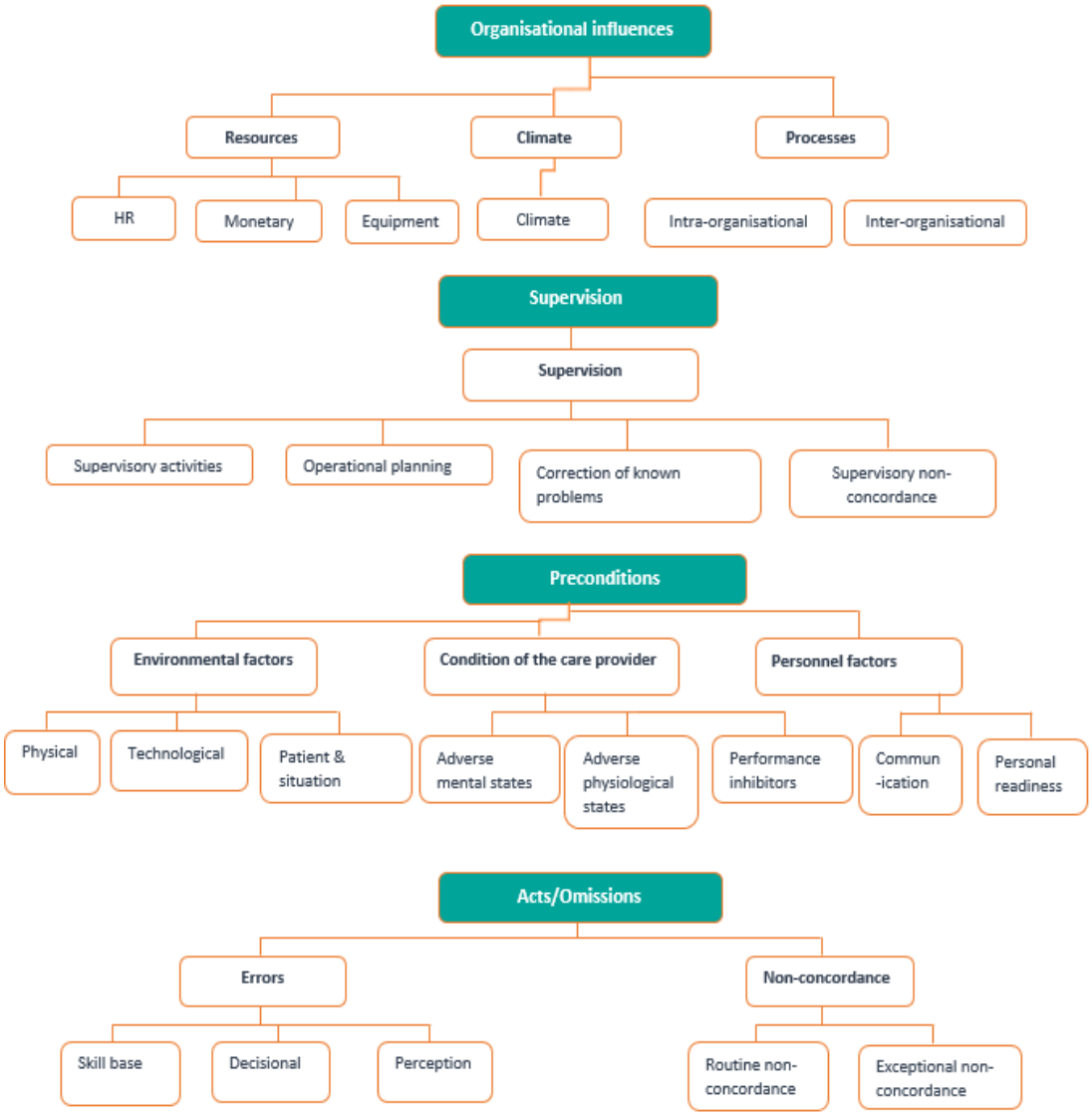
6.7.3 Introducing HFACS in mental health

HFACS[7] was first described as a safety management tool that helps to identify and record sources of error in organisational systems. HFACS helps organisations to systematically analyse and attend to issues that lead to harm.

Shale & Anderson-Wallace (2015) developed the version of HFACS used in this report following their retrospective review of 125 serious incident reports in four mental health trusts. The tool was further adapted by the authors of this report for homicide serious incidents eg inclusion of patient factors in the Historical Clinical and Risk Management (HCR-20).[8] HFACS will be used to analyse homicide reports to identify any trends in human performance and system deficiencies.

[7] Shappell, S. A. & Wiegmann, D. A. (2012). A human error approach to aviation accident analysis: The human factors analysis and classification system, Ashgate Publishing, Ltd.
[8] Douglas KS, Hart SD, Webster CD, Belfrage H. HCR-20v3: (2013).Assessing Risk for Violence: User Guide: Mental Health, Law, and Policy Institute, Simon Fraser University; 2013

Figure 22: HFACS



HFACS highlights four levels of potential error in an organisational system. It consists of a balanced scorecard of four levels and nine categories at the four levels, which map onto 23 sub-categories, these in turn correspond to more than 300 descriptions termed nano codes. Nano codes describe specific types of error, and facilitate database storage and analysis.

- **Level 4: Organisational influences** – human resource management, organisational climate and processes. These relate to the allocation of organisational assets, the prevailing atmosphere within the organisation and organisational decisions, eg operations and procedures.

- **Level 3: Supervision (middle management, clinical)** – supervisory activities, operational planning, correction of known problems and supervisory non-concordance. These relate to the provision of guidance and training by supervisors, non-correction of known problems, wilful disregard of rules and regulations by supervisors and unacceptable operations during business as usual, eg leadership of a community mental health team.

- **Level 2: Preconditions and situational factors** – Environmental, technological and behavioural preconditions (eg workplace design, interface with IT systems, team co-ordination and communication).

- **Level 1: Acts and omissions** – Acts and omissions are categorised as errors and non-concordance/violations and are proximate to the event. Errors are unintentional and predicated on skill base, decision making and perception.

Analysis of homicide data

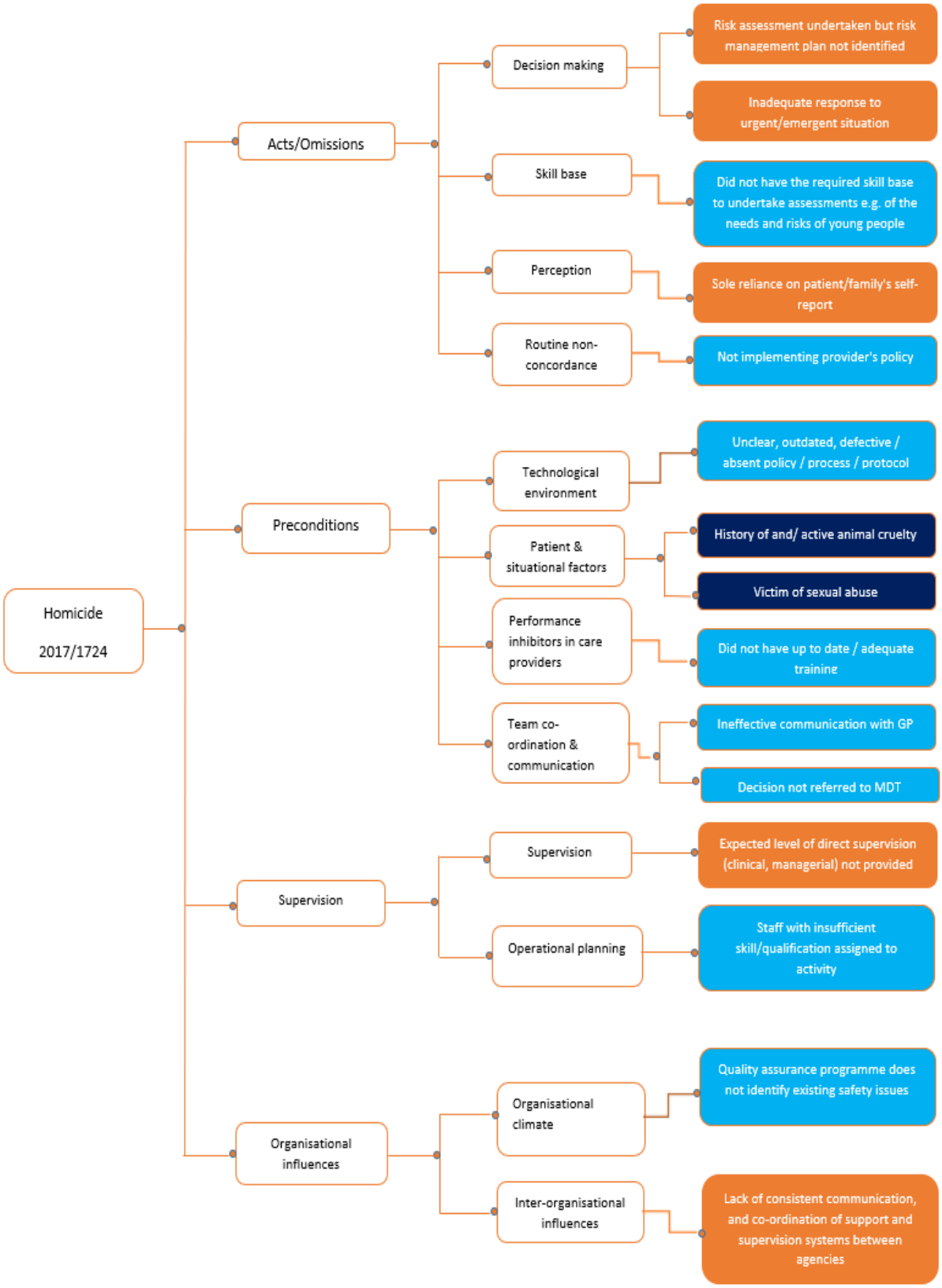
Figure 24 (below) shows an abbreviated example of HFACS applied to one of the homicide investigations. Overall, more than 360 factors ie nano codes were identified, and these are further categorised as either having a 'strong causal factor' in the incident, a 'contributing factor' or a 'risk factor'.

Causal and contributing factors are concerned with problems in care and service delivery that require rectifying. Risk factors relate to organisational risk factors present in that might, or might not have contributed to the occurrence of the incident.

Legend:

	Strong causal factors
	Contributory factors
	Risk factors

Figure 23: Abbreviated example of HFACS applied to NHS England and NHS Improvement homicide investigations



6.7.4 Using HFACS to explore homicide reports

Figures 25 and 26 below show the total number and percentage of factors identified within each report and at which level these occurred. The categorisation is reflective of a retrospective review of incidents investigated through root cause analysis (RCA). Some of the reports reviewed do not always identify all the human factors that HFACS might identify. In mitigation, the reports analysed in this report resulted from independent investigations, which, in general, provide more detailed analysis than provider root cause analysis reports. Given the above, the themes identified in the analysis are tentative.

Figure 24: Total number of factors

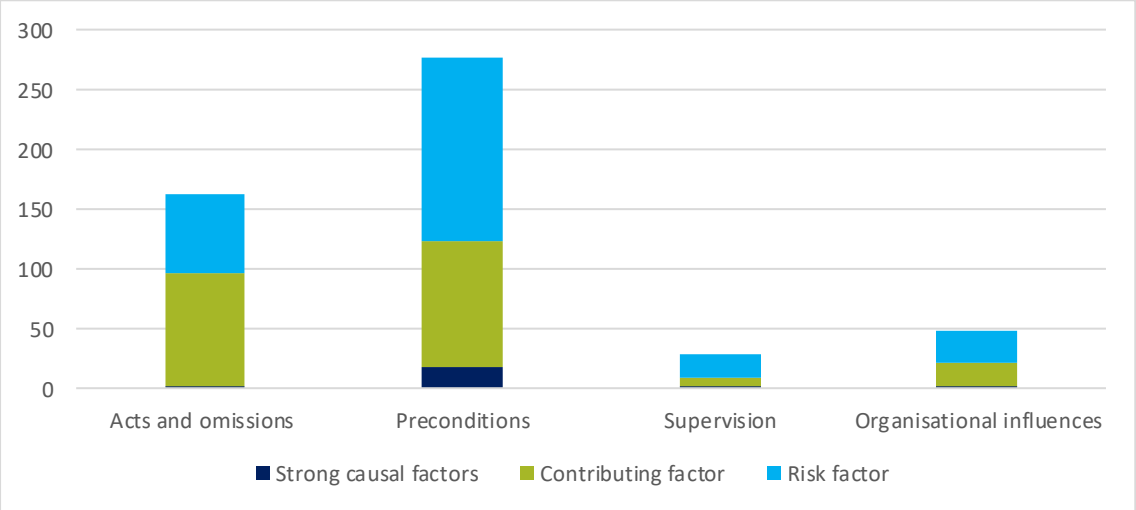


Figure 25: Total percentage of factors

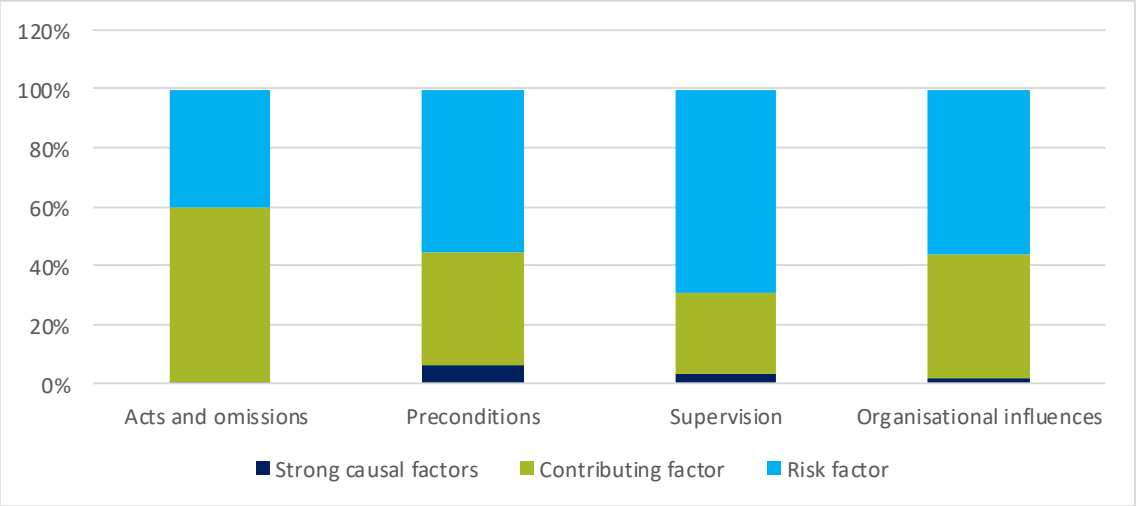


Figure 26: Organisational influences

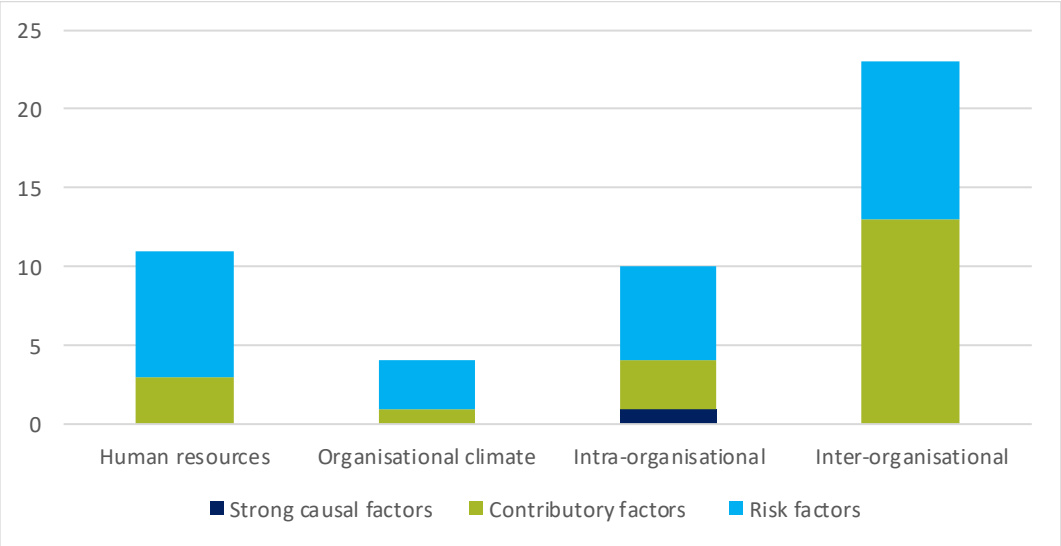
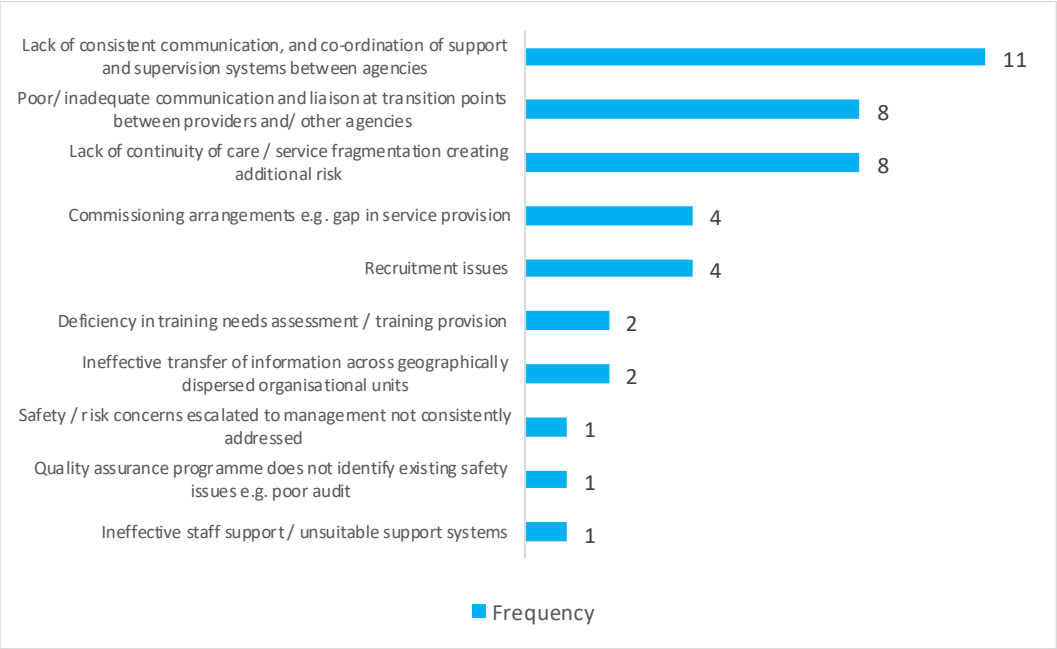


Figure 27: Organisational influences nano-code frequency



Figures 27 and 28 show organisational influences are dominated by inter-organisational factors at the contributory factors level. The most frequent factors ie nano codes are:

- Lack of consistent communication, and co-ordination of support and supervision systems between agencies.
- Poor/ inadequate communication and liaison at transition points between providers and/ other agencies.

- Lack of continuity of care/service fragmentation creating additional risk.
- Commissioning arrangements eg gap in service provision & recruitment.

Figure 28: Supervision

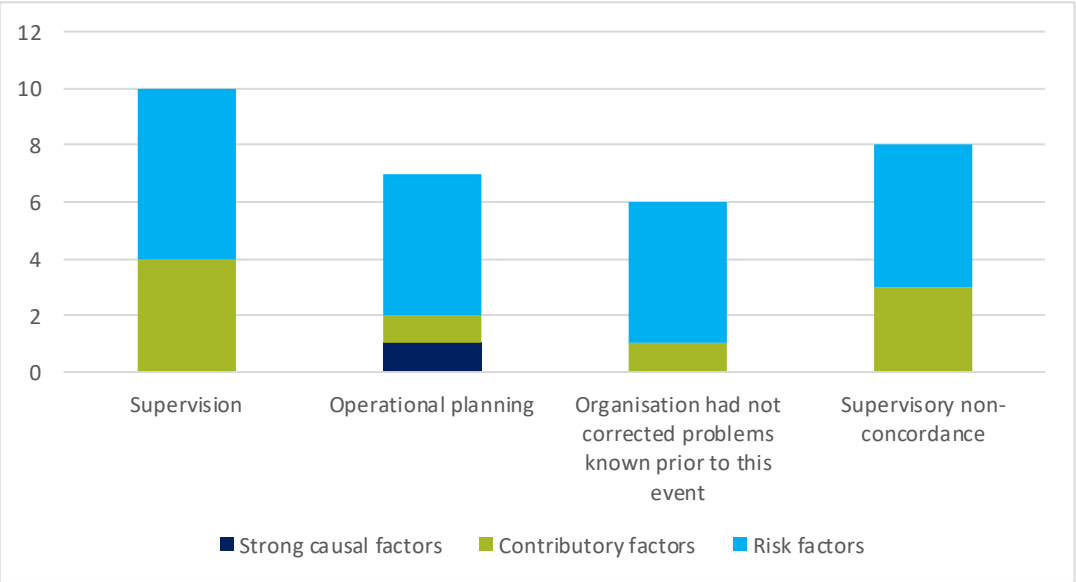
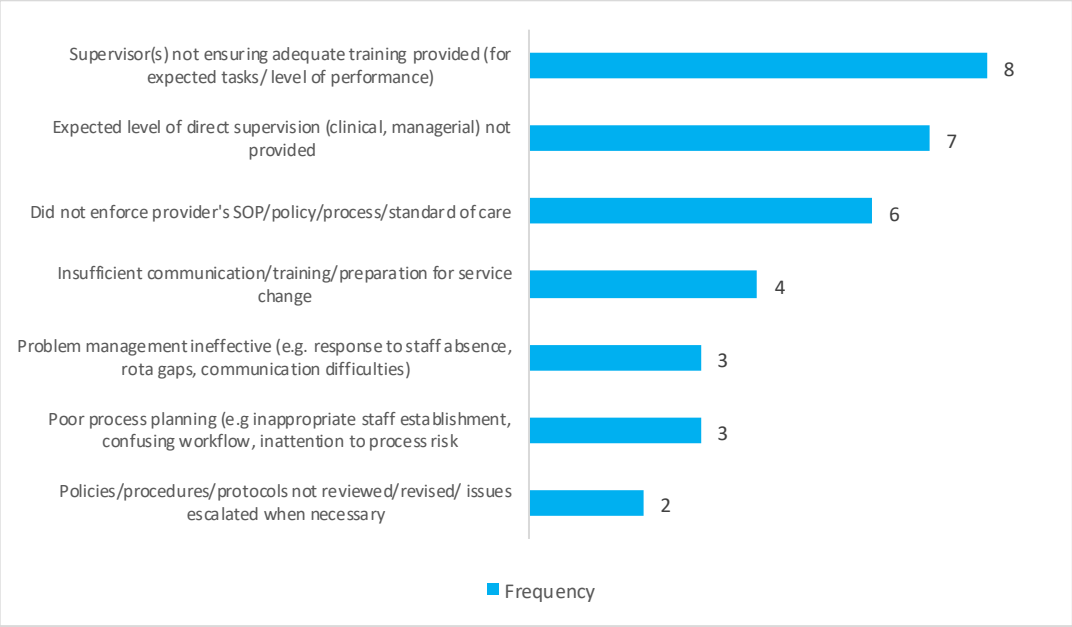


Figure 29: Supervision nano-code frequency



Figures 29 and 30 show supervision risk factors as most prominent. Notable supervision factors relate to:

- Supervisor(s) not ensuring adequate training provided (for expected tasks/level of performance)

- Expected level of direct supervision (clinical, managerial) not provided
- Not enforcing provider's standard operating procedure/policy/standard of care.

The sole strong causal factor relates to:

- Lack of continuity of care/service fragmentation creating additional risk.

Figure 30: Preconditions

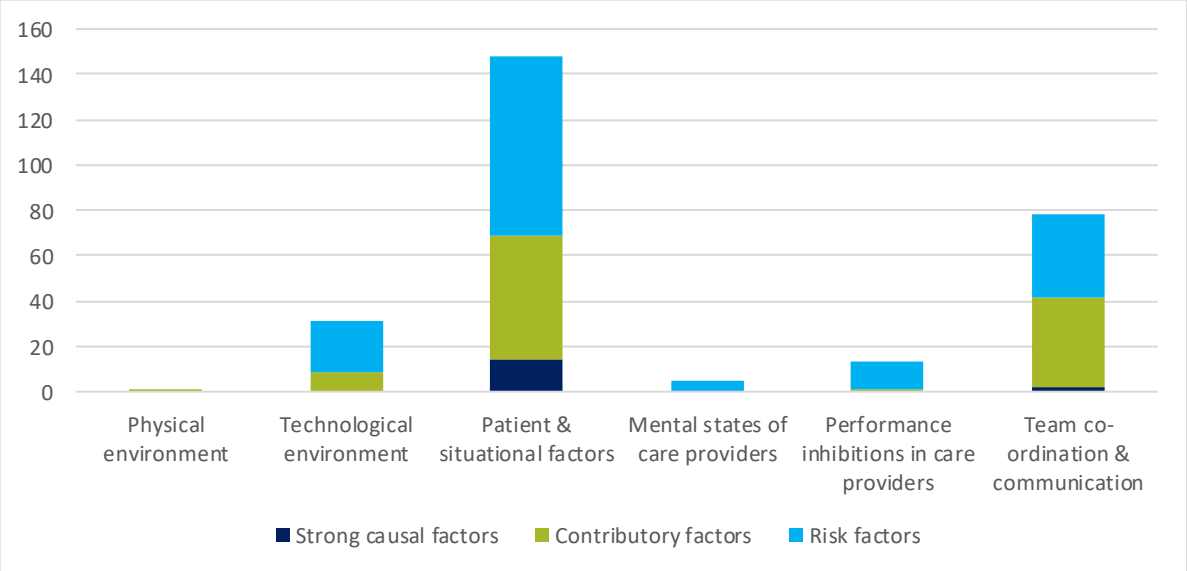
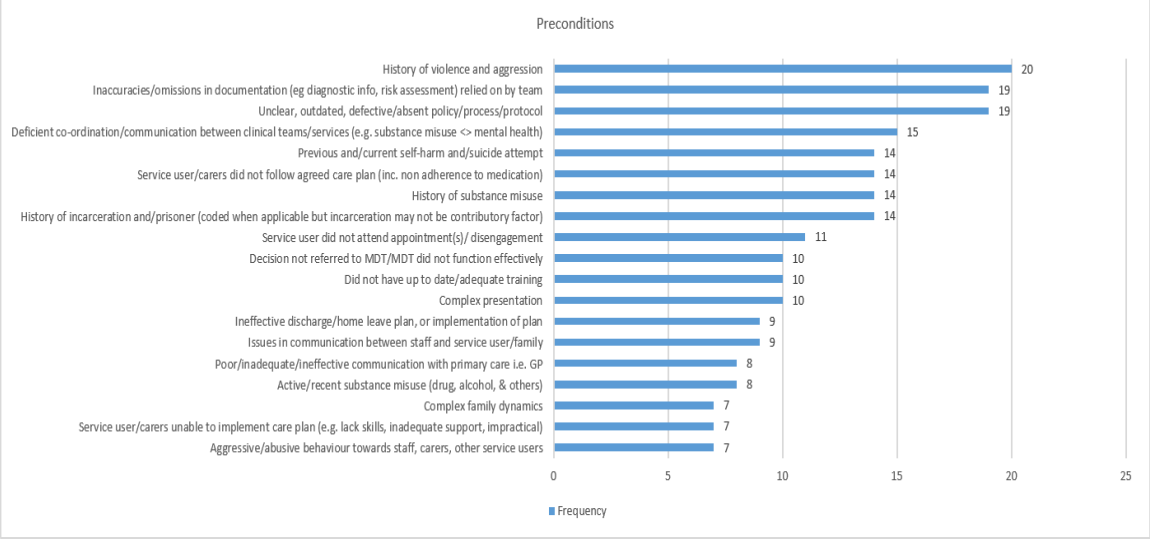


Figure 31: Preconditions nano-code frequency



Figures 31 and 32 show patient and situational factors are most prominent at the contributory factors level. Figure 31 is notable for strong causal factors. Analysis of the nano-codes shows the most prominent are:

- History of violence and aggression.
- Previous and/current self-harm and/suicide attempt.
- History of incarceration and/ prisoner (coded when applicable but incarceration may not be contributory factor) – as risk factor.
- History of substance misuse.
- Inability to follow care plan, eg non adherence to medication.

Notable strong causal factors, though not prevalent are:

- Relationship issues eg divorce, breakup, jealousy.
- History of violence and aggression.
- History of and/active animal cruelty.

Notable team co-ordination and communication factors are:

- Inaccuracies/ omissions in documentation (eg diagnostic info, risk assessment) relied on by team.
- Decision not referred to MDT/MDT did not function effectively.
- Deficient co-ordination/communication between clinical teams/services (eg substance misuse and mental health).

Notable technological environment factors, at the risk level are:

- Unclear, outdated, defective/absent policy/process/protocol
- Inadequate clinical tools eg risk assessment pro-forma.

Figure 32: Acts and omissions

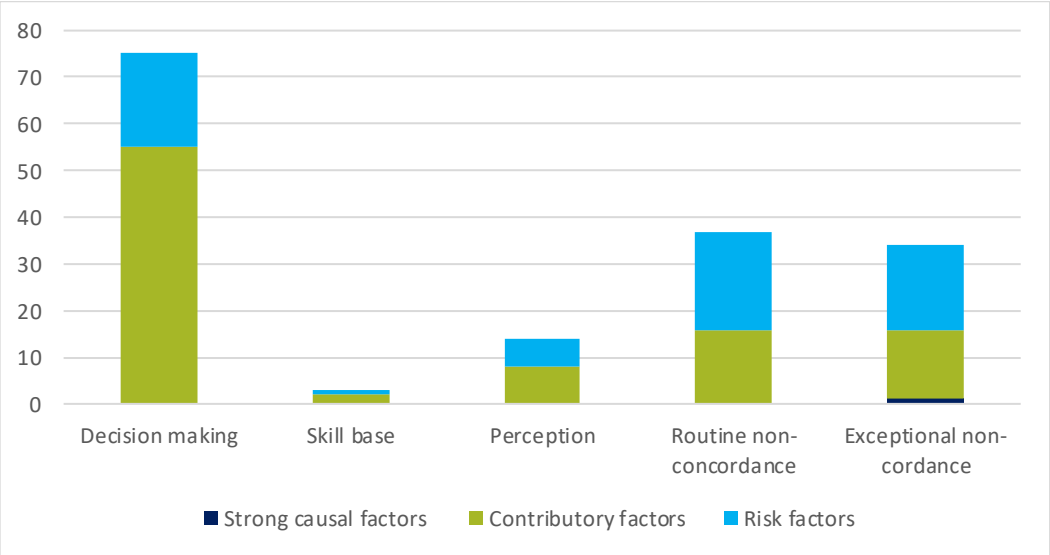
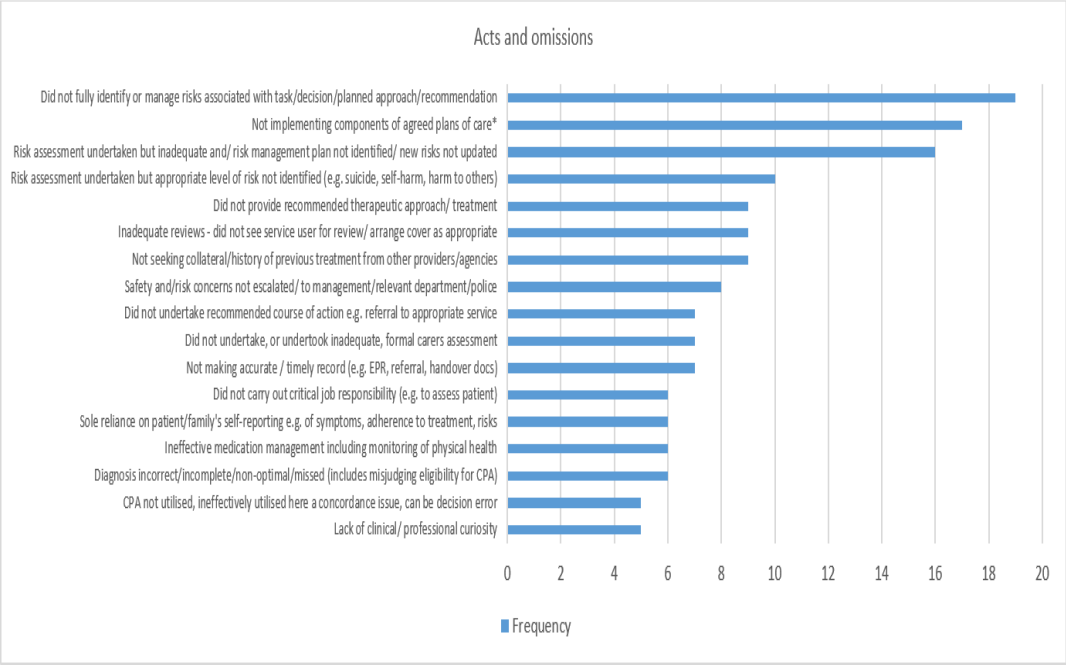


Figure 33: Acts and omissions nano-codes



Figures 33 and 34 show decision making is most prominent as a factor at the contributory factors level in acts and omissions. The most prominent factors include:

- Risk assessment undertaken but inadequate and/ risk management plan not identified/ new risks not updated

- Risk assessment undertaken but appropriate level of risk not identified (eg suicide, self-harm, harm to others)
- Did not fully identify or manage risks associated with task/decision/planned approach/recommendation.

Routine concordance factors include:

- Not implementing provider's policy/process/standard of care
- Not seeking collateral/history of previous treatment from other providers/agencies.

HFACS conclusions

The graphs above show most risk and contributory factors were found to have occurred at the acts and omissions level. Where no or few factors are identified against specific sub-categories or nano codes, it should not be interpreted that these factors do not exist, but simply reflective of the methodology, quality and content of the investigation reports.

Shale & Anderson-Wallace (2015) found reports were short on information about supervision (middle management level). This finding is reflected in this review. Patient factors were most prevalent at the preconditions level and had the most causal factors. This suggests providers ought to pay careful attention to patient factors and methods to mitigate against some of the risks. As the acts and omissions nano codes show, factors relating to risk management were most prominent. These findings align with risk and contributory factors at the organisational level.

To improve knowledge of systemic patient safety risks, underlying contributory factors, and inform decision making to improve patient safety, NHS England and NHS Improvement commissioned homicide independent investigations, investigation reports should meet a minimum set of standards.

Such standards should align with methodologies best suited to uncovering systemic issues and risk factors in the long term in, eg HFACS.

7. RIITs activities 2019/2021

Financial Year 2019/2020

London

Activities included a multi-agency event held in July 2019, to develop a London-wide Memorandum of Understanding (MoU) for the early consideration of joint statutory investigations following a homicide, where a patient was receiving secondary mental health services. The MoU has been drafted, delay in sign off has been as a result of the COVID-19 pandemic.

NHS England and NHS Improvement, London scheduled a multiagency young person's conference. A key objective of this event was to provide an environment for a range of stakeholders to reflect on current practice and work collaboratively to identify how services can meet the needs of young people, with an additional focus on how sustainable improvements in the management of risk can be achieved across London. This event was initially postponed due to the impact of COVID-19 global pandemic, and unfortunately has subsequently been cancelled.

Midlands and East of England

During 2019/2020 the IIRG formally separated to form two separate regional review groups. The separation and establishment of the new review groups affected the ability to commission new cases.

North

Across 2019/2020 pan-North regional team activity centred on the commissioning and delivery of educational and learning opportunities aimed at improving provider and commissioner responses to the various components and requirements of robust patient safety incident investigations (including mental healthcare related homicides). As a result of COVID-19 challenges and resultant government restrictions, delivery of this training and education was converted to a comprehensive e-learning package.

South

The significant activity for the South region during this period, was supporting delivery of six Making Families Count Conferences, to a range of providers and commissioners across England.

Financial Year 2020/21

London

During 2020/2021 the pandemic had a significant impact across the region. The decision to commission an investigation is made by the London IIRG. Since the declaration of COVID-19 as a Level 4 national incident, the regional IIRG was suspended and did not reconvene until September 2020. However, a small panel did convene once to consider previous IIRG decisions to ascertain if further investigation was required.

Due to the scale of the impact of COVID-19 in London, the RIIT were redeployed to support the NHS systems. Therefore, the commissioning of new independent investigations was suspended, ongoing investigations continued but at periods had to cease due to the impact on services. Publications did continue but a proportionate position was taken at any given time and families and stakeholders were kept informed. This approach was endorsed by the London Regional Executive.

The commissioning and publishing of independent investigations has since recommenced.

Midlands

During 202020/21 within the Midland region the ability to progress investigations was severely affected by the COVID-19 pandemic, additionally staff were redeployed to support the response to the pandemic. When possible, ongoing investigations were progressed, commissioning of new investigations was paused apart from a very high-profile case involving multiple stabbings.

East of England

During 2020/2021 within the East of England region the ability to progress investigations was severely affected by the COVID-19 pandemic, additionally staff were redeployed to support the response to the pandemic. When possible, ongoing investigations were progressed and commissioning of new investigations was paused.

North

Across 2020/2021, the North Pan-Regional Investigations Team activity was primarily concerned with maintaining a business as usual position, while supporting

NHS England and NHS Improvement, COVID 19 related regional activities. Transition of the independent investigations function to the North West region began in January 2021 reflecting separate regional footprints, with North East and Yorkshire support and subject matter expertise available until September 2021. The e-learning educational programme 'Investigating well' commenced in January 21 and will conclude Q2 2021.

South

Regional team activities beyond core business were reduced due to the pandemic and there were limited opportunities to work with providers and commissioners. The South region provided two webinars 'Learning from Mental Health Homicide Reviews': one to a provider organisation and the other to a Forensic Psychiatry Academic Programme. The region also contributed to a provider led thematic review of 5 reported homicide incidents to identify any immediate opportunities for learning. The region continues to work with Making Families Count Programme and has supported the transition to online training and webinars, to be delivered in 2021/2022.

8. Regional governance arrangements (IIRG)

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

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

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

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

Table 8: Details of IIRG decisions 2019/20

	Decision to commission criteria met	Decision to commission wider principles of SIF	Decision to commission criteria not met
London	7	0	8
North East and Yorkshire	7	3	15
North West	1	6	17
Midlands	2	0	8
East of England	2	0	9
South East	3	0	4
South West	3	0	3

London

15 cases were considered by the London IIRG of which seven cases were considered to meet the criteria, one joint mental health homicide independent investigation/SAR and one joint mental health homicide/DHR. The remaining eight cases were considered not to meet the criteria for an independent investigation due to the following:

- The perpetrator had not been in receipt of mental health services.
- The incident did not meet the SIF criteria.

North

One investigation system wide was commissioned in the North East and Yorkshire Region which was initiated by the Chief Nurse and subsequently endorsed by the IIRG.

Three investigations commissioned in the North West Region were system wide investigations (x1 commissioned by the Chief Nurse, x1 commissioned under the directive of NHS England and NHS Improvement Chief Executive Officer and x1

under the directive of the Secretary of State), rather than were decisions made by the IIRG.

All investigation reports produced for both the North East and Yorkshire and North West Regions are taken to the IIRG for a decision regarding the level of publication, based upon the circumstances of the case and the family considerations.

One investigation report was not published following consideration of the circumstances and decision by the IIRG (North East and Yorkshire).

One assurance review report was not published following consideration of the circumstances and decision by the IIRG (North West).

Midlands

Ten cases were considered by the Midlands IIRG, of which two cases were considered to meet the criteria, one of which was a joint independent investigation with the DHR, the other was an independent investigation. The remaining eight cases were considered not to meet the criteria for an independent investigation due to the following:

- The perpetrator had not been in receipt of mental health services.
- The incident did not meet the SIF criteria.

A publication was considered by the IIRG and approved for full publication of the report.

East of England

Eleven cases were considered by the East of England IIRG, of which two cases were considered to meet the criteria, both of which were joint independent investigations with the DHRs. The remaining nine cases were considered not to meet the criteria for an independent investigation due to the following:

- The perpetrator had not been in receipt of mental health services.
- The incident did not meet the SIF criteria.

There was one independent investigation publication approved during 2019/2020 and one assurance review.

South

All publications were reviewed by the South IIRG and decisions were taken to publish the full reports in each case. The South commissioned six reviews including one to run concurrently with an SCR, one QAR building on a provider's independent Level 2 report and one independent investigation following a 'near miss' serious incident. The IIRG reviewed seven cases that did not meet criteria for review (either charges were not bought against the alleged perpetrator or cause of death was not deemed to be a homicide by the coroner or local police force).

Table 9: Details of IIRG decisions 2020/2021

	Commission criteria met	Commission wider principles of SIF	Commission criteria not met
London	3	0	12
North East and Yorkshire	1	0	10
North West	4	1	8
Midlands	2	0	14
East of England	5	0	6
South East	1	0	8
South West	3	1	3

London

Five cases previously agreed by London region IIRG in 2019/2020 were reviewed in an exceptional meeting by a panel, to consider if an independent investigation would be appropriate and/or a proportionate way forward to ensure rapid learning during the NHS response to the COVID-19 pandemic. These cases were awaiting an ITQ prior to the pandemic. In four of these five cases a new decision not to commission was agreed and are included in the 12 for decision to commission criteria not met.

North

All investigation reports produced for the North East and Yorkshire and the North West are taken to the IIRG for a decision regarding the level of publication, based upon the circumstances of the case and the family considerations.

One non-MHH assurance review was commissioned, of an independent investigation that had been commissioned by a CCG following a family complaint. The assurance review was not published. Two Decisions were made by the IIRG following consideration of the circumstances, to publish an executive summary in

lieu of the full independent investigation report (x1 North East and Yorkshire and x1 North West).

The IIRG formally separated into the two North regions (North East and Yorkshire and North West) in December 2020.

Midlands

Sixteen cases were considered by the Midlands IIRG, of which two cases were considered to meet the criteria. The remaining fourteen cases were considered not to meet the criteria for an Independent Investigation.

East of England

Eleven cases were considered by the East of England IIRG, of which five cases were considered to meet the criteria. The remaining six cases were considered not to meet the criteria for an independent investigation.

South

There were a significant number of incidents initially reported as mental health homicides that did not, following further review by providers or decision making within the criminal justice system, meet the criteria for NHS England and NHS Improvement commissioned review. Several of those incidents did go on to meet the criteria for other statutory reviews, in particular DHRs.

The single commissioned review under the wider principles of the SIF is a multiagency review where no single agency had clear responsibility for the perpetrator. NHS England and NHS Improvement took the decision that leading on the review in partnership with the local safeguarding adults board would be the most pragmatic approach to identify early learning for all agencies.

9. National governance arrangements

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

The IIGC meets on a quarterly basis and reports into the Executive Quality Group, a sub-group of the board. The committee is jointly chaired by the regional chief nurse, (London) who is the senior responsible officer for mental health homicides, and a lay member.

The IIGC commissioned an independent review of the independent investigations for mental health homicides in England (published and unpublished) from 2013 to 2019. The review was received and accepted by the IIGC in 2019. The purpose of this review was to provide NHS England and NHS Improvement with a credible, objective and impartial blueprint for change and service improvement; and to ensure themes and learning from investigation reports are subsequently transferred and utilised by relevant national mental health programmes.

The review was inclusive of the needs and involvement of victims' families and perpetrators' families and explores the degree of support they receive. The report made nine recommendations which are embedded into the national annual work plan.

10. Finance

The national independent investigations budget is held centrally within the Operations and Delivery Directorate. The budget for this work programme has been revised since the original allocation of £3.2 million in 2013 due to fluctuations in yearly committed spend resulting in both underspend and overspend in subsequent financial periods.

Financial Year 2019/20

The budget for 19/20 was £1.2 million and represents a reduction of £1.1million from the budget set in 2018/19. The current budget for 2020/2021 is £1 million. Budget planning is based on an assumed average cost of £23,530 per investigation; however while this is calculated centrally by financial review and consideration of the numbers of pending investigations to be commissioned, RIITs are experiencing an upward trend in individual case costs, which is directly related to the nature and complexity of specific cases.

Legal costs associated with each case are generally reflected within overall investigative costs, however, occasionally legal costs may be significantly increased for individual complex cases, for example where senior partner or barrister

representation is required to represent the interests of NHS England in discharge of its independent investigation responsibility. Increased legal costs associated with the review of non-homicide system wide investigations is expected due to the complex nature of the investigations which will require senior legal consideration.

Table 10: Investigations and legal fees, financial year 2019/2020

	North East and Yorkshire	North West	East of England	Midlands	London	South
Number of commissioned investigations	7	8	5	2	4	6
Total agreed fee for investigations commissioned	£302,296.00	£486,177.00	£86,756.00	£38,850.00	£75,600.00	£165311.70
Total legal fees paid	£5,380.00	£3,651.00	£6,608.00	-	-	-
Total	**£307,676.00**	**£489,828.00**	**£93,364.00**	**£38,850.00**	**£75,600.00**	**£165,311.70**
Average fee agreed per investigation	£43,185.14	£60,772.13	£17,351.20	£19,425.00	£18,900.00	£27,551.95

Table 11: Investigations and legal fees, financial year 2020/2021

	North East and Yorkshire	North West	East of England	Midlands	London	South
Number of commissioned investigations/ assurance reviews	5	3	2	2	0	4
Total agreed fee for investigations commissioned	£165,230.00	£207,218.00	£52,679.00	£118,465.00	-	£191,783.00
Total legal fees paid	£7,000.00	£2,500.00	£4,000.00	£2,400.00	£5,739.00	-
Total	**£172,230.00**	**£209,718.00**	**£56,679.00**	**£120,865.00**	**£5,739.00**	**£191,783.00**
Average fee agreed per investigation	£33,046.00	£69,072.67	£26,339.50	£59,232.50	-	£47,945.75

11. Regional and national priorities

National work programme

Due to impact on the NHS from COVID-19 the national work programme was temporarily suspended but has since recommenced.

The IIGC commissioned and published an external review of regional processes, independent investigative outputs and findings from investigations in 2019. Recommendations arising from this review were included in the national work plan which subsequently informs regional work programmes, the national work plan is monitored by the IIGC.

RIITs continue to work to regional programmes aligned to the national work programme deliverables and in response to the NHS Long Term Plan.

- **Strategic Objective 1: National and regional governance:**

We will strengthen and improve the governance infrastructure nationally and make the appropriate linkages with other national programmes of work.

We will build on existing regional governance, using data to identify areas of unwarranted variation and highlighting best practice.

We will identify key issues for escalation to relevant senior boards and committees and the Quality Assurance Group and ensure timely interventions and responses

- **Strategic Objective 2: Learning and Prevention:**

We will reduce the risk of future deaths by maximising learning from any system, policy or practice issues or omissions to ensure they are not repeated across the system.

We will identify and share good practice across all regions.

- **Strategic Objective 3: Working with key stakeholders:**

We will work with key partners, internal or external of the NHS and have clear and robust channels of communication.

In addition to the national work programme requirements, regional priorities to be delivered in year (2021/2022) are:

- To support regional recovery programmes following the pandemic
- To support integrated care systems (ICS) to identify effective mechanisms in ensuring that learning opportunities identified from investigations are used in full.

- To ensure that provider collaboratives are engaged in the commissioning and learning from independent investigations.
- To support providers to improve the level of insight and knowledge around investigatory processes (including robust investigative methodology and measurable action planning).
- To support CCGs to ensure they are equipped to support the improvement of the quality of provider action plans and subsequent assurance of recommendation implementation.
- Continue to improve the experience of affected families and reduce the impact where possible of the investigation process.
- Measure the effectiveness of collaborative and joint investigations in terms of stakeholder, family satisfaction and added value.
- Consult on and develop operational principles of collaborative and joint investigations with regional NHS stakeholders.
- Consideration on how the RIITs align with the National Patient Safety Strategy and Patient Safety Incident Response Framework.

12. Risks and mitigation

Financial year 2019/2020

There were five risks on the IIGC register as at the December 2019 IIGC. Note – there was not another meeting until the next financial year due to the COVID-19 impact, as the March 2020 IIGC meeting was cancelled.

These risks are owned at a national level; they have actions to mitigate and are monitored via this governance committee on a quarterly basis. Actions to mitigate the risks are incorporated within the annual work plan of the IIGC.

The risks identified are:

- That unwarranted variations will exist within national and regional governance processes leading to inconsistency of approach and inefficient national oversight, monitoring and timely intervention.

- That there will be ongoing gaps in care pathways due to ineffective learning from completed investigations and lack of implementation of changes to regional and national policy and process.

- There is a lack of suitable independent investigation providers bidding for independent investigation work. There is a risk that this could result in lack of high-quality independent investigations being undertaken due to lack of choice and expertise.

- There is a risk associated with NHS organisational change and the alignment of NHS England and NHS Improvement and work being taken forward to strengthen sustainability and transformation plan (STP) and ICS arrangements. The IIGC needs to ensure that there is continued focus on robust governance arrangements with strong oversight of independent investigations and that there is the most effective multi-agency communication and collaborative working.

- There is a risk that we do not work effectively with key partners, internal or external of the NHS that enable timely responses to improve experience, safety and quality.

Financial year 2020/2021

There were five risks on the IIGC register as at the March 2021. The risks identified are:

- That unwarranted variations will exist within national and regional governance processes leading to inconsistency of approach and inefficient national oversight, monitoring and timely intervention.

- That there will be ongoing gaps in care pathways due to ineffective learning from completed investigations and lack of implementation of changes to regional and national policy and process.

- There is a risk that we do not work effectively with key partners, internal or external of the NHS that enable timely responses to improve experience, safety and quality.

- There is a risk that there will be a delay in investigations being commissioned due to investigation companies not bidding for this work, despite an increased number of companies being part of the framework agreement. There is a current backlog of cases waiting to be commissioned. Delays in the publication of investigation reports affects

potential improvement work and is a reputational risk to the work of the IIGC and independent investigation processes.

- There is a risk associated with NHS organisational change and the alignment of NHS England and NHS Improvement and work being taken forward to strengthen STP and ICS arrangements. The IIGC needs to ensure that there is continued focus on robust governance arrangements with strong oversight of independent investigations and that there is the most effective multi-agency communication and collaborative working.

13. Summary

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

HFACS analysis shows most risk and contributory factors were found to have occurred at the acts and omissions level, in particular factors relating to risk assessment and management. Analysed reports were short on information about supervision (middle management level). The prevalence of patient factors suggests providers ought to pay careful attention to patient factors and methods to mitigate against some of the risks through robust risk management strategies.

14. Recommendations

The IIGC is asked to endorse the report.

1. NHS England and NHS Improvement IIGC is requested to note the independent investigations Annual Report 2019/2021 and to consider the national and regional independent investigation priorities for 2021/2022 as detailed above.

2. NHS England and NHS Improvement to consider the findings of this report as part of the NHS Long Term Plan.

3. Clear links should be established between patient safety risks and actions arising from investigations, in quality improvement projects/processes.

4. To improve knowledge of systemic patient safety risks, underlying contributory factors, and inform decision making to improve patient safety, NHS England and NHS Improvement commissioned independent investigation reports should meet a minimum set of standards. Such standards should align with methodologies best suited to uncovering systemic issues and risk factors in the long term, eg in HFACS.

5. Providers and commissioners should be reminded of the importance of timely accurate data entry and consistent field selection when reporting via StEIS, to facilitate meaningful data extraction.

6. Providers and commissioners are reminded of the importance of identifying ethnicity on STEIS.

Prepared by:

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- East of England Regional Independent Investigation team
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