

## **Independent investigation of adverse events in mental health services**

It is essential that all adverse health care events are reviewed in such a way that lessons can be learnt (An [Organisation with a Memory](#) and [Building a Safer NHS](#)).

This guidance replaces paragraphs 33 –36 in HSG (94) 27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.

### **1: Commissioning**

The Strategic Health Authority (SHA) is responsible for commissioning independent investigations and consequently the reports generated are the property of the SHA. Commissioning in this context refers to determining when an independent investigation is necessary, appointing an independent investigation team, agreeing terms of reference, publishing and distributing the resultant report and ensuring a process for subsequent action to address issues raised.

SHAs, Primary Care Trusts and Mental Health Trusts should come to local agreement with respect to arrangements for funding and supporting independent investigations.

If other agencies or partnerships will be carrying out investigations into the same event(s), eg in the case of a death of a child, then the agencies involved should consider if it is possible to jointly commission a single investigation process. This should help ensure that expertise is most appropriately used, duplication of process is minimised and inter-agency lessons learnt. In cases where joint commissioning occurs, then early agreement on funding arrangements should be made.

#### **Criteria**

An independent investigation should be undertaken in the following circumstances:

- when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- 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, 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.

- where the SHA determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

### Timing

The start of local investigation processes and publication of reports should take place as soon as possible after the adverse event. In circumstances where police investigations or other legal proceedings are ongoing, then the timing for these processes should be agreed with the local police or Crown Prosecution Service to ensure that the legal process is not undermined in any way, but that local NHS investigations can proceed as soon as possible.

Where appropriate, early contact with the coroner is advisable to help determine the scope and timing of local investigations with respect to the inquest process.

### Joint working

In circumstances where other agencies or organisations, such as the police, Health and Safety Executive (HSE) or Local Safeguarding Children Boards are involved, then an early meeting with relevant senior health, local government, police or HSE officials should take place to agree an approach to:

- the timing of investigations;
- sharing of information, including issues of confidentiality;
- communications with families, carers, staff and media.

A Memorandum Of Understanding between the police, HSE and NHS, which will help support this process, is due to be published in Summer 2005. (For further information email Mike Evans at [mike.evans@dh.gsi.gov.uk](mailto:mike.evans@dh.gsi.gov.uk)).

Whenever possible agencies should collaborate to ensure that there is a coordinated process for establishing investigations and acting on recommendations that they make.

## **2: Investigation Process**

- Initial management review.

In all adverse events, a rapid (usually within 72 hours) internal service management review should take place. This should cover any necessary immediate action with respect to staff, safeguarding notes or equipment as evidence, changes in policies and procedures, changes to ensure safety

(such as ligature point removal), communication with relevant individuals and organisations and initial contact with carers and families.

- Internal NHS Mental Health Trust investigation

The management review will usually be followed by an internal Trust-led investigation, using an approach such as root cause analysis (RCA). This investigation should establish a clear chronology of events leading up to the incident; determine any underlying causes and whether action needs to be taken with respect to policies, procedures, environment or staff. The chronology, statements and report of any internal investigation should be made available to the independent investigation team. In situations where it is clear at the time of the adverse event that an independent investigation will be commissioned by the SHA then discussion and agreement between the Trust and the SHA should take place to establish the nature and scope of the internal Trust investigation to ensure that any duplication of investigation is avoided.

- SHA independent investigations

Independent investigations should be set up as soon as possible. Investigations should use a process, such as root cause analysis (RCA), which will facilitate:

- openness
- learning lessons
- creating change

#### Terms of reference

Clear terms of reference should be drawn up which should include review of care and treatment, including risk assessment and risk management, provided in the light of relevant legislation, local and national policies and agreed good practice. The scope of the investigation and therefore the terms of reference should draw on the findings of any relevant other investigations/reports/statements.

#### The independent investigation team

It is likely that the skills and expertise of the members of the independent investigation team appointed would include:

- relevant clinical, social care and managerial expertise;
- other expertise where appropriate eg housing or probation;
- investigation skills such as root cause analysis or similar;
- report writing skills;
- interviewing and communication skills.

In order to create independence and avoid any conflict of interest, no member of the investigation team should be in the employment of the organisation(s) subject to investigation.

Appropriate legal advice and project management should support the investigation team.

Service user consent should be gained for release of their clinical notes to the investigation team.

#### Publication and distribution of the report

The SHA and, where appropriate, other organisations should devise a clear communication and media-handling plan for the investigation report's findings and the actions to be taken in response to any recommendations made. When and how the findings are published should be clearly communicated to all stakeholders, including victim/s, perpetrator, families, carers and staff involved.

### **3: Victims, families and carers**

Local adverse event policies should specifically address the following issues in relation to victims, families and carers (of both victim and perpetrator):

- Communication:
  - appointment of a person from the Mental Health Trust to liaise with families and carers. This person should be of appropriate seniority and possess appropriate skills to enable them to act with openness and empathy.
  - action that could be taken if initial or further contact is turned down by the family eg further attempts at contact should be made even if initial contact is turned down, written contact could continue if face-to-face contact is not wanted or further liaison is through another party, such as the police family liaison officer or the SHA.
  
- Information sharing, including for instance:
  - details of the adverse event itself
  - the plans for investigation of the event, including in what way families and carers will be involved
  - legal proceedings
  
- Advice about and provision of support, this may include:
  - advocacy
  - mental health support eg counselling or bereavement services
  - other services, such as social care

Those responsible for communications with families and carers should take into account that the need for communication, information and support will vary between individuals and, for any given individual, may vary over time.

### **4: Staff and other service users**

Local adverse event policies also need to address the communication, information and support needs of staff and any service users affected by the adverse event.

## **5: Communications**

### Department of Health

All adverse events that are either attracting or likely to attract media interest should be reported to Department of Health via the following e-mailbox: [MB-Health-Alert@dh.gsi.gov.uk](mailto:MB-Health-Alert@dh.gsi.gov.uk). This mailbox should also be used for reporting all significant dates in relation to a mental health adverse event eg court appearances, dates of publication for reports etc including sufficient update briefing for media handling and ministerial briefing.

This mailbox is managed by Department of Health Communications and is regularly monitored by the Ministerial Briefing Unit (MBU).

### National Patient Safety Agency

Adverse events should also be notified to the NPSA through the National Reporting and Learning System (NRLS). Copies of independent investigation reports should be sent to the NPSA to allow national analysis of themes that may arise (email: [Kathryn.Hill@npsa.nhs.uk](mailto:Kathryn.Hill@npsa.nhs.uk)).

### The Healthcare Commission

The Healthcare Commission would be happy to receive copies of independent investigation reports.

### Commission for Social Care Improvement (CSCI)

Adverse events involving social care should be notified through local CSCI business relations managers.

### National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH)

Should be notified of suicides, unexpected deaths of inpatients and homicides by those in touch with mental health services.

## **6: Further information and advice**

Further information and advice about investigations and inquiries can be obtained from the Department of Health Investigations and Inquiries Unit – Elaine Edgar - email: [elaine.edgar@dh.gsi.gov.uk](mailto:elaine.edgar@dh.gsi.gov.uk))

Further information about root cause analysis (RCA) can be obtained from the NPSA (email: [Sally.Adams@npsa.nhs.uk](mailto:Sally.Adams@npsa.nhs.uk) – resource links [www.npsa.nhs.uk/sevensteps](http://www.npsa.nhs.uk/sevensteps) , [www.npsa.nhs.uk/rca](http://www.npsa.nhs.uk/rca))

In addition, the NPSA will be publishing an information pack to help support the commissioning and conduct of independent investigations.