

INDEPENDENT INVESTIGATIONS OF SERIOUS ADVERSE EVENTS IN MENTAL HEALTH SERVICES

1 Introduction

This briefing is to update the Board following the letter received from the NHS chief executive (Dated 4th July 2007-Gateway reference 8481) in relation to the commissioning of independent enquiries following an adverse event in mental health services. The letter highlighted concerns that in some cases independent enquiries may not have been commissioned by SHAs where this was indicated by the Department of Health guidance. All SHAs are asked to assure themselves with regard to their local processes and to provide a report highlighting any issues identified to the Department of Health by July 2008.

2 Background

The SHA is responsible for the commissioning of independent investigations in order to comply with the Department of Health guidance published in July 2005 which builds on and clarified the previous guidance HSG (94) 27.

The guidance requires that an independent investigation will be undertaken in the following circumstances:

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

3 Method

To provide assurance that all adverse events in mental health services have been investigated appropriately and lessons learned from these events, an audit has been undertaken to assess the current systems and processes, and case files.

The period for the audit was from January 2002 to the present day and included the two Mental Health and Learning Disability Trusts in the region and all primary care trusts.

The Serious Untoward Incident system was interrogated using the following categories and their sub-categories:

- Homicide
- Child death
- Child abuse
- Serious incident
- Assault
- Other

Further to this a case note audit was undertaken and findings were checked against those incidents reported within the Trusts for validation purposes. A final check to cross-reference incidents reported to the *Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, which provided data to 2004, was also undertaken to provide a further assurance on the robustness of data.

4 Audit results

Over the past six years (January 2002 to present) there have been 36 adverse incidents which involved services users from mental health and learning disability services committing or being involved in a homicide. All incidents have been reported to the SHA and are logged on the SHA Serious Untoward Incident System.

Of those:

- 16 incidents met or may meet the criteria as set out in the national guidance
- 7 independent enquiries have been published
- 5 of these the implementation of the recommendations continue to be monitored by the SHA
- 4 independent enquiries are ongoing
- 1 enquiry will be commissioned in the near future following completion of criminal proceedings.
- 4 cases are to be considered further following criminal and trust investigations.

- 2 cases involved child deaths where the perpetrators were in receipt of mental health services. Whilst these have been subject to full child protection procedures, the cases have also been considered in relation to the robustness of the review of mental health issues.

All enquiries pending have been appropriately identified and tracked within SHA systems throughout the period under review. There was a delay in commissioning two enquiries during the period of the SHA merger arising from *Commissioning a Patient Led NHS*. These enquiries are now under way and all incidents meeting the criteria continue to be actively managed within the SHA system.

In addition to this audit, the SHA has also recently undertaken a review of all of the recommendations arising from enquiry reports published by the two predecessor SHAs. This review, which is not part of the Department of Health exercise, will be used in discussion with the two mental health and learning disability trusts and primary care trusts to provide further assurance that all key issues arising from individual enquiries have been addressed across the region.

5 Conclusion

Following the systems and case note audit the SHA can assure itself that the local processes within the current organisation and the two predecessor SHAs are and have been robust enough to ensure that where appropriate, independent enquiries have been commissioned and implemented.

6 Recommendation

To note the findings of the review and to report as indicated to the Department of Health by July 2008.

Professor Aidan Mullan
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