

Learning Lessons: Using Inquiries for Change

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“How long does it usually take for an inquiry’s recommendation to be implemented?”

This was the question asked by the son of the late Mrs H who had been killed under tragic circumstances by MN, a young man suffering, so it emerged, from paranoid schizophrenia.

Twenty-one months after publication of the Report of the Independent Inquiry into the Care and Treatment of MN³, her family was waiting to hear whether the inquiry recommendations had been implemented and the lessons learnt. With the pain of bereavement still evident they asked quiet, astute, intelligent questions.

For example, is 75 per cent compliance with an audit standard after nearly two years satisfactory? How would we know whether mental health services were now considered safe? How would we know that our recommendations had been appropriately implemented and the lessons learnt?

We begin by explaining how this situation arose. For this article is not about the procedure of inquiry investigation, nor is it about the content of the inquiry report or recommendations. Our focus here is on the post-inquiry process – what happens after an inquiry’s recommendations are made.

When the perpetrator of a homicide has a history of contact with psychiatric services, an independent investigation into their care and treatment is mandatory and must be commissioned by the Strategic Health Authority⁴. Most such investigations are considered completed once the independent report has been published.

Unusually, the MN Independent Inquiry stated in its terms of reference ‘*the Inquiry Panel will conduct a review of progress against an agreed action plan six months after publication of the report*’. Even more unusually, we carried out an evidence-based review, producing two Recommendation Review Progress Reports⁵ over

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3 *Independent Inquiry into the Care and Treatment of MN commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority (later part of NHS South West) published June 2006*

4 *Department of Health Circular HSG 94(27), as amended by Department of Health guidance issued in June 2005*

5 *Reports by the Independent Inquiry into the Care and Treatment of MN: Six Month Review of Progress in the Implementation of Recommendations presented to the NHS South West Board on 15 March 2007 and Progress Report on the Implementation of Recommendations presented to the NHS South West Board on 19 March 2008*

a period of 21 months and presenting them both in public sessions to the Strategic Health Authority Board. In the week prior to each public presentation, the families of the victim and perpetrator received an embargoed copy of the Review Reports and we met with each family in private. It was at the final meeting with the family of the victim that the above searching questions were asked.

So how did we reply? Whilst we had found there was some real progress on the recommendations, the result was not as clear-cut as we, the families, or indeed the commissioners and providers of services might have hoped. The degree of implementation of a recommendation was often expressed in terms of percentage adherence to an audit standard or against a key performance indicator. Such measures of compliance are less tangible and less satisfying than a 'yes' or 'no' implementation of a recommendation.

And yet for the public, the services must show that lessons really have been learnt. This is a legitimate expectation in terms of public accountability. So, how can inquiries constructively be used to bring about change or at least establish the progress being made?

Post-inquiry: the missing link

The conduct of investigations following serious mental health, child and domestic violence incidents has been the subject of extensive national guidance and research.

However, nowhere is there any focus on the process by which recommendations arising from such investigations should be followed through to implementation. This is the missing link in the chain which should exist between the incident, the investigation and the lessons learned.

It is widely assumed this does not need to be specifically addressed and it may be asserted that implementation is essentially a management responsibility for local services. But we argue that whether the post-inquiry stage is conducted by the independent inquiry or by local commissioners of services, this should be approached in an impartial, structured way. There should be an understanding of the way particular recommendations need to be approached in order to oversee their implementation. There should be guiding principles.

Principles of inquiry follow-up

In order to open debate in this important area we offer our observations on this post-Inquiry stage. These can be considered as a set of principles which may be applicable to other types of independent inquiry in the health and social care sector. They are:

1. **Evidence:** Whether or not recommendations have been implemented should be established by means of evidence-based review.
2. **Independence:** The extent of implementation should be determined by independent, objective scrutiny, ideally by the independent inquiry chair and panel. Commissioning bodies should not leave provider organisations to be final arbiters of their own progress with recommendations.
3. **Accountability:** Independent review reports should be written and report-back should be to the families concerned in private and to the commissioning body in public, notably for the latter to fulfil its duties of direct accountability and openness.
4. **Full implementation of recommendations:** It should be assumed that all recommendations are to be implemented, whether at an agency, local or national level. If it is decided that a recommendation will not or cannot be implemented, for example, because an organisational structure no longer exists

or funding for it is unavailable, the reason for that decision should be made clear. This is especially important where there are potentially controversial reasons for non-implementation.

5. **Planned review of implementation:** A structured plan for review of implementation of recommendations should be agreed between the independent reviewer, the commissioner and provider of services. This should be more than an action-plan. As a blueprint for change, it should try to be comprehensible to service users, carers, victims and other people with legitimate personal interests. It should be made public and it should be up-dated periodically, for example after six months or a year. The implementation plan may include the dates of meetings to discuss progress, prioritisation and re-evaluation of recommendations, decisions on the evidence required to decide upon implementation and what will constitute full or sufficient implementation. It should specify the realistic outcomes sought and who will be involved in the process of achieving them. Consideration should be given to inclusion of service user and carer groups' representatives, along with any local ethnic or other community representation if relevant to implementation of the recommendations.
6. **No blame:** The implementation plan should state that the review is a constructive phase, with a focus upon improvement and provision of safe services rather than upon failure or blame.
7. **Completion:** An independent inquiry should not be considered completed and its lessons learnt until its recommendations have either been fully implemented or reached a satisfactory stage of completion, as decided by commissioners and independent reviewer. The reasons for the decision should be made public. There should be an agreed cut-off point for the independent review process with planned handover of remaining recommendations to other local independent bodies for scrutiny.

Types of recommendation

From the MN Inquiry it was possible to discern distinct types of recommendation.

Identifying the type will help to ensure problems are anticipated, implementation managed effectively and expectations realistic. We suggest that the following may be equally applicable across different organisations with different types of inquiry, investigation and review. Starting with the simplest and quickest type of recommendation:

1. **Practical:** At the simplest level are recommendations which require straightforward practical implementation. These responses to a major incident may be very obvious and may sometimes have been dealt with well before any independent inquiry.
2. **Commitment:** Recommendations may be framed in terms of commitment to a specific service improvement. For example, a commitment to involve service users and carers. Such recommendations may seem easily satisfied by means of publicity or a new post. Unfortunately however, it cannot be assumed commitment will lead to an improvement of standards. For that to be achieved, a commitment recommendation might need to be re-framed as a policy or professional practice recommendation.
3. **Policy and procedural:** At a more complex level are those recommendations which require the drafting and adoption of a revised operational policy or procedure. At its simplest, a recommendation could be considered implemented once the policy is published. If that is the intention, it should be made clear. It is more likely that the intention of the recommendation, even

if not explicit, is that the policy will become operational. Otherwise, it will remain only a hope or expectation. There should be an early agreement on what will constitute implementation and how that will be determined. Audit is likely to provide the key evidence needed.

4. **Professional practice:** Sometimes the clear intention – implicit or explicit – of a recommendation is that standards of professional practice should be improved. It may be intended this will flow from a revised policy, for example on risk assessment, going beyond a simple change in procedure or protocol. Professional practice recommendations may require:

- Examination of records in order to support claims that supervision and training are taking place
- Audit and performance management using validated operational data over a period of years in order to capture evidence of professional standards and sustained improvement in good practice

There are potential pitfalls to the use of audit. It may not be easy to find the standards and key performance indicators that will properly measure the improvements sought and then there is the question of their interpretation. It may be unrealistic to expect 100 per cent compliance with a service standard based upon professional judgement. But what degree of compliance is acceptable – 95 per cent, 75 per cent, 55 per cent or less? This will need to be determined.

Since the ultimate goal is a high professional standard, internalised and fully embedded in practice, professional practice recommendations are the most difficult to implement and may take time to complete. The higher the standard set or more extensive the change required, the longer one might have to wait. Implementation may need to be seen as an incremental process.

5. **Major organisational change:** Recommendations may at times demand large-scale change, either within the organisation or in partnership with other organisations. There may be complex contractual arrangements, funding, legal and political issues. Protracted negotiations may be necessary. Slow progress with major organisational change recommendations is to be expected.
6. **Commissioning:** These are further removed from front line changes in service provision but may be fundamental to lasting implementation of recommendations. Failures of communication across organisational boundaries are frequently cited in inquiries. Implementation planning may need to involve several commissioning bodies.
7. **National:** It may become apparent during an independent inquiry that a finding has national implications. The recommendations can feed into existing consultative structures or national research on specific topics. Alternatively, an inquiry can take the initiative and hold a national seminar of experts. Publicity may already have produced national concerns. The implementation of such large-scale recommendations will commonly require tenacity, the involvement of a number of agencies and support of the commissioning body.
8. **Common theme:** These arise when it is clear from other inquiries that a shared problem is particularly intractable. Mental health Trusts and Strategic Health Authorities are increasingly gathering information from their local investigations for the purpose of identifying themes. Nationally, that is also the trend. Whilst this is constructive, it is important to ensure that individual local recommendations are not forgotten. The various approaches should not be mutually exclusive.

Implementing the recommendations

How might the above work in practice?

During the twenty-one months of the post-MN Inquiry phase, we met on seven occasions with an 'MN Steering Group' set up by the Strategic Health Authority with representation by the Trust at medical director and nursing director level, PCT, local authority and with local service user and carer groups. We met on one occasion with the agencies responsible for implementing the national recommendations. We also received a great deal of evidence including new policies, training material and the results of audit and performance management using key performance indicators.

Were the MN recommendations implemented?

One straightforward practical recommendation had been implemented before the report was published. There were two commitment recommendations and both were completed insofar as there was undoubted commitment. Five of the recommendations required a revised or new policy, with three of these audited and two completed. Only two out of eleven professional practice recommendations were completed, though eight had been subject to audit or performance management and in most cases implementation was described by the inquiry in terms such as '*on its way to completion*' or '*not completed but we are confident it is being pursued*'. Out of four organisational change recommendations, none were in place when the inquiry ceased to exist but one was expected to be implemented within six months and another within two years. Three commissioning recommendations were made and although none reached the stage of completion all were in progress. Following a national seminar of experts a number of national recommendations were made which were taken into account in new national guidance. MN had been the third local independent inquiry to identify insufficient support for carers and inadequate care planning, the identification of these themes lending weight to the implementation of the MN local and national recommendations.

The MN Inquiry exposed the process of implementation to public scrutiny in a rare way. Before it finally withdrew, plans were made for handover of each incomplete recommendation to local bodies for independent oversight. We satisfied ourselves there would continue to be report-back on progress to the Strategic Health Authority in public session and were reassured that the families would continue to have an opportunity to express their views.

Follow-up by independent inquiry, investigation or review team

There is a risk of institutionalising the follow-up process by incorporating it into an organisation's internal action-planning structure. In our experience, follow-up by an independent inquiry can have several unique advantages:

- **Public accountability:** When a duty to undertake an effective investigation arises under Article 2 of the European Convention of Human Rights, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability⁶. Even when Article 2 is not engaged, it is reasonable to expect that weaknesses identified by an official investigation will be rectified. An independent inquiry can dispassionately represent and pursue the wider public and victim's interests in ensuring that recommendations are implemented. It can if necessary expose the workings of the organisations concerned to public scrutiny thus providing authoritative

6 *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance, National Patient Safety Agency, February 2008 and Paul and Audrey Edwards v UK, Application No. 46477/99 14 March 2002, ECHR, Current Law May 2002,477*

credibility to the process of accountability. Pressure exerted by an inquiry, along with families of the victim and perpetrator of the homicide, can ensure that the Strategic Health Authority becomes more truly accountable for the learning of lessons.

- **Familiarity with the recommendations:** Having identified the failures and made the recommendations, an independent inquiry knows exactly why each recommendation is necessary and what changes are needed. It is therefore well-placed to decide when and if learning has taken place, whether satisfactory progress has been made towards that goal or more evidence is needed and can write a recommendation review report linked directly to their original inquiry report. There is the added advantage that if an inquiry team expects to carry out the follow-up, it is likely to write thoughtful, constructive recommendations based on ownership of them.
- **Objectivity and impartiality:** The public look to independent inquiries and place their trust in them. That same confidence is needed for the follow-up, with independent inquiries able to review progress objectively, based on evidence.
- **Continuity and momentum:** Staff and organisational change can hamper implementation of recommendations. But the independent inquiry can provide continuity, maintaining interest in the implementation process through meetings and review reports. Our feedback suggests this was a constructive experience for those participating in the MN Inquiry implementation phase, welcomed by commissioners, providers and the families of the victim and perpetrator.

Of course it might be the case that an inquiry team is not able or does not wish to carry on through to the follow-up stage. It may be that commissioners do not consider it appropriate. And it is not unusual to find there are several investigations under way in one Strategic Health Authority area, which might benefit from shared review of some recommendations. Where there is the problem of potential duplication or overkill or a very real need to consider budgetary restrictions, some of the advantages of independent inquiry follow-up could still be gained by inclusion of members of inquiry teams on more broadly-based commissioner-led implementation teams. Or arrangements could be made for one-off opinions from the inquiry team. In some cases one major follow-up from an investigation might be more effective than too many, taking over several recommendations from others.

However it is achieved, each inquiry should have an objective, evidence-based post-investigation phase which should always be considered part of the whole inquiry process, with the goal of learning lessons from that inquiry.

The seven principles distilled from the MN Inquiry and described above should be applied even if the independent inquiry is not involved and follow-up is conducted entirely by local commissioners, whether that is a Strategic Health Authority, Primary Care Trust, Local Safeguarding Children's Board or new local domestic homicide review commissioning bodies (see below).

Lack of research and guidance on implementation of recommendations

There is a widespread view that lessons will naturally be learnt from a thorough investigation, review or inquiry in the health and social care services. Learning, it is assumed, will somehow occur, whether prompted by the shock of an incident, the investigation itself, publicity, dissemination of recommendations or by unseen provider services' responses.

Most guidance and research has therefore focussed on the process of investigation and formulation of an action plan – as if once the boat has been launched the voyage is completed. But what happens next?

Does this result in implementation of recommendations? No studies have successfully addressed the post-investigation stage and no guidance exists to help services with structured implementation of recommendations.

Below, we review approaches towards the learning of lessons as they have developed since 1994. In the context of one article we cannot cover this extremely interesting area in depth. It is unusual to cross boundaries and bring together investigation in the areas of mental health, children and domestic violence. In doing so, we have found it is striking that whatever the setting and however the investigation is carried out, there are broadly similar approaches – a point to which we return at the end of this section.

Early recognition of the value of inquiry follow-up

Over a decade ago, shortly after the Department of Health Circular on mental health homicide inquiries was produced in 1994, J Crichton and D Sheppard made the far-sighted proposal 'It should be part of any inquiry that the team is reassembled to comment upon the implementation of their recommendations locally'.⁷ Their remarks followed the refusal to adopt such a procedure for the inquiry *Big, Black and Dangerous: Report of the Committee of Inquiry into the Death of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients*⁸. Eleven years later in 2004, it was the absence of any formal procedure for follow-up of those recommendations or explanation for their non-implementation, that was remembered when the *Report of the Independent Inquiry into the Care and Treatment of David Bennett*⁹ stated 'Many of the recommendations made in that report are disturbingly similar to recommendations that we include in this report but it is disturbing to find that little action has been taken upon them.....we express our grave concern at the apparent lack of reaction by anybody in authority to attempt to implement these and other recommendations made in that report'.¹⁰

Adding her voice in 1996, Jill Peay, in *Inquiries after Homicide*, asked 'Do Inquiries have any legitimate continuing role where their recommendations are not implemented?'¹¹ That question remained unanswered.

Learning lessons in the NHS

Across health services generally, the problem of learning lessons from untoward incidents was causing much scratching of heads. In 2000, *An Organisation with a Memory*¹² stated 'four National Confidential Inquiries operate in the NHS, but uptake of their recommendations is found to be insufficiently monitored, with the result that some measures are implemented while other recommendations appear in report after report'. On inquiries and investigations it was said 'inquiry recommendations are not always sufficiently helpful or focussed; implementation and follow-up is patchy; and there is no systematic mechanism for disseminating learning from individual local investigations'. Recommendations for improvement included 'introduce a single overall system for analysing and disseminating lessons from adverse events and near-misses' and 'act to ensure that important lessons are implemented quickly and consistently'.

7 In *Inquiries after Homicide*, Jill Peay (ed), 1996, London, Duckworth, page 74

8 Pins H, Blacker-Holst T, Francis E, Keitch I (1993) *Report of the Committee of Inquiry into the Death of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients. Big, Black and Dangerous*. London, Special Hospitals Service Authority.

9 Blofeld, Sir J, Sallah D, Sashidharan S, Stone R, Struthers J (2003) *Report of the Independent Inquiry into the Care*

and Treatment of David Bennett. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

10 *Supra* page 63

11 *Inquiries after Homicide*, Jill Peay (ed), 1996, London, Duckworth, page 32

12 *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS, Chaired by the Chief Medical Officer, Department of Health*, TSO, 2000

Taking up the challenge, in 2002, *Building a Safer NHS for patients: Implementing an organisation with a memory*¹³ set up the National Patient Safety Agency with the intention of establishing 'a system which ensures that lessons from adverse events in one locality are learnt across the NHS as a whole. The system will enable reporting from local to national level'. This national tool does not deal with how to implement local recommendations arising from individual investigations, at the time they happen. That is a different task.

In their 2002 BMJ paper *The use and impact of inquiries in the NHS*¹⁴ Keiran Walshe and Joan Higgins spoke for many commentators, writing 'Inquiries rely on their credibility and persuasive power to achieve change: they have no formal powers or authority.... The consistency with which inquiries highlight similar causes suggests that their recommendations are either misdirected or not properly implemented. Certainly there are few formal mechanisms for following up the findings and recommendations of inquiries'¹⁵.

Mental health investigations

In an effort to ensure that recommendations are formulated in a workable way, the National Patient Safety Agency published guidance in February 2008 entitled *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance*¹⁶. This emphasises that recommendations should be 'implementable' and that victims, families and carers should receive a copy of the final report and action plan. It does not however say how recommendations should be implemented, neither does it suggest that there should be any independent process to review this, nor that victims, families and carers should be entitled to know whether the recommendations have been implemented.

The *National Confidential Inquiry into Suicide and Homicide*¹⁷ obtains information on the kinds of recommendations made by inquiries and investigations, drawing together themes which have helpfully informed the Mental Health Act 2007 and its Code of Practice. However, this information-gathering has been concerned with the nature of recommendations, not the effectiveness of their implementation.

A Review of 26 mental health homicides in London committed between January 2002 and December 2006: a report for NHS London published in March 2008¹⁸ has examined in detail several different formats for mental health investigations, some identifying themes, but none addressing the post-inquiry process of implementing recommendations.

Serious case reviews

Serious case reviews following child deaths or serious injuries have a very structured format contained in *Working Together to Safeguard Children*¹⁹. Each review is expected to result in action plans describing the change which should result, with findings and recommendations fed to Local Safeguarding Children Boards which 'should put in place a means of auditing action against recommendations and intended outcomes'. Under the heading 'Learning lessons locally' it is said 'Reviews are of little value unless lessons are learnt from them. At least as much effort should be spent on acting on recommendations as on conducting the review'.

13 *Building a Safer NHS for patients: Implementing an organisation with a memory*, Department of Health, 17 April 2002

14 Kieran Walshe and Joan Higgins *The use and impact of inquiries in the NHS*, BMJ 2002; 325; 895–900

15 *Supra* page 899

16 *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance*, National Patient Safety Agency, February 2008

17 *Avoidable Deaths: five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, The University of Manchester, December 2006

18 *Published by Verita and Capsticks*

19 *Every Child Matters: Change for Children: Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote welfare of children*, HM Government, TSO, 2006

However, there is no structured post-review process to check on the implementation of recommendations.

The following three serious case review studies (i) reveal an absence of information on implementation of recommendations, (ii) show how difficult it is to obtain data on this subject, and (iii) indicate how few families are involved in reviews:

- In 2002 Ruth Sinclair and Roger Bullock, authors of *A Study of Serious Case Reviews and the Effects of the 1999 Guidance: A Research report*²⁰ said 'Without proven methods of achieving service change, the effects of revisions to guidance and investment in the post-qualifying training proposed so frequently by Serious Case Review panels will remain unknown'.
- Wendy Rose and Julie Barnes in *Improving Safeguarding Practice: study of serious case reviews 2001–2003*²¹ reveal that out of 40 case reports examined, only 8 included contributions from the family to the investigation, causing the authors to comment 'At the end of the reports read for this study, there was often an over-riding sense of frustration, of only knowing part of the story... There were few insights into the child or other family members' perspectives'²². There was no suggestion of any accountability to the families for implementation of recommendations.

In 30 out of 40 serious case review reports, recommendations were 'focussed and specific, and capable of being implemented' and in 30 cases the accompanying action plan specified 'what action should be taken by whom, and by when'. However in only 15 cases did reports state 'what outcomes these actions should bring about' and in only 12 cases did they explain 'how the agencies will review whether the outcomes have been achieved'.

It was impossible to know whether outcomes had actually been achieved. Astonishingly, the author was not always named in the report. In addition, there had been a fundamental reorganisation of children's services and social care inspection services and it proved difficult to track down the authors who were named. Some reports were incomplete or missing action plans and the authors make it clear that the 40 reports obtained 'should not, therefore, be viewed as a representative sample'.

- In a later study, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: what can we learn?: a biennial analysis of serious case reviews 2003–2005*²³, a full sample of 161 reports were used with an intensive sample of 47 reports. Repeating previous findings, in only 9 out of the 47 cases were families involved in serious case reviews. This report, again, did not reflect upon the means by which recommendations could be implemented.

All in all, this reveals that once serious case reviews have been written it is difficult to establish what happens to the recommendations, let alone whether lessons have been learnt. With no independent oversight of implementation, lack of family involvement in most reviews and no suggestion of accountability to the families concerned (even though they may be potential victims of service failure)

20 *A study of serious case reviews and the effects of the 1999 Guidance; A Research Report*, Ruth Sinclair and Roger Bullock, 2002, Department of Health, London, at page 52

21 *Improving safeguarding practice: Study of serious case reviews 2001–2003*, Wendy Rose and Julie Barnes, The Open University, Research Report DCSF-RR022, Department for Children, Schools and Families, published March 2008

22 *No reason is given for non-involvement of families in serious case reviews. It stands in stark contrast to most*

mental health inquiries and in our opinion needs further investigation.

23 *Analysing child deaths and serious injury through abuse and neglect: what can we learn?: A biennial analysis of serious case reviews 2003–2005*, Marian Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black, Research Report DCSF-RR023, Department for Children, Schools and Families, published March 2008

there is no external check on the outcomes²⁴. Thus, each new serious case review will never know whether there has been implementation of any preceding review recommendations.

The need to learn lessons from earlier inquiries and the importance of independence and accountability of reviewing panels have again become salient in the recent case of Baby P. We argue that the adoption of the principles we have outlined above might help to prevent such a tragedy in the future.

Domestic homicide reviews

Serious case reviews may provide the model for a different form of deaths investigation. Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004 will, when implemented, place a statutory duty upon local bodies to establish a domestic homicide review when it appears that death of an individual over the age of 16 has resulted from violence, abuse or neglect by a person to whom the individual was related or in an intimate personal relationship or sharing the same household, 'with a view to identifying the lessons to be learnt from the death'²⁵.

Currently, police carry out their own investigations of such incidents by means of local Domestic Violence Murder Panels/Forums.

The position was set out in 2003 by the Metropolitan Police in *Findings from the Multi-agency Domestic Violence Murder Reviews in London*²⁶ which described the key aim of these 'murder reviews' as 'murder prevention. It is not about creating a blame culture, but rather about identifying how to improve inter-agency working and better safeguards for victims'. The paper was based on 30 murders and 400 domestic violence cases. The authors refer to thirteen recommendations for health services coming out of one review alone, saying 'There needs to be some form of monitoring mechanism to ensure that this happens and the lessons do not get lost across different Health Trusts'. They conclude 'Multi-agency Domestic Violence Murder Reviews should be put on a national footing' with decisions made for taking forward recommendations at 'three levels: the agency, nationally and regarding legislation' with a 'national warehouse/post-box' so that (reviews) are accessible to all'.

In the same way that mental health homicide investigations and serious case reviews have been analysed to identify local or national themes (see above), the 2003 Metropolitan Police findings and a further 2004 Metropolitan Police analysis of 400 domestic violence cases (including 4 homicides) contained in 'Getting away with it': A Strategic Overview of Domestic Violence, Sexual Assault and 'Serious' Incident Analysis²⁷ has identified themes, but, once again, these analyses have not concerned themselves with the means by which individual review recommendations should be implemented.

24 Evidence suggests this could also be the case internationally. *Child Death and Significant case Reviews: International Approaches* Nick Axford and Roger Bullock, Dartington Social Research Unit for Insight, Scottish Executive Education Department, June 2005 examined child deaths and significant case reviews in Australia, Belgium, Canada, England, Germany, Ireland, Israel, Jordan, New Zealand, Northern Ireland, Norway, Scotland, South Africa, Switzerland, US and Wales.

25 From Executive Summary of Consultation Paper: *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004*, Home Office, June 2006

26 *Findings from the Multi-agency Domestic Violence Murder Reviews in London; prepared for the ACPO Homicide Working Group*, by Laura Richards, Consultant Behavioural Analyst, Metropolitan Police and Police Standards Unit and Commander Andre Baker, Head of Homicide Investigation, Metropolitan Police Service, Metropolitan Police, 9 October 2003

27 'Getting away with it': A Strategic Overview of Domestic Violence, Sexual Assault and 'Serious' Incident Analysis by Laura Richards, Consultant Behavioural Analyst, Metropolitan Police and Police Standards Unit and Commander Andre Baker, Head of Homicide Investigation, Metropolitan Police Service, Metropolitan Police, 16 March 2004

Since 2006, planning has been underway for a national framework for domestic homicide reviews. Between June 2006 and September 2006, the Home Office consulted on its paper *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004*²⁸ which states that ‘*The statutory purpose of a review is to learn lessons from the death*’. It is said that in practice this will include ‘*identifying how those lessons will be acted upon and what is expected to change as a result*’. A local review body is proposed, having a role similar to that of Local Safeguarding Children’s Boards for serious case reviews. Guidance on the management and structure of domestic homicide reviews is awaited to coincide with implementation of Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004.

Domestic homicide reviews will occupy a middle ground, having features of child care serious case reviews and mental health homicide investigations. Where there is a history of mental illness, it is envisaged that the need for a domestic homicide review will usually be satisfied by a mental health homicide investigation.

Whatever the shape of the new domestic homicide review guidance, this is an opportunity to bear in mind the difficulties associated with serious case reviews and ensure independent review reports are produced with feedback to victims, families and the perpetrator. That process will be incomplete without a structured, independent post-review process, with appropriate accountability to families, to ensure outcomes can be tracked in order to establish whether or not lessons really have been learnt.

Inquiries, investigations and reviews

The reader might by now have wondered whether there is any difference between a review, an investigation and an inquiry. To the extent that each makes recommendations with a view to improving services, there is no difference between them.

The Inquiries Act 2005 is the framework for statutory inquiries and the explanatory notes to the Act state ‘*The aim of inquiries is to help restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone*.’²⁹ No reference is made to any procedure for the implementation of recommendations.

Non-statutory independent mental health homicide inquiries may have features of statutory inquiries, but are now being renamed investigations, as illustrated by the recently published National Patient Safety Agency guidance, above. Procedure, in the form of taking evidence, is likely to be little changed, but there will be an additional emphasis upon examination of that evidence by means of root cause analysis. However, root cause analysis does not provide guidance as to the implementation of recommendations.

Child care serious case reviews and domestic homicide reviews are investigations by another name though they may not take oral evidence. They make findings and produce recommendations intended to improve practice, but do not review and publish reports on progress with implementation of recommendations.

Whatever their differences, inquiries, investigations and reviews establish by means of evidence what went wrong with services and make recommendations intended to improve those services. All frame their objectives in terms of learning lessons. This commonality of purpose suggests that a systemised approach to implementation of recommendations would be capable of broad application.

28 *Consultation Paper: Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004*, Home Office, June 2006

29 *Explanatory Notes to the Inquiries Act 2005 Chapter 12*, TSO, 2005, paragraph 8

Conclusions

There is a public interest in the learning of lessons from incidents of death or near-death where a duty of care may be owed by public services.

We do not address the many critics and criticism of inquiries here. It is true that hindsight bias can distort perception of risks resulting in recommendations which do not properly arise from the evidence. Some findings and recommendations have been repeated again and again, suggesting inquiries have proved unsuccessful in bringing about change. Cynics suggest it is the investigative process rather than the outcome which is important, satisfying a public need for explanation, apportionment of blame, sensemaking³⁰ and catharsis,³¹ whilst others focus on the destructive potential of inquiries if they are badly managed³². As to the risk with which inquiries are concerned, serious violence cannot always be predicted³³, some commentators worry about over-predication of risk³⁴ and others reveal that risk is generally under-estimated³⁵. Mental health homicide numbers seem to remain constant³⁶ leading to a popular view that inquiries are ineffective and pointless. But 14 per cent have been calculated as preventable³⁷, the National Confidential Inquiry into Suicide and Homicide saying *'It is time to change the widespread view that individual deaths are inevitable'*³⁸.

The plain fact is that independent inquiries, investigations and reviews still take place. Much is invested in them, financially, organisationally, and often emotionally. And they always produce recommendations, each crafted in the hope that they will be implemented and lessons learnt. We therefore make the straightforward assumption that the function of recommendations is to be implemented.

For the purpose of this article, we do not comment on the content of recommendations. Guidelines for improvement of inquiry, investigation and review procedure already focus on this. Nor do we question the desirability of gathering data from recommendations in order to identify local and national themes. Our concern is more immediate. It is to ensure the implementation of recommendations – the missing link in the chain between the incident, the investigation and the lessons learnt.

Currently, there are three problems.

- **Lack of basic data:** No-one knows how many recommendations made by countless independent inquiries, investigations and reviews have been implemented in health and social care in England.
- **Lack of standards:** There are no standards on implementation, no expectations and no body of data for the purpose of comparison. When the victim's family asked "How long does it usually take for an inquiry's recommendation to be implemented?" we could not provide an answer because there is none.

30 *Making Sense of Inquiry Sensemaking*, Andrew D. Brown, *Journal of Management Studies* 37: 1 January 2000

31 Jill Peay, above, at page 29 and Louis Blom-Cooper at page 59

32 *Review of Homicides by Patients with Severe Mental Illness*, Tony Maden, Professor of Forensic Psychiatry, Imperial College, London, 15 March 2006, at page 66 states 'When reviewing Inquiry reports one is confronted by the unfairness of some comments made with the benefit of hindsight, and the consequent damage to morale in general, as well as to the staff directly involved'.

33 *Supra* page 66.

34 Sinclair and Bullock, above, at page 51 comment that the

difficulty of predicting vulnerable children who are at risk of violent death or serious injury can result in 'false positive' cases, with provision of services to those who do not need them

35 *The National Confidential Inquiry*, above, states at page 5 'At final service contact, immediate risk was judged to be low or absent in 88% of cases'.

36 *Supra* at page 4 'Our data show no clear evidence for either a rise or a fall in the number of homicides by people with mental illness'.

37 *Supra* page 5. It further states that this 14 per cent 'are the cases most clearly related to service failure'.

38 *Supra* page 6.

- **Lack of guidance:** There is no guidance on how the NHS, children's services or multi-agency domestic violence services will ensure recommendations are implemented. There is no model of good practice for this, nor have any factors been identified which might assist or impede progress.

We offer a starting point. Our suggested approach – based on principles and types of recommendation – is unique in that it is capable of application across child deaths, mental health homicides, domestic homicide reviews and where investigations following near-fatal injury and suicide raise public interest concerns.