November 2021

Independent review of the care and treatment of Mr G prior to the incident on 2 December 2015 and the effectiveness of the Trust Serious Incident investigation specifically related to embedding learning across the Barnet, Enfield and Haringey Mental Health NHS Trust

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Introduction

Mr G was a service user at Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) between February 2011 and December 2015. A British man of Jamaican descent, Mr G was 29 years old at the time of the incident. He lived in local authority housing and was unemployed. Mr G had a diagnosis of paranoid schizophrenia and was admitted a number of times to hospital, sometimes under the Mental Health Act 1983 (MHA). Mr G used inpatient and community services including the PICU (Psychiatric intensive Care Unit), acute wards, Early Intervention Service (EIS) and Community Support and Recovery Teams (CSRT).

Mr G's last admission was in January 2015 when he was detained under Section 2 of the MHA. He was an inpatient for approximately six months and was discharged in July 2015, initially to the Crisis Resolution Home Treatment Team (CRHTT) and subsequently to the CSRTs (East and West). A condition of his discharge was that he was subject to a Community Treatment Order (CTO) but this decision was overturned by Consultant Psychiatrist 1, the Responsible Medical Officer (RMO). Mr G's compliance with his depot medication (every two weeks) was variable after his discharge and he was not always available to receive it (at home or at the Wellbeing clinic).

Mr G last received his depot medication at the clinic on 15 October 2015. He did not attend the clinic on 29 October 2015 for his next dose and later told staff that he no longer intended to take the medication. Members of the CSRT and CRHTT undertook five home visits to see Mr G in November 2015 during which he continued to tell staff he would not accept depot medication.

On 2 December 2015 Mr G pushed Mr A – whom he did not know - into the path of an on-coming train. Mr A survived but sustained life changing injuries and psychological trauma.

In May 2016, Mr G pleaded guilty to attempted murder and was detained indefinitely under the MHA.

The Trust undertook an internal investigation into Mr G's care and treatment in 2016. It made seven recommendations which predominantly focused on consistency of care, assurance in relation to the use of CTOs and risk assessment, and family engagement.

NHS England (NHSE) commissioned an independent investigation into Mr G's care and treatment due to the severity of the incident in December 2015 and harm to Mr A. The purpose of the investigation was to consider Mr G's care and treatment, but to also consider the systems and processes now in place at the Trust and whether these mitigated the risk of a similar incident happening.

Terms of reference

The terms of reference were drafted by NHS England and agreed with the Trust and Barnet, Enfield and Haringey Clinical Commissioning Group (CCG) in October 2018.

"Review the care and treatment provided to Mr G prior to the incident on 2 December 2015 and to consider the effectiveness of the Trust RCA investigation and implementation of the Trust's internal investigation action plan, in particular:

- *To understand the decision making in relation to the Community Treatment Order (CTO) and to establish how current practice has changed across the community teams since this incident*
- *To investigate the use of escalation in the team, and consider whether any issues identified have been addressed by subsequent changes*
- *To understand if his previous risk to others was reflected in his current risk assessments/management plan and care planning.*
- *To understand how is a risk of relapse monitored and managed in relation to non-compliance of medication*
- *To review the level of engagement with the family, especially with Mr G's father. To establish current practices with community staff engaging with families and carers.*
- *To seek assurance that supervision reflects concerns for incidents, escalation and learning.*
- *To seek assurance that transition from one team to another are in line with Trust policy.*
- *Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.*
- *To review the Commissioners monitoring and sign off processes.*
- *Make further recommendation for improvement as appropriate."*

Our approach

Mazars Health and Social Care Advisory team is a multi-disciplinary team that provides specialist independent advisory support to health and social care commissioners and providers.

We undertook a joint visit with NHSE to meet Mr A and his family in November 2018 and February 2019, respectively. We met Mr A towards the end of our review to discuss our provisional findings. We would like to thank Mr A and his family for engaging in our review, despite the difficulties this has caused them, revisiting a traumatic period in their lives.

We undertook a joint visit with NHSE to meet Mr G in November 2018. We met Mr G again during our review to discuss his care and later sent him a copy of the draft report which he reviewed with his responsible clinician. We would like to thank Mr G for contributing to our review.

NHSE wrote to Mr G's family but did not receive a response to their requests to meet. We were unable to meet Mr G's mother or father during the review.

We submitted information requests to the Trust and Enfield Clinical Commissioning Group (CCG). A list of the documents reviewed can be seen in Appendix A. We note that the Trust provided a number of documents to us in hardcopy, and whilst we are grateful for the information, the documents were not provided in order and pages were not numbered. In particular, we could not map Mr G's chronology of care with complete confidence, based on the progress notes provided because we could not establish the date of some entries. We highlight this issue, in the context of service users and families receiving notes in a similar format, and the challenge this can present to the reader. Due to delays in receiving documentation from the Trust, it was agreed with NHSE that the review commenced in January 2019.

We undertook interviews with four members of staff from the Trust and CCG. A list of interviewees can be seen in Appendix B.

We held a focus group with 11 staff from the community teams in February 2019. The group provided representation from a number of roles (e.g. team manager, family therapist, care coordinator and social worker) in different localities.

We would like to thank all those involved for taking part in the interviews, meetings and focus groups, for their time and input, and for providing follow-up information as requested.

We submitted the draft report to the Trust for factual accuracy checking and comment. We shared the draft report with Mr G (via his responsible clinician) for his review and comment. We shared sections of the draft report with Mr A that pertained to the Trust's engagement with him, for his review and comment. We shared the CCG section with the CCG for its review and comment.

We undertook a joint visit with NHSE to see Mr A's family in June 2019 to share the draft report findings. We wrote to Mr A offering to meet with him, in a joint visit with NHSE, but did not hear back from him about this.

We submitted our final report to NHSE in July 2019.

Recommendations

Recommendation 1: The Trust should assure itself that it has the appropriate mechanisms in place to formally monitor the ongoing application of CTOs and document any decisions and MDT involvement pertaining to changes in their management (e.g. removal).

Recommendation 2: The Trust should develop a forum in which different community teams are able to meet, share experiences and best practice.

Recommendation 3: The Trust Medical Director should ensure the revised risk assessment template draws on existing good practice in place at other mental health trusts and is available to staff within the next three months.

Recommendation 4: Side effect monitoring should be regularly undertaken and assessed as part of the care plan in place.

Recommendation 5: The Trust should review its communication processes between Inpatient and Community teams with a view to ensuring care coordinators are told in a timely manner of patients' discharge from the ward.

Recommendation 6: The Trust should evaluate the role of GP link workers with a view to ensuring community staff and GP surgeries are confident the role is achieving its remit and facilitating stronger relations between both groups.

Recommendation 7: The Trust must update its Discharge/Transfer policy and procedure within three months.

Recommendation 8: The Trust should review the tools and processes available to support staff working with families who do not endorse clinical decisions and may be reluctant for their relative to take medication. In particular concerns and information about side effects, side effect monitoring and the documentation of those discussions.

Recommendation 9: The Trust should prioritise psychological therapy for high risk patients likely to benefit from it.

Recommendation 10: The Trust should ensure all key stakeholders- including any victim of a patient related serious incident - have an opportunity to review and comment on a draft investigation report in advance of sign off.

Recommendation 11: The Trust should review its processes for engaging with third parties affected by the actions of its patients, with a view to ensuring a comprehensive and supportive communication pathway.

Recommendation 12: NHS England should review the national guidance in place to support the victims of serious incidents and mental health homicides, to develop a strategy to ensure health and social care providers offer appropriate support and engagement as required, both for recovery purposes and assurance that improvements have been identified and implemented.

Recommendation 13: The Trust must provide an evidence based review of its action plan to the CCG with a view to it being signed off within three months.

Recommendation 14: The Trust should assure itself as a priority that it has the correct systems and processes in place to monitor and implement action plans, and that it maintains evidence audit trails of actions implementation

Recommendation 15: The CCG should review itself as a priority that it has the correct systems and processes in place to gain timely assurance of the robustness of Trust investigation reports and action plans.

Recommendation 16: The CCG should assure itself as a priority that it has the correct systems and process in place to be assured Trusts are implementing action plans, and that there are no other historical cases in which action plan assurance has not been sought and provided, specifically for high risk and Board level cases.

Recommendation 17: The CCG should assure itself as a priority that Trusts respond to commissioner concerns regarding investigation reports and action plans, and do not sign off reports in advance of the CCG quality assurance process.

Chronology

The Trust internal investigation into Mr G's care and treatment contains a comprehensive chronology, detailing Mr G's engagement with inpatient and community services. Therefore we do not revisit it here in depth, but set out a summary of Mr G's engagement in 2015.

Mr G first came into contact with psychiatric services in 2011 when he was informally admitted to Barnet Hospital. He had a diagnosis of paranoid schizophrenia. At the time of the incident he was 29 years old and unemployed. By the time of this incident, Mr G had previously been detained under the Mental Health Act between 2011 and 2012, and subject to a CTO between May 2012 and September 2013. In December 2014 Mr G's care coordinator at the time raised concerns about his lack of engagement (with his care coordinator and in activities) and that he was not taking his medication. Mr G was visited by a Consultant Psychiatrist 1 and a Social Worker whom he told he had discontinued his medication. Mr G was not thought to be detainable under the Mental Health Act and he and his father were given contingency contact numbers.

- *January 2015*

On 8 January 2015 Mr G's father called the CSRT to inform them that police had been called the day before because Mr G had posted his passport and a knife through a neighbour's letterbox. The police had been unable to locate Mr G on 8 or 9 January. Mr G's father was advised to bring him to the Springwell Centre (part of BEH) or to A&E for a psychiatric assessment. Mr G's father later told the CMHT social worker that Mr G had not wanted to see a doctor and that his call to the crisis team had not elicited a positive response[1] from the team. He did not feel that Mr G needed hospitalisation or medication at this point.

Consultant Psychiatrist 1 visited Mr G at home on 13 and 16 January to discuss the recent concerns but he was not at home.

Mr G presented to the Cambridge Psychiatric Liaison Team on 19 January saying that he had attended because it was the place of his birth. He was assessed and admitted under Section 2 of the MHA to Addenbrookes[2] hospital. In parallel with this, housing[3] staff contacted the police and reported Mr G to be missing. The team described his flat as being in "disarray". The police were subsequently advised that Mr G had been detained by mental health services in Cambridge. Mr G was transferred two days later to a private bed at Homerton hospital[4] on 21 January 2015. Depixol[5] depot injections were recommenced as treatment (Mr G had previously been on a Depixol depot injection every four weeks until November 2014 when he stopped taking it). During his admission, Mr G was allowed to take regular leave, but on 3 February was listed as absent without leave (AWOL), having not returned to the ward the previous day.

- *February 2015*

Mr G presented at the Springwell Centre and later at the Dennis Scott Unit, Edgware Community Hospital on 5 February, but did not wait to be seen. He was stopped[6] by British

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[1] It is not set out in the notes what constituted a positive response.
[2] Primarily known as an acute hospital, Addenbrookes offers mental health services with the local Foundation Trust, and has a small number of inpatient beds.
[3] Mr G lived in local authority housing
[4] Part of Homerton University Hospital NHS Foundation Trust
[5] An antipsychotic
[6] It is not written in the notes why the British Transport Police stopped Mr G.

Transport Police on 25 February at Victoria station but not detained. He remained missing and did not make contact with his father.

- *March 2015*

The CSRT were contacted by Homerton hospital on 2 March 2015 and informed that Mr G had been brought into A&E having thrown himself into the River Thames. There is no evidence he had been taking any medication since he went AWOL from Homerton hospital in January. Mr G was reported to be presenting as paranoid with delusional and persecutory beliefs. Mr G absconded from A&E on 3 March but was picked up by the police, and subsequently referred and admitted to Thames Ward (Chase Farm hospital at the Trust[7]) under Section 3 of the MHA. He was assessed on the ward the next day and held under Section 3 of the MHA. His presentation at assessment was aggressive and unwilling to engage.

Mr G was transferred two days later to Avon ward, Edgware Community Hospital which is an intensive care unit on 4 March following a serious incident the previous evening on the ward in which he had smashed plant pots, kicked the office door and acted in a threatening manner towards staff, who called the police. A decision was taken later the same day to seclude Mr G due to his behaviour. Mr G was started on monthly Flupentixol[8] and Clonazepam[9].

Throughout March Mr G's behaviour on the ward was observed by staff to be aggressive:

- On 8 March he was verbally aggressive to staff and punched the walls.
- On 9 March he attempted to assault someone and had to be restrained. He also asked for a weapon with which to fight staff.
- On 10 March Mr G walked out of a ward round meeting and pushed staff.
- On 14 March he attacked another service user and member of staff.
- On 15 March he attempted to attack another service user, believing that they had threatened to kill him.
- On 16 March he pulled down a curtain rail and ran towards staff with it. He smashed I.T equipment and office furniture. The police were called and he was placed in seclusion. He was observed to be restless, sometimes pacing, talking and laughing to himself.

Mr G was seen for clinical review on 27 March. He was found not to have capacity to consent to medication because of a lack of insight into his condition.

- *April 2015*

Mr G was being prescribed Flupentixol, Carbamazepine[10], and Diazepam[11] in April 2015. Mr G was interviewed ahead of a ward round on 14 April. He was found to have insight, but described as suspicious/guarded. Mr G said that he did not believe he needed medication, denied hearing voices or command hallucinations. His new care coordinator, Care Coordinator 1, felt Mr G remained paranoid and thought disordered and said that he/she would support a Community Treatment Order. A member of the psychology team wrote in

[7] We believe services have been reorganised and this is now at Edgware Community Hospital
[8] An antipsychotic
[9] Used to treat seizures
[10] Used to treat seizures
[11] Typically used in the treatment of anxiety, depression and sleep difficulties.

the ward round notes that she had the impression that Mr G was unlikely to engage in the community and presented a high risk when unwell.

- *May 2015*

On 6 May Mr G was observed several times during the night talking on the service users' payphone, which had been disconnected. Mr G acknowledged in a ward round (with Consultant Psychiatrist 2, a member of the nursing team and a student nurse) the next day that it was not normal to talk on a payphone to someone who was not there, but said he didn't mind hearing voices as they were company for him. Consultant Psychiatrist 2 wrote in the notes "*he is clearly unwell and showing strong evidence of Positive and Negative Psychotic Symptoms".* Mr G was noted during the ward round to be experiencing side effects – slight tremors in both hands – from his medication.

Mr G was started on Sulpiride[12] and Procyclidine[13] (in addition to his other medication) on 7 May.

Care Coordinator 1 undertook a Care Programme Approach (CPA) Review with Mr G on 1 May. Care Coordinator 1 wrote in the notes Mr G accepted he had a mental illness but didn't think he should take medication and was frustrated with being kept in hospital against his will. His father said he agreed Mr G should stay on section until his mental state stabilised, but he did not believe he needed medication. Mr G was transferred the next day to Finsbury Ward, an acute admissions ward at St Ann's hospital (at the Trust).

Mr G was noted on 14 May to be compliant with all of his medication except Procyclidine.

It was recorded in the notes of Mr G's CPA meeting on 19 May – attended by Mr G, his father, Consultant Psychiatrist 6, Care Coordinator 1 and ward staff - that Mr G wished to reduce his medication. He was noted to be polite and improving, though with some mild paranoia.

- *June 2015*

A medical review with Mr G was undertaken by Consultant Psychiatrist 6, SpR 2 and a member of the ward team on 1 June. Mr G said he did not want to take any other medication and had been refusing his depot. He denied experiencing hallucinations. Mr G acknowledged he was in a different frame of mind from when he was admitted, but not that this was because his illness was being helped by medication. Mr G was found not to have capacity to consent to treatment. He was transferred to Trent ward (a different acute admissions ward) as part of a bed management plan the same day.

Consultant Psychiatrist 3 undertook a capacity and consent to treatment review with Mr G on 3 June. Mr G was noted to have capacity but was not consenting to take medication. Mr G was being treated under a Section 62[14] of the MHA.

Mr G went AWOL on 8 June, having not returned from Section 17 (S17) leave[15]. His father said that he felt that side effects from the medication had caused Mr G to abscond. It was not recorded in the notes what the side effects were or which medication might be the concern. Mr G returned to the ward on 14 June.

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[12] Antipsychotic medication
[13] Used in the treatment of seizures
[14] Used in emergency situations to provide immediate treatment to patients, preventing serious deterioration and/or injury to themselves or others.
[15] Leave granted to detained patients by an RMO which means they are permitted to leave the hospital.

At a ward review led by Consultant Psychiatrist 2, attended by a student nurse and a member of nursing team on 15 June Mr G was assessed to be at medium risk of absconding, and low risk of harm to himself and others. Mr G was noted as saying he didn't think he would be compliant with his depot medication if he wasn't subject to a CTO. Mr G reiterated this at a 1:1 with his named nurse and told her he believed the medication was doing him no good.

At ward review on 17 June led by Consultant Psychiatrist 3 and attended by SpR 1, the ward deputy manager and Mr G's solicitor, a plan was made for Mr G's flat to be deep cleaned and for Mr G to go on Section 17 leave with a view to CTO discharge the next week. Care coordinator 1 and Mr G's father were unable to attend the ward round. Consultant Psychiatrist 3 spoke to Mr G's father the next day to discuss his medication, tidying the flat and discharge to his local Mental Health Team, with a new Care Coordinator. Mr G's current Care Coordinator, Care Coordinator 1, told Consultant Psychiatrist 3 on 18 June that he/she did not think that Mr G should be discharged until he was capable of looking after himself and that he was at serious risk of self-neglect. Care Coordinator 1 asked Consultant Psychiatrist 3 arrange an OT assessment for Mr G before his discharge.

Mr G was granted Section 17 leave from 18 June and began to leave the ward, usually to spend time with his family.

Mr G's risk assessment at a ward review led by Consultant Psychiatrist 4, attended by SpR 1, the ward deputy manager and Doctor 1 (role unclear) on 23 June was recorded as low risk of harm to others and a medium risk of self neglect.

Mr G initially declined to participate in an occupational therapy assessment of his Activities of Daily Living (ADL) but agreed to undergo one on 26 June. He was found to have the functional skills and capacity to engage safely and independently in his ADLs. On 29 June Mr G's flat was cleaned and electricity restored in preparation for his discharge from the ward.

- *July 2015*

It was recorded in the notes that Mr G told his named nurse during a 1:1 on 4 July that he did not know whether he would take medication if not on a CTO discharge.

A "white board meeting" (ward meeting) and Multi-Agency Discharge Care Plan Assessment (Section 117 meeting) were held on 7 July and formulated plans for Mr G to be discharged on a CTO under HTT support. The whiteboard meeting was attended by Consultant Psychiatrist 5, SpR 1, the deputy ward manager and admin support. The Multi-Agency Discharge Care Plan meeting was attended by Mr G, his father, Care Coordinators 1 and 2, Consultant 5, the deputy ward manager, Consultant 4, Doctor 1, a housing officer, an AMHP and a member of the Barnet Outreach team.

Mr G was noted as having poor insight into his illness. Mr G's risk was noted as "*low risk of harm to self or others, low risk of self-neglect. He has a history of non compliance with medication leading to relapse and risky behaviours. In case of non compliance, risk to self and others will be high.*"

His housing officer (from the Local Authority) raised concerns about his ability to live alone. Care Coordinator 2, who was to be Mr G's new care coordinator[16], said a package of care

[16] Care Coordinator 1 continued to be Mr G's care coordinator until September 2015 there was an informal overlap between care co-ordinators from 23 July.

would be arranged. Mr G was said to be satisfied with the decision to discharge him on a CTO and assessed to have capacity to make decisions.

Mr G was discharged under a CTO on 8 July. His medication was Flupentixol decanoate 60mg IM twice weekly and Clonazepam 200g BD. He declined a package of care from the enablement team.

Consultant Psychiatrist 1 and Care Coordinator 1 undertook a home visit to see Mr G with his father on 9 July. Mr G told them he did not have a mental illness and did not like taking Carbamazepine, but he did not mind taking his depot.

A member of the HTT visited Mr G on 11 July. Mr G said he was expecting his depot injection. The member of staff said that they were unable to give it to him as they were not a nurse but that they would discuss this with the team.

The HTT made another home visit on 12 July to give Mr G his depot injection, but Mr G was not home. The team made attempts to contact him by telephone on 14 July to arrange administration of the depot injection, but he did not answer.

Mr G was discussed at an MDT meeting on 15 July. The roles of the meeting attendees are unclear (first names predominantly used), other than a mix of nursing and medical staff[17]. It was noted he had not had the depot injection due on 12 July and this was said to be due to his "poor engagement[18]". A joint visit by Care Coordinator 2 and a member of the CRHTT took place later the same day.

On 17 July Consultant Psychiatrist 1 made an assessment for CTO and decided Mr G's should be discontinued (it is unclear what prompted this assessment). His written assessment said that having considered all the evidence including Mr G's progress notes, reports prepared for the tribunal, and a recent interview on 9 July with Mr G, he could not see that further detention and treatment under the CTO were justified. Consultant Psychiatrist 1 acknowledged that Mr G's current Care Coordinator was in favour of Mr G receiving ongoing treatment under the CTO. However Consultant Psychiatrist 1 noted that Mr G had indicated during their meeting that he was willing to comply with his depot injections though was less sure if he would take Carbamazepine. Mr G had previously requested hospitalisation and had been treated as a voluntary patient, had been willing to comply with his depot at the last meeting and had said he no longer smoked cannabis. Consultant Psychiatrist 1 also noted that Mr G was close to his father who now supported regular use of medication[19]. He added that after a previous discharge from a CTO in 2013 Mr G had been treated in the community for a long period during which time he continued to take his (depot) medication. He judged that when acutely unwell, Mr G's predominant acts appeared to be destruction to property, not harm to people.

The HTT made another home visit on 19 July but Mr G was not there. He subsequently presented to the Barnet Recovery Centre (Dennis Scott Unit) on 20 July seeking assurance of continued supply for Carbamazepine. The HTT handed over to Care Coordinator 2 on 23 July, noting that Mr G needed a referral to the depot clinic for his Depixol (Flupentixol), but he was aware of the date his next depot was due.

[17] Consultant Psychiatrist 1 was not an attendee.
[18] The Trust Board level inquiry later challenged this point, noting Mr G had been available, and expected to receive his depot, on 11 July.
[19] The notes do not say how and when Mr G's father became supportive of him taking medication.

The CSRT contacted Mr G's father on 27 July, asking that he help Mr G register with a GP. The CSRT voiced concerns that Mr G did not appear to be washing and wore the same clothes continually. Mr G's father was asked to encourage his son to look after himself.

During a home visit on 29 July it was noted that Mr G did not appear to be washing and that he continued to wear the same clothes. Mr G was advised to collect his medication prescription from his GP surgery because he only had six days of medication left.

- *August 2015*

Care Coordinator 1 saw him on 5 August. Mr G was noted to be wearing the same clothes since he'd left hospital and had not showered. Care Coordinator 1 offered to take him to his GP appointment, but he declined, saying he would take the bus. Mr G was reminded he needed to attend the appointment to collect his prescription. Care Coordinator 1 wrote in the notes that Mr G presented no risk to himself or others.

Care Coordinator 1 contacted his GP on 6 August and was informed Mr G did not attend his appointment or collect his medication. The Care Coordinator contacted Mr G's father to express concern that he was wearing the same clothes he had worn on leaving hospital and appeared not to be washing or cleaning. Mr G's father said he thought this could be related to his Depixol dose being too high.

Mr G did not attend for his depot injection on 13 August and was uncontactable as his phone was switched off.

- *September 2015*

Care Coordinator 1 saw Mr G at home on 2 September. He was noted to be compliant with medication despite not attending the Wellbeing Clinic for his depot injection on 13 August. He was said not to have washed since his discharge and was seen to be wearing the same clothes.

Mr G attended the Wellbeing Clinic on 17 September for his depot injection. Mr G's CPA review took place on 17 September with Consultant Psychiatrist 7, Care Coordinators 1 and 2, Mr G and two medical students. His care was handed over from ECSRT to WCSRT and Mr G was formally allocated to his new care coordinator, Care Coordinator 2's, caseload. Consultant Psychiatrist 7 reviewed Mr G's mental state and did not report anything unusual – Mr G was noted to be well. Mr G declined the offer of medication to counter the side effects (shaking) he was experiencing.

- *October 2015*

Mr G did not attend for his depot injection on 1 October. Care Coordinator 2 contacted him and he said he would attend the following day. When Care Coordinator 2 phoned the next day to see if Mr G was coming the call was unanswered. He attended for his injection on 6 October. He was seen again on 13 October at home by Care Coordinator 2. He was noted to be compliant with his medication, denied hearing voices or having delusional thoughts. He received another depot injection on 15 October, but did not attend his appointment for the next injection on 29 October.

- *November 2015*

Mr G was visited at home by Care Coordinator 2 on 4 November and again on 6 November. He refused a depot injection each time. He told Care Coordinator 2 that he had also stopped taking his oral Carbamazepine. He said he felt he hadn't ever needed to be on medication.

Mr G was 'adamant' he would not take any more medication. His risk form was updated on 6 November, recording that he had missed his depot injection on 29 October, he had a history of becoming vulnerable if he didn't take his medication, and his mental state could relapse. Care Coordinator 2 recorded in the notes[20] that his risk increased when he stopped taking his medication and became a danger to himself and others.

Mr G's care coordinator referred him the same day to the HTT for assessment given his refusal to take his medication and he was potentially becoming unwell/relapsing.

The WCSRT and HTT undertook a joint visit to see Mr G on 11 November. Mr G was clear he would not take any more Depixol depot injections but agreed to a plan of weekly visits from Care Coordinator 2 with re-referral to the crisis team should his mental state deteriorate. Mr G was deemed not to be high risk enough to require the intervention of the crisis team. Care Coordinator 2 spoke to Mr G's father later the same day. He said he was not surprised his son was not taking his medication given it had been wrong[21] in the past and he had experienced incontinence problems (as a side effect of the medication). There is no evidence that any incontinence problems were followed up alongside any other side effects as part of his care plan.

Mr G's care coordinator phoned him on 18 November, but he did not answer the phone.

Care Coordinator 2 and a student social worker saw him 19 November. Mr G showed signs of improvement in his self-care. He had bathed, shaved and had his hair cut and his flat was tidy. He said that he had no plans to restart his medication but had decided to change the way he lived his life.

Care Coordinator 2 undertook a joint visit with a social worker to see Mr G on 27 November. Mr G was noted to look presentable and his personal care remained improved. He appeared calm and said he felt well with no concerns in relation to self-harm or suicidal thoughts. Mr G continued to decline any medication. He denied experiencing auditory or visual hallucinations.

- *December 2015*

On 2 December Mr G pushed a commuter, Mr A, from the platform of a London underground station into the path of an incoming train. Mr A sustained life threatening and life changing injuries. Mr G was arrested on 3 December and charged with attempted murder. He later pleaded guilty to attempted murder and was detained indefinitely under the MHA.

[20] The date of this entry is unclear owing to the format in which the notes were provided, but it is assumed it was made on 4 November 2015

[21] The notes do not set out why Mr G's father thought the medication had been wrong in the past.

Themes

We set out in the following sections our analysis of Mr G's care and treatment, and our review of the Trust's investigation and progress with its action plan.

Community Treatment Order (CTO)

A Community Treatment Order (CTO) comes under Section 51 of the MHA 2007. It is "*a legal order made by the Mental Health Review tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community… A CTO authorises compulsory care for a person living in the community. If a person breaches a Community Treatment Order, by not complying with the conditions of the Order, the person may be taken to a mental health facility and given appropriate treatment, including medication*[22]"

A CTO can last up to 12 months, at which point it will end, unless there is another application for a CTO. CTOs can also be removed subject to a successful appeal to the Supreme Court, or if a Tribunal, responsible clinician, or Director of a Mental Health facility/hospital manager revokes it.

The Trust has a Mental Health Act information policy (2015[23]) which details the requirements of staff in relation to CTOs. The policy:

"… sets out the Trust's statutory duty to take all practicable steps to ensure all detained and Community Treatment Order (CTO) patients are given both general and specific information are required under Section 132 and 132A of the Mental Health Act

… *The ward or community team responsible for a patient must inform the patient:*

- *Of the provision of the Act under which they are detained or subject to a CTO and the effect of those provisions;*
- *… for community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances which their responsible clinician may recall them to hospital;*
- *that help is available to them from an IMHA*[24]*, and how to obtain that help;*
- *what the Act says about their treatment for mental disorder – including the circumstances under which they may be treated without their consent…"*

The policy sets out that the service user should be told:

- the reason for the CTO and maximum length
- that the CTO may be ended sooner if it is no longer required or the criteria is not met
- that the service user may not be automatically discharged when the CTO ends
- that the CTO will not automatically be renewed/extended
- the reasons for recall or revocation of the CTO
- the legal and factual grounds for the CTO

The policy sets out what documents and information should be given to the service user. It adds that service users no longer liable to a CTO must be informed that they are no longer subject to the relevant provisions of the MHA. The policy also details the role of the local MHA office (e.g. sending a letter setting out the service user's legal status).

The policy does not detail the process for staff implementing or overturning a CTO.

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[22] https://www.mhrt.nsw.gov.au/civil-patients/community-treatment-orders.html
[23] The policy was scheduled for review in October 2018.
[24] Independent Mental Health Advocate

Mr G was originally subject to a CTO as a condition of his discharge from the ward on 7 July 2015. However, Consultant Psychiatrist 1 removed his CTO ten days later on 17 July 2015 citing:

- Mr G had previously asked for hospitalisation and been a voluntary patient
- Mr G had indicated he was willing to comply with depot medication
- Mr G was in close contact with his father who was now supportive of medication
- Mr G had previously been discharged from a CTO in 2013 and complied with medication
- Mr G recognised that he had been previously unwell
- When unwell, Mr G could be verbally and physically aggression, but tended towards destruction of property as opposed to harming people.

Consultant Psychiatrist 1 noted that Mr G's care coordinator was in favour of Mr G continuing to receive treatment under the CTO, but concluded, based on the above "*I cannot see that further detention and treatment under the community treatment order is justified*"

The Trust undertook a Board Level Inquiry in response to the incident in December 2015 (we discuss this further under 'Trust Investigation'). The Inquiry subsequently identified three contributory factors pertaining to the decision to remove Mr G's CTO, specifically:

- Consultant Psychiatrist 1 removed Mr G's CTO ten days after he had been discharged from a long inpatient stay, and despite the concerns of Mr G's care coordinator. This removed the power to recall Mr G when he became non compliant with his medication at the end of October 2015.
- The CTO was removed less than two months before Mr G was to transfer to another Consultant Psychiatrist and Community team. The receiving team were not consulted about the decision to remove the CTO, which would remove its power to recall Mr G.
- Mr G's July 2015 discharge arrangements were under the proviso he would be subject to a CTO on discharge. No arrangements were in place if his CTO was removed.

We spoke to the service Clinical Director and interim Assistant Clinical Director about the use of CTOs. They were clear they did not consider Consultant Psychiatrist 1 had made the decision to remove the CTO in isolation, rather he reviewed and took into consideration the care coordinator's written concerns. However we note there is no documentary evidence of a multi-disciplinary team discussion in relation to removing Mr G's CTO.

The Clinical Director and interim Assistant Clinical Director noted there is no clear guidance on the use of CTOs and that there are varying professional opinions locally and nationally as to their validity. They added that in instances where a service user is resistant to be recalled to the ward, a CTO was no more effective than a Section 3 (e.g. a warrant had to be applied for).

The Clinical Director told us he considered CTOs were being used less frequently at the Trust and consultants were possibly more rigorous in their selection of who required a CTO (in his opinion). He told us that it was best practice to undertake a multi-disciplinary decision about the use of a CTO, which included the service user, family and/or carers.

We were told that the Clinical Director and interim Assistant Clinical Director had discussed the use of CTOs with other consultants, and there was a general consensus that decisions were undertaken on a multi-disciplinary basis, but ultimately final decisions lay with the Responsible Clinician who had a legal responsibility to rescind a CTO if they did not consider conditions were met.

We spoke to the focus group about CTOs and whether they considered it an effective tool. We were told that CTOs worked in instances where service users were willing to adhere to the law. If a service user is not following the conditions of their CTO, it is relatively straightforward to recall them to hospital if they are willing to return to the ward. However we were told that the application of CTOs could be challenging if the service user is resistant, at which point staff are required to get a warrant and sometimes involve the police. A further challenge when recalling a service user is bed availability. A member of staff described a situation when she had issued recall papers to the service user, but then had had to wait four hours, with the service user and police, whilst a bed was sourced. We were told the Police could sometimes be reluctant to become involved in supporting the recall of service users and this too could lead to further delays, however we were not given evidence to quantify this. However, steps had been taken to develop relationships with the police (e.g. the AMP Manager attends a Police Liaison meeting, though it is unclear how regularly these meetings take place) and that the police and CMHT staff now undertake joint welfare checks.

The Clinical Director and interim Assistant Clinical Director told us the Trust approach to reviewing CTOs had not changed since the incident in 2015, though both emphasised the importance of community and inpatient liaison when implementing and reviewing a CTO. In the context of Mr G's case, his CTO was rescinded shortly after he was discharged into the community – both said it was important for there to be a dialogue between community and inpatient staff, particularly when an inpatient consultant was initiating a CTO. Equally community teams should be referring back to their inpatient colleagues if they intend to overturn a CTO shortly after a service user has been discharged from the ward (we have not seen evidence of whether this is happening). The Clinical Director gave us an example when he had recently reviewed a CTO for a colleague who was unwell, and took the decision to not renew it. He told us he wrote to the service user's care coordinator and family as part of this process, setting out the rationale for his decision.

We were told the number of service users subject to a CTO was minimal – roughly between 20-30 service users at any time. The Trust provided an audit of CTOs in Barnet Community services between 10 August 2018 and 23 November 2018 (roughly three and a half months). The audit looked at 31 cases where the service user is subject to a CTO. We set out below the results:

Measure	Yes	No
Care plan in place	31	
Frequency of contact recorded	14	17
Changes to care plan documented	23	8 N/A
Risk grading and summary sufficiently detailed and up to date	21	10

We note that whilst each service user had a care plan in place, less than half of the service user notes recorded the frequency of contact, and a third did not provide sufficient, contemporary detail of risk.

The Trust process for initiating and overturning CTOs has not changed since the incident in 2015. A multi-disciplinary approach to CTOs should involve community and inpatient staff, though ultimately responsibility for any decisions rests with the Responsible Clinician. Trust CTO audit data for November 2018 indicates that there are gaps in the quality of CTO service user's records, in relation to documenting and updating risk, and recording frequency of contact.

We note in Mr G's case, the removal of the CTO reduced the powers available to staff to encourage him to take his medication when he had started to refuse to take it. There is evidence the Responsible Clinician considered the concerns of the Care

Coordinator in relation to removing the CTO (and they had jointly seen Mr G on 9 July) but we have not seen evidence of a broader MDT discussion.

Recommendation 1: The Trust should assure itself that it has the appropriate mechanisms in place to formally monitor the ongoing application of CTOs and document any decisions and MDT involvement pertaining to changes in their management (e.g. removal).

Escalation

The issue of escalation – how/when to raise concerns with senior members of staff/fellow clinicians was discussed in the focus group. The group were not all familiar with the case of Mr G and none of them could recall having his case brought to their attention in the context of lessons learned from incidents.

Staff were clear that they were able to raise issues with colleagues and would receive a timely response. Medical staff were available to speak with and advise care coordinators for example, and to assess service users in an ad hoc way if this was deemed necessary by the person expressing the concern. The group all felt that there were no barriers to communicating concerns to seniors.

We were told any service users causing concern were discussed in the regular weekly team meetings and in multi-disciplinary meetings.

The interim Deputy Clinical Director confirmed that there was protected time in team meetings to discuss service users causing concern and to develop a plan.

Two focus group members spoke about a system of "cold calling" service users that they were particularly concerned about, e.g. those with poor medication compliance, trying to ensure that risks were minimised by clinicians following them up assertively. We are unclear if this was part of the patients' care plans or an additional step undertaken by the staff.

The group told us that the AMP service was stretched and that it could take up to six weeks for a MHA assessment to be undertaken, but a referral could be made to the HTT for quicker resolution. The group noted that HTT is also busy and that it was not always possible to respond quickly, and the CMHTs do not always feel they receive enough support. Despite this, the group members agreed that the professional relationship between the teams was positive and that there were many opportunities and mechanisms for them to discuss difficult clinical issues.

We were told that the Trust uses Ulysses as a risk reporting tool, and that risk reports are regularly reviewed by managers and issues raised are discussed in supervision and team meetings.

We were advised that a new forum that was facilitated by psychology gave staff an opportunity to discuss service users with a wide variety of other mental health professionals in order to have dialogue, seek advice and support with their management.

The focus group were all familiar with and had used the various escalation apparatus, but were not all acquainted with each other. It would be helpful for the various teams to have more forums whereby experiences, knowledge and practice could be shared.

Recommendation 2: The Trust should develop a forum in which different community teams are able to meet, share experiences and best practice.

Reflecting Mr G's risk in risk assessments, risk management and care plans

The Department of Health[25] (2009[26]) describes risk assessment as:

"…working with the service user to help characterise and estimate each of these aspects. Information about the service user's history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving."

It defines risk management as:

"… developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review."

The Trust Clinical Risk Assessment and Management policy (2005[27]) aims to ensure *"… staff who undertake assessment of service users are competent in relation to clinical risk assessment and the management of clinical risk"*

The policy sets out four fundamental principles that include

"Risk management should be conducted in the spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible"

The policy describes the basic ideas and best practice for managing risk which include:

"Risk management involves developing flexible strategies aimed at preventing any negative event from occurring, or, if this is not possible, minimising the harm caused"

"Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach"

The policy sets out the role of individual practitioners and team:

"Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice"

We asked the Trust for copies of Mr G's risk assessments and risk management plans. We were given a document called 'Risk Summary'. We were told that this was Mr G's risk assessment document and any risk management plan would be within his care plan. There is no separate risk management plan. We were told that Mr G's progress notes would be a key source of any detail of his risk assessment and management.

The risk summary sets out subsections of Mr G's risk. We set out below details of these subsections and Mr G's assessed risk:

Risk category	**Risk**	**Date updated**
Evidence of risk of harm to self	Medium	11 November 2015
Evidence of risk of harm to others	High	11 November 2015
Evidence of risk of harm to others	Medium	Undated – but after the incident on 2 December 2015

[25] https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services
[26] This is the most recent Department of Health publication.
[27] Reviewed in November 2015 and due for review again in November 2018

Evidence of risk of accidents	Medium	3 December 2015
Evidence of other risk behaviours and issues	Medium	10 May 2015
Overall risk rating	High	Undated but after the incident on 2 December 2015

We note that there are some discrepancies in the risk documents we reviewed and the findings of the Board Level Inquiry in relation to Mr G's risk. For example, the Board Level Inquiry says:

"On 3 December 2015 a Risk Assessment has been updated. Under Risk Heading 'evidence of risk from others' the risk assessment states that [Mr G] *has a history of becoming vulnerable when he does not take his medication, with a risk rating of high. Under risk to others it states a risk of deterioration with a risk rating of Medium. The overall risk rating is high"*

We identified an entry in Mr G's risk summary about his medication but it was dated 6 November 2015. The risk rating for that section – evidence of risk of harm from others - recorded as 'high' was updated on 11 November 2015, not 3 December 2015 (as far as we can tell).

Mr G's overall risk rating was recorded as 'high' but in relation to the incident on 2 December 2015. The overall risk rating is undated.

The Risk Summary document was difficult to navigate. Subsections were updated on different dates, and it is unclear what Mr G's overall risk rating was, in advance of the incident on 2 December 2015. Mr G's overall risk rating was recorded as 'high' after the incident. Mr G's risk assessment was not updated after he was seen by Trust staff on 19 November 2015 and 27 November 2015. The Trust Board Level Inquiry was critical of Mr G's risk assessment not being updated after staff saw him on 27 November 2015 (his progress notes were updated in retrospect on 2 December 2015).

We were told by the interim Associate Clinical Director that Mr G's care plan would be key to his risk management but we did not identify a comprehensive risk management plan in response to Mr G's risks and there is no evidence the care plan was updated after he was seen on 19 November 2015 and 27 November 2015. We discuss Mr G's care plan below, but do not consider it equated to a risk management plan.

Department of Health guidance sets out that a risk management plan should include a set of action plans. Mr G's care plan was updated on 29 October 2015 after he did not attend a depot clinic, but we do not consider the actions (to send Mr G information about his medication and for Mr G to complete a Glasgow Side Effect monitoring form[28]) to equate to a risk management plan. However we note that Mr G's care coordinator did increase contact with him, referred him to the HTT and was taking steps to arrange a medical review – all of which were actions set out in his Contingency Plan within the care plan (the fourth action was to arrange a MHA assessment).

We consider that Mr G's risk was being assessed and managed by his care coordinator – as detailed in his progress notes - but we do not consider the Trust risk documentation to reflect this, beyond describing Mr G's risk. The Trust Board Level Inquiry noted that Mr G's risk assessments did not fully reflect his behaviour and unpredictability when he became unwell. Mr G's Risk Summary was difficult to follow and he had no tangible risk management plan.

[28] We have not seen a copy of this completed form and are unclear if this was the first time an attempt was made to formally assess the side effects Mr G was experiencing.

The Trust advised the Medical Director is reviewing the risk assessment template with a view to developing a more intuitive and dynamic approach for clinicians to assess and monitor risk. The Trust did not set out when it anticipated the new risk assessment template would be introduced.

Recommendation 3: The Trust Medical Director should ensure the revised risk assessment template draws on existing good practice in place at other mental health trusts and is available to staff within the next three months.

Care planning

A care plan outlines how a service user's care and support needs will be met. Creating a care plan should be a collaborative process between the service user and the healthcare team (typically overseen by a care coordinator). A care plan should be documented – the service user should be given a copy – and be subject to regular review.

NICE guidance (2011)[29] recommends that the community teams develop care plans jointly with the service user and:

- *"include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents*
- *Provide support to help the service user realise the plan*
- *Give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it"*

The Trust Care Programme Approach (CPA) Policy (2017[30]) says a care plan will:

"… be based on the assessment of their [service user] *health and social care needs, including risk factors and identified through the risk assessment process, **with the patient**, and where appropriate the carer(s) being central to the process… care plans should focus on patients' strengths and aspirations as well as their needs and choices"*

Care coordinators are responsible for regularly reviewing care plans and to coordinate the ongoing assessment of the service users' mental health needs and risk. The policy says the care coordinator should

"… ensure that prevention and associated support has been considered to prevent the escalation of care needs…. Ensure dynamic risk formulation and risk management is undertaken and a crisis, relapse and contingency plan is established to support the delivery of care at home or in the community. To record care plan assessment including changes, decisions goals on RiO"

The policy sets out that care plan assessments should take into consideration a number of factors including 'Live' (e.g. finances, medication, offender history, physical health), 'Love' (e.g. relationships, children, carer issues) and 'Do' (e.g. substance misuse, daily activities, spiritual and cultural needs).

We were given the 'Care plan overview' for Mr G. This provides a list of Mr G's goals, activities and a section for his views. We identified four goals within the care plan that were dated before the incident on 2 December 2015:

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[29] https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#community-care

[30] We asked the Trust for a copy of the CPA policy in place at the time of Mr G's care, but this was not provided.

- To understand his prescribed medication
- To comply with his medication
- To understand the side effects of his medication
- To manage his unusual thoughts/feelings/experiences

As with Mr G's risk summary, we noted differences between the care plan reviewed by the Board Level Inquiry and ourselves. The Trust Board Level Inquiry chronology says that Mr G's care plan was updated on 4 November 2015, recording that Mr G did not wish to take his medication anymore. The report says a risk rating of 'high' was recorded in relation to Mr G not taking his medication and the implications of this. There is no entry in the Care Plan Overview we have been provided for 4 November 2015. An entry pertaining to Mr G's wish to not take his medication was dated 29 October 2015.

There is an entry in Mr G's progress notes (which we assume is for 4 November 2015, but cannot confirm on the basis of the presentation of the notes) which says Mr G could become a risk to himself and others when he didn't take his medication. Mr G's Risk Summary records his risk of harm from others as 'high' in relation to medication, but there is no entry for 4 November 2015 – entries were made on 6 and 11 November 2015.

Mr G's compliance with medication was a significant aspect of his care and risk management but we could not identify a care plan for Mr G beyond this. His progress notes detail challenges in relation to his personal hygiene, presentation, diet, engagement, and historically that his father did not want him to take medication. His progress notes also recorded that Mr G experienced side effects from his medication, though the detail was relatively limited, but Mr G's father had indicated that his son experienced incontinence. Mr G's care plan did not set out an approach towards assessing and managing the medication side effects he experienced.

NICE guidance sets out that care plans should be holistic, but we saw no evidence of a broader, holistic care plan for Mr G. For example, his care plan did not detail activities to promote social inclusion (e.g. employment) and leisure activities, nor was there any evidence or a dialogue about longer term plans for Mr G. However we note that Mr G stopped taking his medication within a relatively short time of being assigned to his care coordinator's caseload (and had demonstrated variable compliance prior to that since his discharge in July 2015) and it is likely that this took priority ahead of developing a broader care plan with him.

We found the Trust documentation pertaining to risk and care plans to be confusing given they appear overlap significantly but are not clearly linked. The Trust guidance set out above does say the care plan should form the basis of the risk management plan and it would be helpful to separate out risk management and care planning for this purpose (the Trust has advised that the Medical Director is reviewing the templates). We have previously highlighted the level of detail recorded in Mr G's progress notes but this is not reflected in his overall treatment plan – i.e. his risk assessment, risk management and care plan.

Recommendation 4: Side effect monitoring should be regularly undertaken and assessed as part of the care plan in place.

Monitoring relapse and non compliance with medication

We have previously set out details of the Trust CTO policy and the recourse available to staff managing service users who are subject to the MHA. However if a service user is based in the community, and not subject to conditions of the MHA, there is limited recourse available to staff. There is no legal requirement for such service users to take their medication and some may choose not to due to the side effects they experience.

We were told by the Interim Deputy Clinical Director that in these circumstances, community staff would be expected to increase their contact with the service user, and seek to explore their decision to not take medication. She advised there would be an expectation on community staff to explore the service user's mental state with them, and seek to involve their family, where possible. The Interim Deputy Clinical Director advised that community staff would be aware of the service user's history and the time in which they might relapse; she emphasised the importance of ongoing engagement with the service user.

The Focus group echoed a similar sentiment adding that it can be difficult to monitor a service user's compliance if they say they are taking medication (unless levels can be monitored e.g. Clozapine). We were told community staff would check medication blister packs, speak to the service user's family (if possible) and ask the GP if prescriptions were being collected, as means of checking whether a service user was taking his/her medication.

The Community Team Manager told us in cases where a service user is reluctant to take their medication, the team will seek to explore the reasoning behind this with them. This is likely to include discussing the medication side effects, what medication might have worked for the service user in the past, and whether there was merit in changing the dose or medication entirely. The latter would involve a medical review.

In Mr G's case, he was clear that he did not wish to take his medication any more. He received his last depot medication on 15 October 2015 and did not attend his next appointment on 29 October 2015. There was no legal requirement for Mr G to take his medication – he could choose to stop taking it.

We set out below details of Care Coordinator 2's (who's caseload he was added to in mid-September 2015) engagement with him after his missed depot appointment on 29 October 2015:

Date	Event
4 November 2015	• Care coordinator 2 calls Mr G, he does not answer • Care coordinator 2 undertakes an unannounced visit to see Mr G. Mr G says he does not want to take his medication.
6 November 2015	• Care coordinator 2 and social worker undertake home visit. Mr G reiterates he does not want to take his medication. • Care coordinator 2 refers Mr G to the HTT in view of his decision to not take his medication • Care coordinator 2 updates the risk assessment
11 November 2015	• Care coordinator 2 undertakes a joint visit with HTT • Care coordinator 2 agrees a plan of weekly visits with Mr G • Care coordinator 2 advises Mr G he can be referred to the crisis team if needed • Care coordinator 2 contacts Mr G's father to discuss his non compliance

18 November 2015	• Care coordinator 2 phones Mr G – he does not answer
19 November 2015	• Care coordinator 2 undertakes a home visit with a student social worker. • Mr G showed signs of improvement in personal hygiene, tidied his home and said he has decided to change how he lives his life. • Plan recorded in the notes to arrange a medical review for Mr G
27 November 2015	• Care coordinator 2 and a social worker undertake a joint visit to see Mr G. • Mr G is given the Crisis team phone number • Plan recorded in the notes to arrange a medical review

The above details that Care Coordinator 2 was engaging with him and seeking to address his decision not to take medication. She was seeing him regularly, gave him the crisis number, spoke to his father and intended to arrange a medical review (though there is no evidence this was arranged prior to the incident).

It was recorded in the notes on 19 November that Mr G should have a medical review but there is no evidence this was arranged before the incident in December, two weeks later. Timeframes are not mandated as to when medical reviews should be arranged, rather it is the discretion of the care coordinator. In Mr G's case, Care Coordinator 2 was taking reasonable steps to engage with him and mitigate his decision not to take medication. The notes did not indicate a medical review was urgently needed, therefore two weeks would not be considered an unreasonable timeframe.

It was Mr G's decision to stop taking his medication and there was limited recourse available to the care coordinator, in terms of compelling him to take it, unless he relapsed. There are a number of steps community staff can take to monitor service user's compliance with medication and their risk of relapse, but it is the choice of a service user to stop taking their medication, and there is limited recourse available to staff to compel service users to take medication unless they have relapsed (and require admission) or are subject to conditions of the MHA.

Supervision

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18[31] says in relation to staffing:

"… providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service… Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities"

The Trust 'Multi-disciplinary supervision policy for clinical and non clinical staff (2018[32]) says:

"All staff within the trust should receive management work supervision from their operational line manager. This is central to ensuring management accountability…

The line manager is responsible for delivering or delegating and monitoring management supervision… Management supervision provides an opportunity for staff to:

- *Review their management/administrative responsibilities and tasks.*
- *Review progress against objectives and priorities, and reset them as required.*
- *Review how individual objectives relate to Team/Directorate/Trust objectives*
- *Gain support and feedback on performance*
- *Identify and plan for learning and development needs"*

The policy uses the Department of Health (1993) definition of clinical supervision:

"… a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations"

The Trust policy sets out a number of aims of supervision, including to ensure:

- *"the overall quality of the worker's performance*
- *Policies and procedures are understood and followed*
- *Work is reviewed regularly in accordance with corporate and statutory authority*
- *Records are maintained according to corporate and statutory requirements*
- *The worker is given an appropriate workload"*

We spoke to the focus group about supervision. We were informed the Team Manager is responsible for providing all management supervision, and that qualified staff also undertake clinical supervision. There is a structured supervision system whereby supervision can be planned in advance.

Clinical supervision can include a review of care plans, risk assessments, last medical review and potential discharge (from the ward).

We were told there were also opportunities to discuss cases as a team - in the Managers Risk forum and team meetings – and were given an example of one team where the psychologist organises monthly reflective practice, though attendance could be variable.

We were told there were other forums available to staff according to discipline e.g. the Psychology service has a monthly structured clinical management meeting, there is a monthly Family Therapy forum, and a Mental Capacity forum. Staff are also able to raise concerns at their weekly staff meeting.

Our focus group identified a number of forums in which staff could discuss cases and raise concerns, though we noted not all staff were aware of these different forums. It

[31] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing

[32] The policy was due for review in July 2018. We have not been given an updated version.

would be helpful if details of each team's meetings/forums were shared more broadly – where appropriate - with a view to sharing experiences, problem solving and best practice. We have set out a recommendation in relation to this.

The interim Assistant Clinical Director – formerly the Service Manager for Community Services – told us supervision was taken seriously within the service, and that she undertook supervision on a monthly basis with team mangers.

Supervision records and team meeting minutes are audited on a quarterly basis to ensure supervision remains in date. We were told supervision is reported on a quarterly basis to the Directorate Deep Dive meeting but were not provided with an example of this.

We asked the Trust to provide supervision records but these were not given to us. We were not told why. We spoke to the Team Manager for the South locality CMHT, who confirmed she undertook supervision with all of her team. We cannot definitively confirm that supervision is regularly and effectively undertaken as we have not seen formal documentation.

- Meetings

We were given copies of minutes for three South Locality Clinical meetings held in November 2018. The minutes demonstrate service users are discussed on the basis of risk each week and we were able to track conversations pertaining to some service users across meetings.

We were given minutes for the locality team meetings, which demonstrated staff discussing service users and highlighting risks (e.g. DNA, not allowing carer access, and not taking medication). The minutes record the discussion, risks and action plan pertaining to each service user discussed (e.g. request MHAA, liaise with GP).

We reviewed a small number of minutes – three for each locality – which indicate reasonable staff attendance and a broad representation of roles e.g. CPN, senior practitioner, community engagement work, psychiatrist and speciality doctor.

We were also given minutes for the Barnet Intensive Enablement team[33] and Link working team[34]. The minutes for the latter, dated 6 November 2018 record that staff were encouraged to book supervision[35].

We have not seen examples of individual supervision records, or the Trust's monitoring of supervision, but meeting minutes demonstrate staff are discussing service users on the basis of risk, escalating concerns and identifying action as required. Anecdotal evidence from the focus group indicates that staff feel able to raise concerns about service users within their teams or individually with their manager.

[33] A community team that provides *"…rehabilitation treatment and support for adults with moderate to severe mental health difficulties* - http://www.beh-mht.nhs.uk/services/barnet-intensive-enablement-team.htm

[34] A service for adults *"experiencing difficulties with their emotional and mental health"* - http://www.beh-mht.nhs.uk/services/barnet-link-working-team.htm

[35] The minutes do not record whether this was a general reminder or a prompt.

Transferring between Trust teams, inpatient and community

We cross-referenced our discussion with the focus group about transfer between teams against the Trusts Discharge/Transfer Policy and Procedure. This policy is out of date, having been written in 2013 with a review date of 2015 which has not been followed up. The policy outlines very clearly the roles and responsibilities of all staff involved in a person's care with regard to seamless transfer/discharge. However, since it has not been updated recently the policy may no longer accurately reflect the configuration of the Trust. We were informed by the focus group that there had recently been significant service reorganisation.

Our focus group told us that there were good handovers between community teams and it was easy to speak to colleagues. There was consensus that the teams worked well together and made every effort to invite each other to relevant meetings to ensure seamless transition for service users. There was agreement that it was important to invite third parties and Trust colleagues to CPA meetings and to ensure that enough notice was given in order to ensure good attendance. We were told the development of link workers liaising closely with GPs, and basing staff for part of their time in the surgeries, had improved the relationships with primary care and made for easier and timelier discharges, though we have not seen evidence to quantify this.

The group discussed the way in which they managed those service users that are discharged from the service, for example to supported housing. They described "case managing" these individuals for a short time whilst they are in transition in order to assist continuity and support the change. All in the group felt that this worked well (we do not know if this has been formally evaluated) and although it temporarily increased caseloads in some circumstances, the positives for patients outweighed any negatives that may arise.

With regard to transfers from inpatient units to CMHTs, the group told us there were some difficulties. The most significant issue for the group was the discharge of service users from the wards without making contact with the Care Coordinator. We were advised that this happens very frequently (we did not quantify), but is being reviewed and discussed through regular meetings between community and inpatient personnel. There was also some debate around HTT discharging service users at times which were not always convenient for community staff and that this could cause friction. Again, there are mechanisms in place for dialogue between the teams in order to work on these issues in a positive way.

The focus group did not have concerns about managing transfers between teams, with the exception of inpatient to community, when care coordinators are frequently not informed a service user has been discharged. Anecdotal evidence indicates that staff are confident in engaging in the transfer process, though we note the Trust Transfer policy should have been reviewed in 2015, and there is no evidence it has been updated to reflect changes in the service structure. There is not a contemporary transfer policy against which to assess current practice.

Recommendation 5: The Trust should review its communication processes between Inpatient and Community teams with a view to ensuring care coordinators are told in a timely manner of patients' discharge from the ward.

Recommendation 6: The Trust should evaluate the role of GP link workers with a view to ensuring community staff and GP surgeries are confident the role is achieving its remit and facilitating stronger relations between both groups.

Recommendation 7: The Trust must update its Discharge/Transfer policy and procedure within three months

Family engagement and engaging with Mr G's family

The Mental Health Act Code of Practice 1983 (2015) says:

"Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contrary to the views expressed, professionals should explain the reasons for this[36]"

The Triangle of Care[37] (2016 – though we have referred to the 2013 version in place at the time of Mr G's care) sets out a framework for involving and supporting carers. It details six standards to achieving a Triangle of care – between the service, service user and carer/family – which includes identifying the role of the care at the earlier opportunity, and, having appropriate policies and procedures in place. The framework highlights that staff should be mindful of a number of factors pertaining to carer needs, including religious and cultural needs.

The Trust has an Engagement and Involvement Strategy 2016-2019. The strategy seeks to actively involved service users and their carers in their care. A core objective of the strategy is to:

"Always listen to service users, their families and carers and improve the way we respond to and act upon feedback to improve their experience"

The strategy sets out a number of ways in which the Trust can gather information from service users and carers including surveys, complaints (formal and informal), the Patient Experience Committee, and Friends and Family Test.

The strategy contains an action plan which sets out a number of actions, individual responsibility (e.g. Clinical Director) and timescales. An example action is:

"To improve the way we respond to and act upon feedback to improve service user and carer experience by:

Regularly sharing information and learning with people who use services and their family/carers and display this in clinical/ward areas including the 'You Said, We did' initiative"

The strategy does not set out detail of its assurance processes to ensure the actions are implemented.

The Trust CPA policy (2017[38]) says that where possible and appropriate, families should be involved in developing a service user's care plan. In instances where there are concerns about a service user, or they disengage, the policy highlights the role of the service user's family:

"Where there are serious concerns regarding risk, further effort should be made to engage with the service user and their family and support system"

The policy also says:

"Care plans should recognise the diverse needs of patients, reflecting their cultural and ethnic backgrounds as well as their gender and sexuality"

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[36] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

[37] https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

[38] Previously reviewed in 2013

The policy sets out the role of a service user's family in developing their care plan, CPA and changes in care. The Trust's Absent Without Leave (AWOL) policy (2015) also highlights the importance of engaging families when a service user goes AWOL.

Mr G's father was involved in his son's care - inpatient and community based.

We set out below, the number of contacts made between Trust staff and Mr G's family, primarily his father. Engagement was two-way, though was not always clear from the notes who initiated contact. We have included three instances where the notes said Mr G was visited by his family, parents or mother – all other contact was made by his father. We have included visits to the ward to see Mr G because the notes indicate that Mr G's father would often ask staff questions whilst on the ward, usually about his son's medication.

Month (2015)	Number of contacts
January	7
February	4
March	6
April	4
May	4
June	12
July	10
August	1
September	1
October	3
November	1
	53

There is evidence of Trust staff engaging with Mr G's father, and that they often initiated contact by phone[39], though Mr G's father was clearly proactively involved in his son's care and there is evidence of him regularly contacting the ward. The notes reflect that he would telephone the ward to speak to ward staff, would ask staff questions when visiting his son on the ward, and attended Mr G's CPA and discharge meetings.

The notes document that Mr G's father had concerns about the care his son was receiving on the ward, and that in particular he had reservations about the medication being prescribed to Mr G. The notes of Mr G's CPA meeting held on 11 May 2015 say:

"The carer [Mr G's father] *was very critical of staffs* [sic] *and the treatment that was being offered to his son. He said he does not have much to say about his son* [sic] *treatment and he is not kept informed about his progress or invited to the ward round meetings. He* [said] *that his son does not need medication. He wants him to have 'talking therapy'.* [Mr G's father] *however agrees that his son should stay on section until his mental state becomes stable again"*

There is evidence that staff were trying to maintain a dialogue with Mr G's father about the medication, though it remained a contentious issue i.e. he did not always want Mr G to take medication. This included contact to try and locate Mr G when he went AWOL from the ward in June 2015. It was documented in the notes on 11 June 2015 that Mr G's father had complained about the volume of contact from staff trying to locate Mr G.

Mr G's father contacted the ward on 17 June to find out the outcome of his son's CPA meeting. Consultant Psychiatrist 3 contacted him the next day to discuss Mr G's medication,

[39] Sometimes Mr G's father was not available and the notes say a message was left.

accommodation and impending change in care coordinator. Mr G's father said Care Coordinator 1 had not contacted him for three weeks.

On 22 June three members (including his care coordinator and responsible clinician) of staff separately contacted Mr G's father to tell him they would be undertaking a home visit to see Mr G the next day.

Mr G's father attended the ward on 24 June and asked that a member of the clinical team contact him about Mr G having blood tests because he was concerned about the effects of the medication he was taking, particularly regarding Mr G's liver function. He also asked to be invited to Mr G's future care meetings. Three contacts were recorded in the notes shortly after:

- Care Coordinator 1 phoned Mr G's father (in response to an earlier message) on 25 June 2015 about arrangements for Mr G's discharge (e.g. key cut for the flat)
- A member of the inpatient team spoke to Mr G's father on the telephone on 26 June 2015 (no further detail recorded)
- The Consultant Psychiatrist[40] covering Mr G's ward had a telephone call with Mr G's father on 26 June 2015, during which he provided feedback on Mr G's blood tests, current medication and plans for a graduated discharge.

There is evidence the team contacted Mr G's father when they had concerns about his son's personal hygiene after his discharge from hospital. The team also contacted Mr G's father when Mr G missed an appointment with his GP at the end of July 2015.

There is extensive evidence of Trust staff engaging with Mr G's father from January 2015 until the incident in December 2015, though contact did decline after Mr G's discharge in July 2015. The extent of this contact fluctuated and at times contact could be inconsistent or uncoordinated. For example, Mr G's father complained that he had not heard from the Care Coordinator[41] during a three week period (during which Mr G went AWOL), though other staff did contact him during this time. Equally three members of staff contacted Mr G's father on the same day to tell him they would be undertaking a home visit the next day. Though it was good practice to inform and involve Mr G's father in his care, one call should have been sufficient. It is documented in the notes that Mr G's father had significant concerns about the medication his son was being prescribed (e.g. because of the side effects) and that in turn, staff took steps to maintain a dialogue with him about this, though again, this was not always consistent. For example, when Mr G's father spoke to Consultant Psychiatrist 3 in June, he was concerned that his son was being prescribed an anti-epileptic, despite not being epileptic. Consultant Psychiatrist 3 wrote in the notes that he would look into Mr G's Carbamazepine prescription, but there is no evidence in the notes that he followed-up with Mr G's father. Equally the Trust Board Level Inquiry noted staff did not inform Mr G's father in June 2015 that Mr G was refusing blood tests (to monitor his depot levels). We were unable to speak to Mr G's father during our review and cannot comment as to the extent he felt listened to by staff, particularly in relation to his concerns about Mr G's medication and the side effects he experienced. Equally we cannot comment as to the extent he felt staff were exploring his concerns and/or considering whether other options might be viable.

We discussed family engagement in general terms with the focus group. We were told that it could be challenging, particularly if the medical and nursing decisions were in conflict with cultural or religious beliefs. For example, we were told that some families considered medication to be black magic and others preferred prayer rather than medication. It can be

[40] Consultant Psychiatrist 4 – now the Clinical Director

[41] The Trust Board Level Inquiry identified concerns that Care Coordinator 1 was based on nights, and therefore unavailable during the day, so we do not revisit them.

difficult if families do not want their relative to take medication, and that equally, it can be difficult for them to witness medication side effects. Some service users do not want to take medication because they consider there to be a stigma attached to it, or that recreational drug (e.g. cannabis) were equally effective. We were told staff try to see the service users with their family, ideally in the family home, to help develop an understanding of the family dynamics.

We were told that if service users aren't happy to take medication (e.g. because of side effects) the team will consider other options, for example staff will review the service user's history to see if different medication had been more compatible in the past. Equally psychology and talking therapies are considered. However, we were told that demand for individual psychological therapy is high and that the waiting time is in excess of a year. Steps have been taken to counter this – the community psychology team is now at full capacity and has been reorganised so is half hub and half team based – but ultimately demand for individual meetings outweighed the resource available, and there is a much longer wait than for group therapies.

We were told that the Early Intervention Service (EIS) has a family therapist and two psychologists to support family engagement, and that the waiting list for this was shorter than the community teams, though we did not quantify the waiting times.

The Barnet 'Borough Report to Deep Dive Meeting' in June 2018 detailed an analysis of Trust SIs. One of the themes identified was communicating effectively with families and carers. It was reported:

"Serious investigations within all service lines found a continuing concern in teams communicating effectively with families and carers. This was also evident when concerns were raised and managing these concerns effectively."

In response to this point, the report set out two actions:

- *"continuing integration of Patient Experience processes*
- *A greater emphasis on resolving concerns informally through services by the Patient Experience Team"*

Members of the community teams identified a number of challenges they can experience when engaging with families, particularly if they are reticent for their relative to take medication – reasons were not limited to religious or cultural beliefs. For example, we were told that families with medical or nursing backgrounds were not always supportive of the use of medication. The focus group described different steps they take to work with the families, including offering alternative therapies, but advised these were not always successful and that family engagement could be an ongoing challenge if medical/nursing decisions were in conflict with religious or cultural beliefs. We did not see evidence of a Trust policy in relation to supporting staff to engage with families who did not support medical/nursing decisions.

Recommendation 8: The Trust should review the tools and processes available to support staff working with families who do not endorse clinical decisions and may be reluctant for their relative to take medication. In particular concerns and information about side effects, side effect monitoring and the documentation of those discussions.

Recommendation 9: The Trust should prioritise psychological therapy for high risk patients likely to benefit from it.

Trust investigation

NHS England's Serious Incident Framework (2015[42]) defines a serious incident as:

"… events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

… The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these."

The framework gives examples of serious incidents, which include unexpected or avoidable deaths, unexpected or avoidable injury that have resulted in serious harm, actual or alleged abuse (e.g. sexual, physical and psychological). In addition, never events, and incidents that threaten or prevent the organisation from delivering services also qualify as serious incidents.

NHSE says serious incidents should be reported within two working days of being identified. The guidance identifies seven key principles for managing all serious incidents:

1. *Open and transparent*
2. *Preventative*
3. *Objective*
4. *Timely and responsive*
5. *Systems based*
6. *Proportionate*
7. *Collaborative*

It recommends that investigations be conducted using a systems-based investigation (i.e. Root Cause Analysis) methodology that sets out:

- *"The problems (the what?);*
- *The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and*
- *The fundamental issues/root cause (the why?) that need to be addressed."*

The framework details the stages to the investigation process which include 'gathering and mapping information' and 'analysing information'. Examples of the former include interviewing staff, reviewing notes and mapping services. Examples of the latter include considering the fundamental issues and root causes to be addressed – this extends to mapping against best practice.

The framework advises that the investigation team have a lead investigator with appropriate accountability at manager/director or Chief Executive level. The team should be knowledgeable of the investigation process and have the appropriate skills and competencies to complete the investigation.

[42] https://www.england.nhs.uk/wp-content/.../2015/04/serious-incidnt-framwrk-upd.pdf

The framework highlights the importance of involving patients, victims, their families and/or carers in investigations:

"involvement begins with a genuine apology. The principles of honesty, openness and transparency must be applied. All staff involved in liaising with and supporting bereaved and distressed people must have the necessary skills, expertise and knowledge of the incident in order to explain what went wrong promptly, fully and compassionately…

An early meeting must be held to explain what action is being taken, how they can be informed, what support processes have been put in place and what they can expect from the investigation. This must set out realistic and achievable timescales and outcomes."

The framework sets out the stages in which a service user, victims, families should be involved in an investigation or kept informed of its progress. These include having an opportunity to ask questions and raise concerns, comment on the terms of reference, be given access to the investigation findings and given an opportunity to comment on the findings and recommendations.

Trust policy

The Trust 'Incident Reporting, Investigation and Learning Lessons' policy (2015[43]) and a 'Management of Incidents' policy (version 8) were both developed in line with the NHSE SI framework. The' Management of Incidents' policy is undated, but its next review is scheduled for May 2019. Both policies set out the different levels of investigation and detail the responsibilities of different committees in signing off an investigation (e.g. Serious Incident Panel). Neither policy details the definition of, or the process and procedures, for a Board Level Inquiry, such as that undertaken to review Mr G's care and treatment.

The 'Management of Incidents' policy contains the (undated) Trust Serious Incident (SI) policy in its appendices. The policy identifies the Medical Director as holding overall responsibility of the investigation process. The policy sets out an RCA approach for investigations e.g. examine what was well managed, what went wrong, any gaps in process and procedure etc. The policy also contains an investigation report template in the appendices, which is a different format to that used for the Board Level Inquiry.

We have not seen a Trust policy specifically for undertaking Board Level Inquiries.

Trust Board Level Inquiry

The Trust commissioned a Board Level Inquiry into the care and treatment of Mr G which was finalised in November 2017. The Inquiry was undertaken by a panel consisting of internal and external staff:

- External reviewer and Chair
- Non-Executive Director (NED), Barnet Enfield and Haringey Mental Health NHS Trust
- Consultant in Old Age Psychiatrist, Camden and Islington Mental Health NHS Trust
- Executive Director of Patient Service, Barnet Enfield and Haringey Mental Health NHS Trust

[43] The policy was scheduled for review in May 2018, or sooner in the event of any legislative changes. We asked the Trust to provide copies of the policies in date at the time of the incident and also the most recent versions available. We received the Trust policies from November 2018 onwards and consider these to be the most recent available at the time of writing. A number have not been reviewed in a timely manner.

The Board Level inquiry Panel was composed of members with extensive clinical, nursing and managerial/executive experience.

We set out below our assessment of the Board Level Inquiry.

- *Was the Board Level Inquiry undertaken in line with the NHS England SI framework and Trust SI policy?*

The Trust Board Level Inquiry was undertaken in line with the NHSE framework, using an RCA methodology. The Trust incident management policies were developed in line with the NHSE SI framework.

- *Did the Board Level Inquiry answer its terms of reference?*

The terms of reference for the Board Level inquiry set out a comprehensive framework to review Mr G's care and treatment. The terms of reference consisted of 11 points, considering a number of areas including the decision to discharge Mr G to the community, the management of Mr G's medication, communication between health services and Mr G's GP, and the Trust's communication with Mr A and his family.

The report provides a clear chronology of Mr G's care, including his father's contact with services. The report sets out care/service delivery problems and their resultant implications.

- *Were the relevant staff and third parties involved?*

The Inquiry interviewed 11 members of Trust staff and one who had left the Trust. The Inquiry report does not provide the detail of which members of staff they interviewed. The inquiry also interviewed Mr A's Family Liaison Officer (FLO), and Mr G's father. Mr A declined to be interviewed for the Board Level Inquiry, but asked that his FLO attend on his behalf.

- *Was appropriate Trust policy, procedure and national guidance applied?*

The Inquiry report lists one policy in its appendix – the Care Programme Approach Policy (incorporating Section 117 of the Mental Health Act 1983) – and National Patient Safety Agency (NPSA) guidance in relation to victim, perpetrator and family/carer support. There is no further specific reference to Trust or national policy.

The report recommendations contain a number of references to Trust policy, in the context that practice should be undertaken in line with policy, but is not specific, and the report itself does not set out any benchmarking of practice. For example, in relation to the lifting of Mr G's CTO, the report does not set out what the policy was (i.e. what should have been done), and whether the actions of the Consultant were in line with Trust policy. The report notes that it would have been helpful for the Consultant if he had sought the views of the broader team, but does not say whether an MDT approach was Trust policy.

We have previously noted the Inquiry Panel's extensive clinical, nursing and managerial experience. The Panel was well placed to review Mr G's care and treatment, but reference to Trust and national policy would have underpinned its findings and provided a useful guide to the reader as to whether practice was appropriate and in line with expected practice.

- *Were root causes and contributory factors identified?*

The report did not identify a root cause for the incident. This is not unusual – it is often the case that an investigation or inquiry will be unable to identify a root cause. The report says:

"Whilst there are several contributory or associated factors... findings from the investigation have determined that there is no one fundamental root cause. [Mr G's] *evident risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that he would have pushed someone in front of an underground train"*

The report identified a number of contributory factors including key staff changes, the removal of Mr G's CTO, and Mr G's illness and non-compliance with medication. The report did not explore Mr G's side effects and whether these were a factor in his non-compliance. The report did not set out a judgement in relation to the timeliness or adequacy of the staff response to Mr G's non-compliance from October 2015 onwards but noted his Risk Form was not updated for eight days and that the risk summary on 4 November did not fully detail Mr G's risk when unwell.

- *Is the report written in clear English and has spelling and grammar been checked?*

The report is written in clear English, with appropriate spelling and grammar.

- *Does the Board Level Inquiry set out appropriate recommendations in response to findings?*

The report sets out a number of clear recommendations in response to the Inquiry findings

- *Is there evidence the draft report was shared with Mr A and his family, and that they had an opportunity to review and comment on the draft report?*

The Chair for the Panel wrote[44] (we do not know when) to Mr A and his family via the Police FLO to offer a meeting. Mr A declined to meet but asked that the Panel meet his FLO instead to provide feedback. The meeting took place on 21 June 2016. The FLO provided detail of the concerns of Mr A and his family; notes were made of the meeting, which were later sent to the FLO for his approval and to send on to Mr A. It was recorded in the report the FLO was told that once the report had been approved at Board Level, Mr A and his family would be invited to meet with Trust representatives to discuss the report findings and recommendations.

Mr A's FLO informed the Trust that Mr A wished to have a copy of the report and there is evidence that the Board Level Inquiry Facilitator contacted Mr A to invite him to meet with the panel to discuss its report (we do not have the original email[45]). Mr A wrote to the Inquiry Facilitator on 1 August 2017 asking for a copy of the Inquiry report, so that he and his family could consider the findings and formulate their questions, in advance of the meeting.

The Inquiry Facilitator (listed in the report) sent Mr A the report on 17 August 2017. Mr A replied to the Trust on 29 August, noting that the report was not signed or dated, and asking if he had been given the final report. He added that information (e.g. details of staff) appeared to be missing. The Inquiry Facilitator replied to Mr A on 1 September 2017 saying he had been given the final version of the report, and asking if he wished to take up the Trust's offer to meet with the Medical Director (we have not seen the earlier correspondence about this meeting but assume it pertains to that referenced by Mr A in his 1 August email). Mr A emailed the Trust on 3 and 6 September 2017, reiterating his request for a signed and dated copy of the report. The Trust replied on 6 September 2017, acknowledging Mr A's emails, saying it would reply to him as soon as possible.

The Trust Medical Director wrote to Mr A on 12 September 2017. He advised that Mr A could not be given a full copy of the report because it contained confidential information pertaining to Mr G which could not be made public. This was the first time that Mr A was advised he had been sent a redacted version of the report. The Medical Director said that he would review both versions of the report with a view to providing Mr A with detail about what had been redacted. He wrote that he anticipated being able to answer any questions Mr A might have, and that he would be happy to meet.

[44] We have not seen a copy of this letter.
[45] Later correspondence suggests the meeting was to involve Mr A, his family, the Trust Medical Director and members of the Inquiry Panel.

The Medical Director confirmed to Mr A that Trust reports are not signed and dated, but that the Inquiry report had been submitted to the Trust Board and signed off [on 28 November 2016[46]]. He said there were no plans for further drafts or changes to the report.

The Medical Director emailed Mr A again on 12 September 2017, setting out his review of the Trust Board Level Inquiry and the redacted version given to Mr A. The Medical Director reiterated he would be happy to meet Mr A or answer any questions in email if preferable.

Mr A told us that the Trust took steps to arrange a meeting with him to share the Board Level Inquiry report, but cancelled it without explanation. He declined the Trust's offers to reschedule the meeting.

Mr A was given one opportunity to meet members of the Inquiry Panel (e.g. the external reviewer and Chair) during its Inquiry and he provided detail of his concerns via his FLO. Mr A was not given a copy of the Inquiry report in advance of it being accepted by the Trust Board on 28 November 2016. The report was sent to Mr A on 17 August 2017. Mr A was told on 12 September 2017 that he had been given the final version of the report, rather it was redacted. At this time the report was still subject to external review, with the CSU, CCG and NHSE. It had not been signed off externally.

The Trust told Mr A he had been given a 'final' version of the report, and he was not given an opportunity to review and comment on the draft before Board sign off. The report was going through external review at the time of the Trust's exchange with Mr A, in August and September 2017, therefore should not have been considered 'final' despite Board sign-off the previous year. We further discuss the Trust's engagement with Mr A under 'Duty of Candour'.

Recommendation 10: The Trust should ensure all key stakeholders- including any victim of a patient related serious incident - have an opportunity to review and comment on a draft investigation report in advance of sign off.

- *Is there evidence the draft report was shared with Mr G and his family, and that they had an opportunity to review and comment on the draft report?*

The Trust has provided no evidence that the draft report was shared with Mr G or his family to review or comment on in advance of it being finalised. Mr G's father was interviewed by the Inquiry team and the report sets out that it was intended the final report would be shared with him, but we have not seen evidence of this.

- *Is there evidence that staff involved in the Inquiry had an opportunity to review and comment on the draft report?*

The Inquiry adopted a Salmon[47] complaint procedure to the investigation, part of which includes providing anyone subject to criticism in the report, to be given an opportunity to review the detail and provide a response. The report says staff were given a full opportunity to respond.

[46] The Trust did not provide the minutes of the November 2016 Board meeting but we have seen correspondence between the Trust and CSU in October 2017 which says the Trust Board accepted the report on 28 November 2016.

[47] The Salmon process is also known as 'Maxwellisation'. This is the process by which individuals criticised within a report are given the opportunity to review and respond to the criticism prior to the report being finalised and/or published.

- *Is there evidence the Board Level Inquiry report was subject to appropriate internal/external sign off?*

The Board report we hold has not been physically signed off (i.e. the 'report signed off' section is blank). We understand that the Trust no longer physically signs off report. With this in mind, it would be prudent to remove the 'report signed off' section to avoid confusion on this or any other Trust SI reports. It would also be helpful to date the report – it is only through reviewing the correspondence between the Trust and Enfield CCG that we established when the report was signed off by the Board.

We have seen evidence that the report was shared with the Barnet, Enfield, Haringey CCG/Trust/CSU quarterly SI meeting (e.g. July 2017), and that Enfield CCG and NHSE (London) both reviewed the report. NHSE (London) provided feedback about the report to the CSU on 28 September 2017. NHSE (London) raised a number of questions which the CSU subsequently directed to the Trust. The Trust Medical Director responded that the questions went beyond a normal request for further information and would not be answered.

We have not been provided with a complete timeline for sign off, but our understanding is that in November 2017 it was agreed between the Trust, CCG and NHSE (London) that the report would be finalised. We have not seen any formal agreement of this decision. Please see the CCG section on page 54 for more detail.

The Trust Board Level Inquiry into Mr G's care and treatment, is a detailed report that comprehensively explores its terms of reference. The report identified a number of lessons learned and set out a series of appropriate recommendations in response. The report does not set out assessments of practice against Trust or national policy, but the Panel was experienced as such that it was well placed to make such assessments.

We are aware that NHSE's review of the inquiry report resulted in a number of questions (please see CCG's monitoring of the report on page 54) which the Trust said it could not answer without re-investigating, though in some instances we do not consider this would have been required. For example, NHSE questioned why the Consultant rescinded Mr G's CTO without an MDT discussion, and why the Care Coordinator not take his/her concerns further. We do not consider either question would have warranted reinvestigation, rather, both could reasonably have been addressed by speaking to the staff involved, and subsequently reflected in the report. Neither of the aforementioned questions were unreasonable, rather both could be considered as key to facilitating a full and comprehensive Board Level Inquiry.

However we have no evidence to suggest that the Board Level Inquiry Panel was aware of NHSE's feedback, rather the Trust Board had already accepted, and closed the report several months before NHSE was asked to provide feedback in September 2017. Indeed the Trust had sent a redacted version of the final report to Mr A in August 2017. We discuss this further under the CCG's monitoring of the report, but note NHSE's feedback was provided promptly and within the timeframe agreed to the CSU (on behalf of the CCG) in September 2017, but there is no evidence of communication by the Trust to the CSU to indicate that it considered the Inquiry closed by this stage.

Duty of Candour

Duty of Candour refers to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20[48]. CQC guidance says aim of the regulation as:

"… to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment.

The Regulation sets out the responsibility of a provider to be open and honest with patients about their care and treatment. It details the requirements of a provider in the event of something going wrong e.g. there is an incident. The regulation relates solely to patients and their families and/or carers.
Mr A, the victim, and his family were not contacted by the Trust in the immediate aftermath of the incident in December 2015. No one from the Trust has met Mr A or his family.

The Chair of the Board Level Inquiry wrote to Mr A during the course of the Inquiry, offering to meet Mr A and his family, but Mr A declined, asking that his FLO attend on his behalf. Mr A's FLO met with the Board Level Inquiry Panel in June 2016, six months after the incident, to give details of Mr A and his family's concerns.

Mr A was not given a copy of the final inquiry report in advance of it being signed off by the Trust Board on 28 November 2016. A redacted report was sent to Mr A on 17 August 2017. Mr A contacted the Trust upon receipt of the report, querying whether he had been given the final version because he felt there were gaps. He was informed on 1 September 2017 that he had been given the final version of the report. This was in fact not the case as the report was still subject to external review with a number of agencies and there had been no external sign off. The Trust did not tell Mr A on 1 September that he had been given a redacted version of the report.

The Trust Medical Director emailed Mr A on 12 September, informing him that the report was redacted in the interests of Mr G's patient confidentiality[49]. The Medical Director emailed Mr A a second time the same day to provide detail of the redactions. The redacted sections pertained to Mr G's care and treatment and therefore could reasonably be considered of significant interest to Mr A. We were concerned that given the extent of the redactions and in the spirit of Being Open it would have been preferable if the report had been discussed with Mr A face to face and explanations given before it was sent to him.

We met Mr A on 21 March 2019. He expressed disappointment with the Trust report, since the redactions, in his view, had rendered the report "useless", and expressed concern with the issues around sign off (e.g. he had to ask more than once whether he had been given the final version of the report given it was undated and unsigned). He had had no further contact from the Trust since the letter from the Medical Director in September 2017, and advised us that he had been contacted by the Ministry of Justice, to inform him that Mr G was having leave from his forensic unit, which Mr A found surprising and alarming. Mr A said the Trust had not kept him apprised of the arrangements for Mr G's leave, and was concerned how this knowledge might impact his health and well-being.

We briefly met the Forensic Psychiatrist with responsibility for the care of Mr G on 27 March 2019. She advised that there had been attempts to make contact with Mr A whilst Mr G was

[48] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation

[49] We do not know if the Trust considered approaching Mr G and his father about sharing the full report with Mr A – we did not explore this with the Trust.

under her care, but that he had not responded. It was unclear how those contacts had been made and we have not seen a record.

During our review of the Trust's implementation of its action plan we met with the Clinical Director who advised that Duty of Candour did not apply to Mr A as the regulation is for patients and their families/carers. The Trust did not offer an alternative policy or approach for engaging with Mr A or other parties linked to the Trust e.g. the families of victims of mental health homicides.

The Trust is clear that Duty of Candour did not apply in Mr A's case. We raised this with Care Quality Commission (CQC) via NHS England, who confirmed that the Regulation is for patients and their families and/or carers only – it does not extend to third parties such as Mr A.

Victims in the situations are invariably seeking assurance that lessons will be identified and improvements made to prevent similar situations reoccurring. As such engagement should extend to sharing recommendations and evidence of improvement or changes.

Regardless of the Regulation, in the spirit of Duty of Candour, Mr A, as a victim of such a serious assault (and /or his family given the extent of his injuries immediately following the incident), should have been subject to more robust attempts to keep him informed about the Board Level Inquiry and subsequent issues e.g. Mr G's leave, which would naturally be alarming to a victim in such circumstances. The Trust's stance that Duty of Candour does not extend to Mr A, did not exempt it from a moral responsibility to engage with him and ensure his wellbeing where possible. Mr G was under the care and treatment of the Trust when he caused life changing injuries to Mr A, and as such the Trust had a responsibility to engage with Mr A, offer support, and keep him informed of the Board Level Inquiry and later decisions pertaining to Mr G's leave. We would expect the Trust to adopt a similar approach to other third parties, whom though not treated by the Trust, have had their lives impacted by those receiving treatment e.g. the families of mental homicide victims.

Recommendation 11: The Trust should review its processes for engaging with third parties affected by the actions of its patients, with a view to ensuring a comprehensive and supportive communication pathway.

Recommendation 12: NHS England should review the national guidance in place to support the victims of serious incidents and mental health homicides, to develop a strategy to ensure health and social care providers offer appropriate support and engagement as required, both for recovery purposes and assurance that improvements have been identified and implemented.

Trust action plan

1. General Observations

- The implementation of recommendations arising from the action plan has not been robust and was dependent on operational staff to disseminate learning through clinical supervision etc. There is no evidence of implementation and does not appear to have been audited. Given the seriousness of some of the learning, we would expect policies and procedures to have been reviewed and refreshed as necessary, and issued with mandatory instructions to take note of any amendments and reiteration of key points relating to these incidents. In addition, audit of clinical supervision relating to the key points should be undertaken.
- Evidence of implementation of several actions is either not provided or weak. The Trust consequently have missed action deadlines. We have highlighted for the Trust in the table below additional evidence which would be helpful to provide more comprehensive assurance that the actions resulting from the investigation's recommendations have been implemented or there are clear plans to do so. We contacted the Trust several times to request evidence to underpin its action plan. We were told that though the Trust considered the action plan had been implemented, there was no evidence available beyond what we had received, to verify this.
- The actions put forward do not adequately cover the recommendations made in several instances as indicated in our detailed analysis below. In particular, actions do not reflect the need to review, update and communicate changes to key Trust management and operational policies with respect to the issues arising from this incident.
- The action plan is not dated or given a version number. The version provided for our review indicates that some actions are complete but dates are not provided as to date of completion and whether by the due date. The action plan would be clearer with two separate columns; one for target date for completion and one for actual date for completion.
- The action plan does not provide a section for responsible individuals and Executive team member to sign-off once complete. This should be added to the document to ensure appropriate governance. We would expect the action plan to be signed off by a lead Executive Director.
- It is not possible to confirm in some cases whether individual actions have been signed off by those allocated responsibility as there is no section for sign-off by the individual leads for each action.
- In many instances, there is a lack of specificity with regards to individual responsibility for actions – some actions are assigned to more than one individual or to generic staff groups, for example clinical directors, acute team leaders/service managers. This makes it difficult to monitor whether actions have actually been completed. We recommend that a single individual is responsible for each action.
- The names of those signing off actions are not stated; roles and acronyms are used which are not clear in all cases. We recommend that, for clarity, the positions and names of individuals signing off the key actions are stated.

- There is a column on the action plan called “Monitoring Arrangements” which provides some information on how the ongoing implementation of the recommended action is monitored in some cases. This is a useful addition to the action plan and should be applied consistently to all actions with links to evidence of the monitoring arrangements indicated.
- There are typographical errors and inconsistent terminology, for example with regard to governance groups.

2. Summary of Action Plan Progress

Actions	Key Observations (see Section 3. for detailed assessment)	Outstanding Evidence	Status (RAG rated*)
Recommendation 1. The Trust should ensure that the provision of Locum Consultants does not have a detrimental effect on the clinical team and the patient in terms of care consistency. The Trust should introduce a process for monitoring Locum Consultants and reviewing their effectiveness.			
1. The Trust continues to ensure locum doctors have appropriate GMC registration, are subject to appraisal and revalidation and have valid references. For agency doctor this is managed via the use of framework agencies and for NHS Locum doctors this is via Trust pre-employment checks **Responsibility:** Head of Medical HR **Target Date for Completion:** Not provided	• This action is marked as complete but there is no evidence provided to support the action plan relating to this action. • Monitoring of implementation refers to responsibility of “All – Trust-wide SI Assurance Group”. Evidence of this is not provided within the action plan. • There is no target date for completion for this action.	• Evidence of HR policy review, update and communication to staff • Evidence of new process introduced for monitoring effectiveness of locum consultants • Confirmation of target date for completion of this action	RED
2. Locum Consultants are to be offered 1:1 meetings with their Clinical Director or nominated senior consultant during the first week of appointment and monthly for the first three months	• The due date for this action was November 2017. • Responsibility is assigned to a group of individuals rather than a single person	• Confirmation that this action is complete and date of completion • Evidence of monitoring, e.g. by HR department, of supervision meetings to provide assurance that these take place as required by the action	RED

Responsibility: Clinical Directors **Target Date for Completion:** November 2017	• The Clinical Director told us that he did not record supervisory meetings and the action had not been implemented. • The evidence proposed for this action is "Records of supervisory meetings" for locum consultants. No records are provided or evidence of monitoring that these meetings occur routinely. • It is unclear how the monitoring of implementation of this action is overseen by the SI Assurance Group.	• Evidence of how the SI Assurance Group is monitoring this action	
3. Locums are to be included in invitations for all Trust educational and CPD events **Responsibility:** MD/DME **Target Date for Completion:** November 2017	• It is unclear whether this action is complete. The due date was November 2017. • Responsibility appears to be assigned to two individuals but it is unclear who these are from the acronyms used. • No evidence provided within action plan for this action but references "Attendance Lists" • It is unclear how the monitoring of implementation of this action is overseen by the SI Assurance Group.	• Confirmation that this action is complete and date of completion • Evidence that locums are routinely included in invitations for all Trust educational and CPD events and that attendance lists demonstrate their engagement with these events • Evidence of how the SI Assurance Group is monitoring this action	**RED**
Recommendation 2: Ward Managers should be advised that in cases where patients are guarded, uncommunicative and difficult to engage, it is good practice for their Named Nurses to be working on day duties, and where this is not possible to ensure that they are able to contribute to reviews by another means. The Trust is recommended to achieve this through the dissemination of this lesson to Ward Managers across the Trust by the relevant Service Managers			
1. Sharing of this specific learning point via BEH 'Quality News' **Responsibility:** MD **Target Date for Completion:** November 2017	• The Trust refers to the publication of the Quality Newsletter as evidence for this action and provides a text extract of the bulletin published in December 2018. • No evidence is provided as to the date of dissemination of this Trust newsletter and the target audience. It appears that the target date for completion has been missed.	• Evidence of dissemination of the newsletter to relevant staff • Confirmation by the Trust of how the specific learning point referred to in the recommendation has been shared with staff and reflected in policies and procedures.	**RED**

	• The newsletter text does not address the specific learning point indicated in the recommendation relating to the involvement of named nurses in reviews and does not reference any associated policies for staff to take note of. • It is unclear how the monitoring of implementation of this action is overseen by the SIRG and whether this is the same as the SI Assurance Group.		
2. Follow-up discussion in Ward Managers' individual supervision **Responsibility:** Acute team leaders /service managers **Target Date for Completion:** December 2017	• It is unclear whether this action is complete. The due date was December 2017. • Responsibility is assigned to a group of individuals rather than a single person so this is difficult to monitor. • The evidence proposed for this action is "Supervision Records". No records are provided or evidence of monitoring that the learning points have been discussed in supervision meetings. • It is unclear how the monitoring of implementation of this action is overseen by the SIRG.	• Confirmation that this action is complete and date of completion • Evidence of monitoring, e.g. by HR, team leaders/service managers that discussions have taken place in supervision meetings with Ward Managers relating to the specific learning in the recommendation • Evidence of how the SI Assurance Group is monitoring this action	**RED**
Recommendation 3: Key decisions regarding a patient's Care Pathway such as rescinding CTOs should be taken in a multi-disciplinary setting where the input of other healthcare professionals involved can be obtained and considered, as per Trust Policy. It is recommended that Team Managers should raise awareness of this good practice to staff in their areas, and compliance can be audited annually as part of the CPA audit.			
1. Sharing of this specific learning point via BEH 'Quality News' **Responsibility:** MD **Target Date for Completion:** November 2017	• The Trust refers to the publication of the Quality Newsletter as evidence for this action, published in December 2018. • No evidence is provided as to the date of dissemination of this Trust newsletter and the target audience. It appears that the target date for completion was missed. • The newsletter text does not address the specific learning point relating to rescinding CTOs and other key	• Evidence of dissemination of the newsletter to relevant staff • Confirmation by the Trust of how the specific learning point referred to in the recommendation has been shared with staff and reflected in policies and procedures (and copies of these).	**RED**

	decisions during a patient's care. The newsletter makes reference to adherence to Trust policy but does not name the policy/ies involved which would be helpful for staff to refer to. • We understand that the Trust's RCA report which is undated was produced in 2016. The target date for completion of this action was November 2017. It is therefore of concern that a further incident occurred in 2018 (as referred to in the text of the newsletter) which involved similar learning recommendations. This implies that the learning has not been robustly implemented following the incident under review. • It is unclear how the monitoring of implementation of this action is overseen by the SIRG.	• Confirmation by the Trust of how the learning was shared directly following the incident under review and whether this has been readdressed given the incident occurring in 2018. • Evidence of how the SIRG is monitoring this action • Evidence of how compliance has been audited/assured	
2. Follow-up discussion in Managers' individual supervision **Responsibility:** All service managers **Target Date for Completion:** December 2017	• It is unclear whether this action is complete. The due date was December 2017. • Responsibility is assigned to a group of individuals rather than a single person. • The action requires more precision as to whether it covers both Managers' supervision and their staff supervision. • The evidence proposed for this action is "Supervision Records". No records are provided or evidence of monitoring that the learning points have been discussed in supervision meetings. • It is unclear how the monitoring of implementation of this action is overseen by the SIRG.	• Confirmation that this action is complete and date of completion • Clarification on scope of action in terms of which supervision meetings referred to, e.g. Managers and/or their teams • Evidence of monitoring, e.g. by HR, line management that discussions have taken place in supervision meetings relating to the specific learning in the recommendation • Evidence of how the SIRG is monitoring this action	**RED**
There are additional actions referred to relating to this recommendation which have not been explicitly addressed	• No evidence is provided as to how Team Managers have raised awareness of good practice to their teams. It would be appropriate to review, refresh and communicate any changes required to staff through the	• Evidence of how awareness of good practice relating to this recommendation has been raised.	**RED**

	Mental Health Act Information policy, dared 26/10/15 which has been provided separately by the Trust. • No evidence is provided with the action plan on annual audit of compliance through CPA audit on an ongoing basis. Separately the Trust has provided an excel file called "Audit Results Final" which appears to relate to an audit undertaken in Barnet community services relating to the CPA approach.	For example, update and dissemination of relevant policies. • Evidence of ongoing audit of Care Programme Approach	
Recommendation 4: In cases where patients are due to be transferred between service areas and key decisions need to be taken, the incoming team should be involved in the decision-making process whenever possible, and in accordance with Trust Policy. The Trust should ensure that this is audited annually as part of the CPA audit.			
1. Quality Assurance audit template to be updated to include item on evidence of inclusion of relevant parties in transfers of care (where applicable) **Responsibility:** Head of Effectiveness **Target Date for Completion:** November 2017	• The Quality Assurance Audit Tool Community Adults – CPA is provided as evidence against this action. • The document is not dated so we are unable to confirm whether this tool has been updated following the incident. • There does not appear to be a new item included in the template relating to this recommendation. • There is no indication of monitoring arrangements for implementation of this action.	• Confirmation by the Trust that a revised audit template has been introduced to reflect the recommendation • Evidence of how the implementation of this action is being monitored on an ongoing basis, e.g. through audit	RED
Recommendation 5: Team Managers should reinforce to staff in their areas that Risk Assessments must be updated on a regular basis in order to reflect the current risk which is being documented in the progress notes, in accordance with Trust Policy. The change in practice resulting from the effective implementation of this recommendation must be monitored by routinely including an examination of the RiO records in the clinical supervision of individuals and teams, and compliance should be audited on an annual basis, as part of the overall Risk Management Audit.			
1. Clinical Supervision Template to be refreshed to include clear record of review of assessments and recording of risk, risk summary/formulation and management.	• This action does not appear to have been completed by the due date of March 2018. • The Multidisciplinary Supervision Policy which contains the Clinical Supervision Template attached to the action plan does not appear to have been updated to take	• Refreshed set of relevant policy documents which reflect the learning from the incident relating to risk assessment • A revised clinical supervision template to ensure focus on risk	RED

Responsibility: Deputy DoN **Target Date for Completion:** March 2018	account of the recommendation based on the evidence provided in the version control to the document. • There does not appear to have been any specific changes to the template to reflect the action required in terms of recording review of risk assessments and examination of RIO records for individuals and teams.	assessment and copy to be provided	
2. Audit of adherence to refreshed supervision template **Responsibility:** Head of Effectiveness **Target Date for Completion:** February 2018	• No evidence is provided to show the audit completion or results of the audit although the action is marked as complete. • The action plan states that an audit to assess the effectiveness of supervision is in place but it is not clear whether this is to take place on an annual basis as required. • The action plan does not indicate how audit results will be monitored on an ongoing basis.	• Evidence of completion and date of audit • Evidence that the specific audit is included in the audit plan on an annual basis • Confirmation of the governance arrangements for ongoing monitoring of the results of this audit	**RED**
Recommendation 6: The Trust did not contact the Victim and his Family, as per Duty of Candour requirements, to offer support immediately after the incident. Duty of Candour records which have been submitted to the Trust Board should now be scrutinised by the Clinical Effectiveness Team to ascertain whether or not there is Trust-wide compliance with the need to contact victims and their families following Serious Incidents. The findings should be presented to the Trust Board or delegated Committee on a bi-annual basis.			
1. The Trust's Duty of Candour is to the patient/service user rather than the victim and in this instance the family of the patient was contacted in line with D of C principles. **Responsibility:** n/a **Target Date for Completion:** n/a	• This is not an action but rather a statement. • We have previously commented on the Trust's engagement with Mr A (see pages 38-39) and set out our view that the Trust should have taken more robust steps to engage with him and/or his family, both during its inquiry and following its completion. • The Trust's stance that Duty of Candour does not extend to Mr A does not exempt it from a moral responsibility to engage with him and ensure his wellbeing where possible. • The NHSE SI framework is clear that Trust's should involve patients, victims, families and carers.	• Details of the Trust's adherence to NHSE SI framework • Details of the Trust's Being Open policy • Details of the Trust's contact with Mr G's family after the incident in December 2015 • Details of the Trust's contact with Mr A and his family after the incident in December 2015	**RED**

	• We would expect the Trust to have a Being Open policy that extends to engaging with victims and families as required		
2. NHS England (London) will develop, facilitate and support implementation of guidance for Mental health provider organisations on supporting families of victims of homicides. This guidance will include details of support available for families. **Responsibility:** Director of Nursing(NWL) and Lead for Patient Safety **Target Date for Completion:** November 2017	• This action is for NHSE so it is unclear as to what the action required of the Trust involves. • The draft NHSE guidance relating to victims and alleged perpetrators was attached to the action plan as evidence but it was not clear what steps the Trust intended to take to implement this guidance once formalised. • The action plan indicates that monitoring of implementation is through the Quality and Safety Committee but no evidence is provided of their oversight. • NHSE published guidance on 1 May 2019	• Clarification on the wording of this action to make this relevant to the Trust • Confirmation by the Trust of the actions undertaken with respect to this new guidance.	**RED/ AMBER**
3. Trust will work with the third sector organisations and Family Liaison officers to ensure that support for victims and families can be identified and delivered in a timely way. MD to lead discussions with third sector and Family Liaison Officers on developing robust support and information processes **Responsibility:** MD **Target Date for Completion:** December 2017	• No evidence of documentation of the joint working protocols referenced in the action plan is provided. • Separately the Trust has provided its Information Sharing Policy with reference to inter-agency working and Management of Incidents Policy. It would be reasonable to suggest that these policies should be refreshed and changes communicated to staff with respect to this recommendation. • No evidence is provided of discussions with the parties referred to on developing the appropriate processes. • It is therefore unclear whether this action has been completed.	• Evidence of procedures put in place by the Trust for liaison with the parties referred to • Minutes of discussions with Third Sector and Family Liaison Officers led by the Medical Director	**RED**
There are additional actions referred to relating to this	• There is no evidence with the action plan of scrutiny of Duty of Candour records submitted to the Trust Board	• Evidence of scrutiny of Duty of Candour records by the Trust Board	**RED**

recommendation which have not been explicitly addressed	by the Clinical Effectiveness Team to ascertain whether or not there is Trust-wide compliance with the need to contact victims and their families following Serious Incidents. • There is no evidence submitted with the action plan that the findings of these reviews have been presented to the Trust Board or delegated Committee on a bi-annual basis. • However separately, the Trust has provided the November Quality Dashboard (October 2018 reporting period) and this reports on % compliance by month with Duty of Candour requirements. • The Trust has provided an example email sent by the Governance Facilitator to staff to complete Duty of Candour requirements relating to an incident by the due date.	through Board papers/minutes (in addition to the Quality Dashboard which reports on % compliance) • Confirmation by the Trust as to which action the email referred to from the Governance Facilitator refers to as evidence. • Details of the Clinical Effectiveness Team compliance review • Details of Clinical Effectiveness Team presentation to Board and/or delegated committee	
Recommendation 7: When Staff De-Brief meetings are being organised following serious incidents, every effort must be made to invite everyone who has been involved with the care of the service user – including other teams who are involved and those who have moved to other service areas. This practice should be reinforced to Debriefing Facilitators by the Trust's Communication Forum, and evidence of this practice reviewed and documented.			
1. Compile register of staff across Trust with competency and capacity to facilitate de-briefs to teams affected by incidents **Responsibility:** Trust-wide psychological therapies lead **Target Date for Completion:** November 2017	• The action plan refers to a register of relevant staff from across the Trust being available. Three members of staff are referred to in the action plan as follows: "Psychological therapies Leads who can delegate". • No further information is provided with regards to the complete register and how this has been communicated to staff across the Trust.	• Confirmation that a register has been put in place of staff with the appropriate skills and communicated to teams to refer to	**RED/ AMBER**

2. Produce guideline for team managers and facilitators on de-briefing **Responsibility:** Trust-wide psychological therapies lead and Barnet Assistant Director **Target Date for Completion:** November 2017	• Formal guidance is not provided as evidence. An undated presentation attached provides a useful basis for development of guidelines. • There is no evidence of formal guidance being issued to staff through the Trust's communication mechanisms. • There is no evidence of the required practice being reviewed and documented. • There is a generic statement on the action plan which indicates that the action is not complete and requires further work: *"The purpose, things to consider and natural responses have been considered and the trust are in the process of developing a formal response. Will take time".*	• Documented, approved guidance on debriefing • Evidence that the guidance has been communicated to staff • Evidence that the guidance has been implemented and complied with. • A copy of the guidance	**RED/ AMBER**

***Key to RAG rating**

The RAG rating is intended to provide an indication only of the status of the action plan against the required actions based on the evidence provided by the Trust at the date of completion of this part of the review. These ratings may change should the Trust be able to share further evidence to substantiate actions noted as having been taken on the action plan update. Additional evidence required is indicated in the table above.

RED	Significant elements of recommended actions not complete and significant gaps in evidence provided by Trust
RED/AMBER	Some actions not complete and significant gaps in evidence provided by the Trust
AMBER	Actions are substantially complete but there are some significant gaps in evidence provided by the Trust
AMBER/GREEN	Actions are complete but there are some minor gaps in evidence provided by the Trust
GREEN	Actions are complete by due date and sufficient evidence has been provided by the Trust

We discussed the action plan with the Clinical Director and interim Assistant Clinical Director, particularly the lack of evidence that the action plan has been completed, despite the Trust telling us that it has been closed. We were told that recommendation 6 was not practical which was why 'N/A' was subsequently recorded in the action plan. The Clinical Director told us it would have been helpful to have been involved in discussions about the proposed recommendations in advance of the action plan being drawn up. We were told that the level of engagement for drafting action plans in response to Board Level Inquiry was less than would be expected with SI reports. The Clinical Director told us that there had not been much engagement about the action plan prior to its implementation though was able to give other examples where there

had been more dialogue with Panel Inquiries. As it was, the action plan was shared with staff once it had been drafted and there is no evidence steps were taken to refine the recommendations in view of staff push back, with a view to ensuring the actions were helpful and practical.

The Board Level Inquiry was a comprehensive report, and we consider it a missed opportunity by the Trust to develop and implement a robust action plan that built on the report's findings. The report set out seven recommendations yet staff were not engaged to test whether the proposed actions were practical and appropriate prior to the action plan being implemented. However, we note members of the Inquiry panel included a Trust Non-Executive Director and the Executive Director of Patient Services who should have been able to consider whether the recommendations were practical and/or appropriate for the Trust. In particular, the Trust's response to the recommendation around Duty of Candour and engaging with the victim and his family, detracts from the wider, important issue of engagement with victims and their families. The Trust/service could have refined the action with a view to improving how it engages with victims and their families, as opposed to responding 'NA'. The Trust has not provided any evidence of it addressing this recommendation, rather draft NHS England guidance was submitted.

The Trust has provided little evidence of implementation and monitoring of its action plan. We asked the Trust for evidence but were told that the un-evidenced action plan provided was the only document available. We were told there have been extensive changes at the Trust and that the Board Level Inquiry took place some time ago, therefore it was not possible to provide further information. However we note that the action plan was developed in 2017 and would expect – based on experience with other Trusts – that an evidenced action plan should be available for such a timeframe. We have no assurance that the Trust has implemented its action plan and note that the Clinical Director told us recommendation 1 had not been fully implemented. We recommend as a priority, the Trust review and assess its progress with this action plan, with a view to providing assurance to the CCG, NHS England, the victim and his family.

Recommendation 13: The Trust must provide an evidence based review of its action plan to the CCG with a view to it being signed off within three months.

Recommendation 14: The Trust should assure itself as a priority that it has the correct systems and processes in place to monitor and implement action plans, and that it maintains evidenced audit trails of action implementation.

Reviewing processes, embedding learning and improving patient safety at the Trust

We asked the Trust to provide us with any examples in which they had reviewed processes, sought to embed learning and/or improve patient safety, as a result of a patient safety incident.

There is a quarterly 'Deep Dive' meeting chaired by the Nursing Directorate Director of Nursing or Deputy Director. It is attended by team leads from across adult services, including older adults, inpatient and acute settings. The interim Assistant Clinical Director told us that any concerns raised at this meeting would be fed back to the teams.

We were given Barnet's 'Report to Deep Dive meeting' dated 14 June 2018, covering the 2017/18 financial year. The report provides a breakdown of the borough's performance against a variety of indicators within the CQC five domains of care (safe, caring, effective, well-led and responsive to people's needs). Under 'Safe' there is detailed section reporting on serious incidents, moderate investigations, desktop reviews and After Action Reviews (AAR). The reporting for each incident contains the service detail, a brief description of the incident and lessons learnt. It is also recorded whether the associated action plan is complete. The report also has a subsection detailing theme and trend analysis from Trust SIs.

We discussed learning from incidents at a local level with the interim Assistant Clinical Director. She told us that SIs are signed off at their respective local SI panel and that a lot of thought is given to where any learning should be shared, and that some of this learning is reported to the local clinical governance meetings. The Clinical Directors and Chairs of local SI meetings meet on a quarterly basis to identify themes and Board level learning. The Clinical Director told us the Directorate has undertaken its own annual review of SIs, identifying themes, which are then shared with colleagues.

There is a trust-wide quality news bulletin that focuses on patient safety and learning. The Trust gave us 'Quality News Issue 32' dated 3 October 2018. The bulletin contained links to a number of NICE guidance including 'Preventing suicide in the community and custodial settings'. The bulletin also contained details of upcoming NICE webinars and a subsection called 'Trust Learning'. This provide a trust-wide incident report for the quarter and details of the highest reporting teams and three highest reported incidents. The subsection concluded with a request from the Patient Safety team to make contact if:

"…there are any team stories in ways which you increased reporting or any tips for helping others to increase theirs… to help share learning"

The bulletin also provide details of clinical governance training and mandatory training. The news bulletin provided additional information including a patient experience story, links to Trust policies and relevant news stories.

The Medical Director oversees a quarterly programme of events typically focusing on specific incidents or themes. Examples included promoting patient physical healthcare and the effects of patient suicide on families and staff.

The Trust gave us an example of an SI action plan being emailed to three staff in November 2018, one of whom was the Head of Trust wide Access and Crisis Services (we do not know the roles of the other two staff). The email recipients were asked to take note of the action plan evidence that was required and asked whether the report could be shared with '*the network… as there is learning for their team too?*' We are unclear who is the network.

The Trust gave us an undated presentation called "*After the Event… Debrief or digest – working with staff after a serious incident"* as part of its action plan evidence, presented by

one the Trust Psychological leads. The Trust did not provide evidence of who or where this presentation has been shared.

The Trust has a number of mechanisms which are utilised to share learning with staff. It is not possible to quantify whether this equates to improved patient safety and the extent to which such learning becomes embedded.

Clinical Commissioning Group monitoring

Assurance and sign off processes

The terms of reference for this investigation include a review of the CCG's monitoring and sign off processes for Trust serious incidents. The NHSE SI framework (2015) says that CCGs are responsible for signing off and quality assuring Trust SI reports:

"On receipt of the final investigation report and action plan from the provider, the commissioner should acknowledge receipt by email. They will then undertake a quality assurance review of the report within 20 calendar days. Where necessary an alternative timescale may be agreed."

Commissioners must ensure:

"…the report, action plan and implementation of necessary actions meet the required standard. The serious incident report, closure process and meeting minutes must clearly describe the roles and responsibilities of those involved in the reporting, investigation, oversight and closure of the serious incident to demonstrate good governance and provide a clear audit trail. The commissioner must seek assurance that the report fulfils the required standard for a robust investigation and action plan."

The framework provides a closure checklist which can be completed by providers or commissioners as part of their SI sign off and closure process.

We asked the CCG to provide us with details of its monitoring and assurance processes, and any information that specifically related to Mr G's case.

- North Central London (NCL) CCGs SI assurance and sign off processes

There is a Serious Incident panel for North Central London CCGs, which Enfield CCG is a member. Membership includes four other local CCGs[50] - represented by their quality leads - and the North East London Commission Support Unit (NEL CSU) safety and quality teams. The NEL CSU monitors provider serious incidents on behalf of the CCGS, whom are ultimately responsible for monitoring and assurance.

The terms of reference (2017/18[51]) for the serious incident panel set out three responsibilities:

1. Serious incident quality assurance: Review and management

The SI panel is meant to meet monthly to review the monitoring and quality assurance of SIs by the NEL CSU Patient Safety team. In instances of SIs being closed subject to actions being completed, Trusts are required to provide updates of progress against actions to the Clinical Quality Review Group (CQRG). The Panel must also review SIs and seek expert input in relation to outstanding concerns in the investigation report or action plan, with a view to confirming whether the incident can be closed.

The CSU presents each SI to the panel, categorising them as 'for closure', 'to be discussed at SI panel' or 'not for closure', which in turn the SI panel will either agree or change the categorisation. In the case of the latter two, more information will be sought.

[50] Camden, Islington, Haringey and Barnet
[51] The terms of reference were scheduled for review in April 2018.

The Lead commissioner for the provider is required to formally sign off the decision to either close the SI or seek further information.

2. Analysis of themes and trends

The panel is meant to receive quarterly reports from the NEL CSU safety team detailing SI themes and trends identified during the SI review process. This analysis extends to system-wide learning and commissioning decisions.

The panel is responsible for ensuring any learning and pertinent points identified in the quarterly reports are discussed and escalated as required to the appropriate CQRG or NCL CCGs Quality Directors' Committee.

The panel is also required to monitor the NEL CSU Patient Safety team key performance indicators to ensure SIs are reviewed robustly and in a timely fashion.

3. Promotion of learning from serious incidents across North Central London

The panel is required to facilitate collaborative working and sharing learning across North Central London, extending to North and East London as required. The Panel is also tasked with promoting a six month rolling programme that focuses on learning from SIs and sharing learning. The Panel is required to agree the topics of discussion and ensure outcomes and learning are included in the NCL Quarterly SI Trend report.

SI Panel decisions are reported to CCGs' delegated Committees for Quality. Any issues pertaining to provider SI performance are addressed via the CQRG, Contract Management Group (CMG) or direct meetings with the provider. Each CCG quality lead is responsible for reporting to their CCG quality committee.

- Serious Incident Panel for Barnet, Enfield and Haringey NHS Trust ToR

The terms of reference (2018) identify Enfield CCG as the lead commissioner and each CCG – Barnet, Enfield and Haringey – as responsible for monitoring SIs, supported by the NEL who undertake this role on their behalf. Enfield CCG has a Serious Incident Panel for the Trust, chaired by Enfield CCG Director of Quality and Clinical Services. The meeting is also attended by the CCG head of clinical quality, members of NEL and Trust medical director. Additional attendees, as required, include the CCG adult and children safeguarding leads, and Trust representatives.

Following the review of an SI, the panel is able to make one of three recommendations – much like the North Central London SI panel:

1. Recommend the CQRM review further information and/or undertake further investigations
2. Recommend the CQRM ask the Service Performance Review (SPR) meeting issue a Performance Notice or conduct a joint investigation
3. Agree follow-up action in relation to issues raised and lessons identified

Engagement with the Trust

There is a Serious Incidents Management Standard Operating Procedure (SOP), version 5 (December 2018) written by the NEL Patient Safety team which sets out the processes to manage an SI.

The SOP sets out the reporting requirements CCGs the area, including the NCL pod – Barnet, Camden, Enfield, Haringey and Islington CCGs. This includes weekly reports of SI notifications from Trusts, monthly SI tracker reports, and quarterly trend analysis and individual provider reports.

Enfield 'Incident and Serious Incident policy and procedure' (2018) says the NEL CSU Patient Safety team is *"responsible for monitoring provider serious incidents on behalf of ECCG*". It goes on to say that the CCG is responsible for ensuring the Patient Safety team also monitors the implementation of action plans.

The policy details the CSU/CCG SI management process from the point an incident is classified as an SI. The process sets out that a Trust should submit its report to the CSU but it is the CCG which is responsible for quality assuring the report and providing comments to the CSU who in turn report back to the Trust. The NEL CSU Patient Safety team must submit its recommendations to the Trust and - for closure or further information – within 15 days.

The policy highlights NHS England's SI framework (2015) and says all staff are expected to comply with the framework guidance.

CCG monitoring the Trust's Mr G investigation and action plan

The CCG advised that the CSU – as per CCG policy - was responsible for engaging with the Trust in relation to Mr G's case.

We were given minutes of the Barnet, Enfield, Haringey CCG/Trust/CSU quarterly SI meeting held on 25 July 2017. The meeting was attended by Trust representatives, including the Medical Director, and the NEL CSU Assistant Director for Safety.

In relation to Mr G's case it was noted that the report had been to the Trust Board and the action plan was to be returned to the NEL CSU. The case remained open. The minutes provide an update on 88 cases – there is little narrative pertaining to any one case.

The CSU Patient Safety team sent the Trust report to Enfield CCG for review on 22 September 2017. The email noted that the NHSE SI framework said that SI reports should be reviewed within 20 calendar days, and that as a result it was no longer possible for the CSU to undertake an initial review of the report and share a summary with the CCG. An amended process had been agreed in which high-profile SIs would be sent directly to the CCG upon receipt from the Trust. The CSU asked for CCG feedback to be provided by 6 October 2017. The CSU also shared the report with the NSHE Patient Safety Lead for Mental Health (London) the same day, again asking for feedback by 6 October 2017. The email to NHSE included a closure checklist, though the report was not for closure at that time.

NHSE submitted feedback and a completed closure checklist to the CSU on 28 September 2017. It noted the report was not for closure at that time.

The Safety Co-ordinator from the CSU Quality and Safety team emailed the Trust on 12 October 2017 saying that the Trust SI report had been reviewed by the NEL CSU and NHS England, and though it was '*well written and considered'*, the report did not set out an understanding of why a number of incidents happened. The email included a number of questions in relation to this point (e.g. *"why did the Consultant rescind the CTO without discussion in the multidisciplinary team and the West Team"*) and asked for responses within 15 working days by, 2 November 2017.

The Trust replied to the CSU on 23 October 2017, saying that the Trust Medical Director had reviewed the CSU's information request and considered it to go beyond the scope of a

Further Information Request (FIR). The Trust advised that the report had been accepted by the Trust Board on 28 November 2016, and the Trust did not consider it was able to respond to the CSU's questions. The email said *"While it is always possible to iterate the question 'why' in response of any clinical decision, it is not feasible or helpful to do so in this case. Addressing the questions as asked would effectively require a reinvestigation and not simply the provision of further information".* The Trust said it would be happy to discuss the report further at a quarterly meeting with the commissioners or that a meeting could be arranged with the Medical Director and CSU to review the report. The CSU forwarded the Trust's response to NHS England and Enfield CCG on 26 October 2017 for advice on what the next steps should be in view of the Trust's response (the NHSE Patient Safety Lead for Mental Health received the email internally on 7 November 2017).

The Trust report was discussed at the NCL PoD – Barnet, Camden, Enfield, Haringey and Islington CCGs Serious Incident Panel meeting on 31 October 2017. The meeting was attended by the NCL CCG Quality Leads (including Enfield CCG's interim Quality Manager) and members of the NEL CSU Patient Safety team. The CSU Specialist Clinical Expertise Lead for Mental Health provided a summary of his review of the report and advised that NHSE had reviewed the report and requested further information. The meeting was told that the Trust Medical Director's response to the request had been forwarded to the CCG and NHSE. The CCG interim Quality Lead advised that the SI remained open and would be discussed with the Trust at the next SI review meeting in November.

The CSU emailed NHSE on 7 November 2017, advising that the Enfield CCG Quality Leads, NEL CSU Mental Health Specialist and Assistant Director for Quality and Safety were scheduled to meet the Trust on 20 November 2017. The CSU reiterated the request for advice as to how to proceed with the Trust in view of its response to the FIR.

The NHSE Patient Safety Lead for Mental Health replied to the CSU on 7 November 2017 (in response to the CSU's emails on 26 October and 7 November) that the case would be reviewed at the December[52] Independent Review Group (IRG) meeting and she would provide an update to the CSU and liaise with the Trust Medical Director about questions she had, in due course[53]. The Patient Safety Lead for Mental Health added that if the CCG was satisfied with the Trust response and wanted to close the case on STEIS, NHSE did not have an issue with this.

We did not see the CCG response to the CSU.

The NEL CSU patient safety coordinator emailed an FIR to the Trust on 24 April 2018 saying a specialist reviewer had reviewed the report and set out nine questions e.g. was a joint medical review undertaken with the care coordinator. We do not know what prompted this correspondence. The NEL CSU asked for a copy of the Trust action plan, complete with deadline dates, action owners and arrangements for monitoring. The Trust was asked to respond within 15 days by 16 May 2018.

A quarterly review meeting had taken place on 27 June 2018, attended by both the Trust and NEL CSU, in which the report was discussed[54].

The Trust Medical Director replied (via the Trust Head of Effectiveness) to the NEL CSU Specialist Clinical Expertise Lead for Mental Health on 12 July 2018. The Trust said it would address the corrections raised by the FIR (e.g. remove the patient's name) and would

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[52] The NHSE Patient Safety Lead for Mental Health told us the case was discussed at the February 2018 Independent Review Group. NHSE confirmed with the Trust and CCG in April 2018 (after it had spoken to Mr A) that it would commission an independent review.

[53] The NHSE Patient Safety Lead for Mental Health told us her questions pertained to the commissioning of an independent review. They were not about the Trust's response to the FIR

[54] This meeting was referenced in an email from the Trust Medical Director (via the Trust Head of Effectiveness) on 12 July 2018.

provide a copy of the action plan. The Medical Director said the report had been signed off by the Trust Board and this limited the benefit of responding to the FIR. He added NHSE had commissioned an external review which could address any outstanding points. The Trust would not be reviewing the report any further.

The NEL CSU Specialist Clinical Expertise Lead for Mental Health emailed NHSE on 16 July 2018 asking how it should proceed following the Medical Director's response. NHSE's Patient Safety Lead for Mental Health replied on 18 July 2018 that the case could be closed if the CSU/CCG was satisfied with the Trust response to NHSE's comments.

We spoke to the Director of Quality and Clinical Services, and the Head of Clinical Quality for Enfield CCG. We asked what happened to the CCG's oversight after November 2017. We were told that discussions took place between the Trust and NHSE, which the CCG was not part of, and that no further amendments were made to the report. We were told by NHSE that these discussions focused on the nature of the injuries Mr A had sustained. We have seen emails between NHSE and NEL CSU which indicated the former was seeking information about Mr A's injuries (for commissioning purposes) and they said they would approach the Trust Medical Director directly.

We asked the Director of Quality and Clinical Services, and the Head of Clinical Quality for Enfield CCG, for detail of the CCG's handling of the Trust action plan. We were told that action plans are meant to be submitted to the quarterly SI meeting for discussion, but no one had been able to find any meeting minutes or correspondence specifically pertaining to this SI action plan. We were told that there had been discussions about the action plan, but again, evidence of this was unavailable. The CCG said it could not provide evidence of monitoring the action plan because it said it had no further involvement in the case after NHSE became involved in November 2017. However as per the NHSE SI framework, the responsibility for monitoring the action plan lay with the CCG.

We were told that the CCG intended to raise the action plan at the February 2019 quarterly SI meeting with a view to it seeking assurance that the actions had been implemented and could be appropriately evidenced. We received no further update from the CCG.

There is a clear process by which the CSU engages with the Trust in relation to its SIs, on behalf of Enfield CCG. There is evidence the CCG is kept informed about SIs and undertakes a final review of Trust SI reports. The CSU and CCG reviewed and monitored the Trust's report into Mr G's care and treatment in line with CCG policy.

However we were provided with no evidence of CSU or CCG oversight of the Trust action plan, either in terms of helping to develop recommendations, monitoring progress or agreeing to close actions. The CCG said this was because it was not involved in the discussions between NHSE and the Trust in November 2017 and heard nothing further about the report. However correspondence we have seen from NHSE indicates this was about the nature of Mr A's injuries. The emails did not indicate that NHSE was assuming responsibility for the action plan. Such action would be a deviation from the NHSE SI framework and we would expect a clear audit trail if this had been the case. There is no evidence NHSE was assuming responsibility for the action plan. We have seen two emails from NHSE Patient Safety Lead for Mental Health which said she did not object to the case being closed subject to the CCG being satisfied the case could be closed. Responsibility lay with the CCG.

The CCG could have contacted NHSE to clarify the next steps if it was unclear as to its role in monitoring and closing the Trust action plan. The NHSE SI framework is clear that it is the responsibility of a CCG to monitor an action plan and therefore we would have expected the CCG to have taken steps to assure itself that the matter was being addressed and its assumption that NHSE had assumed responsibility for the action plan was correct.

We note that the Trust could not provide evidence to underpin its action plan which leads to concerns in terms of both the Trust's implementation of its action plan, but the CCG's monitoring and assurance processes, specifically in relation to this SI. We note the serious nature of the incident, but neither the Trust, nor CCG, could provide an audit trail of the response to the Board Level Inquiry Panel recommendations. The CCG should have contacted NHSE if it lacked clarity as to whether it, or NHSE, was responsible for monitoring the action plan after November 2017.

The Trust was clear when NHSE submitted questions about the report in late 2017 (via the CSU) that though it was willing to engage in a discussion about the case, it considered NHSE's questions to go beyond the scope of an FIR, and consequently it would not undertake further action. This was reiterated when questions were raised again in April 2018. We note that Trust Board had signed off the report in November 2016 and shared what it considered to be the final the report with Mr A in August 2017; both in advance of the CCG or NHSE being given an opportunity to review the report. Equally the Medical Director told Mr A (by email) on 12 September 2017 that the report had been signed off by the Trust Board and there were no plans to change the report further. We have seen no evidence to indicate that the report was anything but considered final by the Trust at the time of the CCG and NHSE's review which indicates a significant breakdown in the application and adherence of the assurance process.

Recommendation 15: The CCG should review itself as a priority that it has the correct systems and processes in place to gain timely assurance of the robustness of Trust investigation reports and action plans.

Recommendation 16: The CCG should assure itself as a priority that it has the correct systems and process in place to be assured Trusts are implementing action plans, and that there are no other historical cases in which action plan assurance has not been sought and provided, specifically for high risk and Board level cases.

Recommendation 17: The CCG should assure itself as a priority that Trusts respond to commissioner concerns regarding investigation reports and action plans, and do not sign off reports in advance of the CCG quality assurance process.

Appendices

Appendix A

Documents reviewed

Trust

- Mr G's clinical notes, including risk summary and care plan
- Trust Board Level Inquiry report
- Trust action plan
- Trust policies and procedures
- Meeting minutes (locality teams, Link working team, Intensive Enablement team)
- Audit results
- Correspondence
- Details of inpatient and community incidents and near misses in the past 12 months
- Borough deep dive report June 2018
- November 2018 Quality dashboard
- Quality Assurance audit tool – community adults, May 2018
- Working with staff after an SI debrief
- Quality news issue, October 2018
- Barnet Directorate organisational chart

Mr A

- Redacted Board Level Inquiry report provided to him by the Trust
- Correspondence between Mr A and the Trust

CCG

- BEH CCG CSU quarterly SI meeting minutes
- NEL SI management SOP
- NCL pod minutes
- MH report Q3, 2017/18
- Emails
- ToRs
- ECCG Incident and SI policy

Appendix B

Interviewees

- BEH Clinical Director – Barnet
- BEH interim Assistant Clinical Director – Barnet
- BEH South Locality CMHT Manager
- Enfield CCG Director of Quality and Clinical Services
- Enfield CCG Head of Clinical Quality

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