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An independent review of the internal investigation and action planning associated with that internal investigation and a serious case review into the care and treatment provided to a mental health service user Mr M in Manchester

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Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive Summary

1.1 Mr M had been convicted in 1999 (aged 22) of the murder of a neighbour, who had died from severe head injuries. Mr M received a life sentence with a tariff of 12 years.

1.2 In June 2013 Mr M was released on life licence and resided in Approved Premises but was recalled in August 2013 after breaching residence conditions by consuming alcohol. He was released again in August 2014 but was again recalled in July 2015 after being arrested for affray, possession of an offensive weapon and bladed article following a drunken dispute with a neighbour. Mr M was released on licence for a final time in June 2016 and moved from prison to the THOMAS[1] project in Salford.

1.3 On 22 March 2017 Greater Manchester Fire and Rescue Service informed Greater Manchester Police of a fire at an address in Salford where they thought people were trapped. Soon afterwards firefighters discovered the body of a man, Mr Z, inside the building. The circumstances surrounding the discovery were suspicious and the flat was declared a crime scene. It later transpired that Mr Z died from multiple stab wounds.

1.4 A woman (Ms N) was arrested on suspicion of murder but released without charge. Mr M was later arrested and in October 2017 he was convicted of the murder of the man concerned. Mr M was given a whole life tariff.

1.5 NHS England North commissioned Niche Health and Social Care Consulting (Niche) in 2018 to carry out an assurance review of the internal investigation into the care and treatment of Mr M, who received care and treatment from Greater Manchester Mental Health NHS Foundation Trust (the Trust hereafter). The terms of reference for the assurance review covered the Trust internal investigation reports and associated action plans. Also included was a requirement to review the action plans developed by NHS funded organisations in response to the Serious Case Review that was commissioned by the Greater Manchester Multi Agency Public Protection Arrangements (MAPPA) Strategic Management Board. The terms of reference for this review are given in full in Appendix A.

1.6 Niche is a consultancy company specialising in patient safety investigations and reviews, the investigation was carried out by Ms Naomi Ibbs, Senior Consultant, Dr John McKenna, retired Consultant Forensic Psychiatrist, and Nick Moor, Partner, Niche.

[1] THOMAS delivers a range of recovery focussed services, which take people from within prison or hospital, through detox and residential rehabilitation into community-based provision. www.thomaslonline.org.uk

1.7 The assurance review follows the NHS England Serious Incident Framework (March 2015)[2] and Department of Health guidance on Article 2 of the European Convention on Human Rights[3] and the investigation of serious incidents in mental health services.

Mr M's history

1.8 Mr M was reported to have a history of anxiety, depression, post-traumatic stress disorder, and substance misuse. It was also reported that Mr M had been subjected to emotional, physical and sexual abuse during his childhood and became involved in criminal activity in his teenage years.

1.9 Mr M had an extensive forensic history prior to the death of Mr Z. Previous offences include drug offences, theft, stealing vehicles, criminal damage and murder. At the time of the incident Mr M was subject to a lifetime licence and had been discussed at MAPPA meetings.

Internal investigation

1.10 The Trust undertook an internal investigation that was completed by the Strategic Lead for Health and Justice and a Consultant Forensic Psychiatrist. The report authors noted that they were limited in drawing conclusions and making recommendations because at the time of writing Mr M was on remand and criminal proceedings were ongoing.

1.11 Further, they noted that they were unable to identify any causative or contributory factors because it would be inappropriate given the case was subject to a criminal investigation.

1.12 It is our view that this stance reduced the depth of analysis undertaken, hence potentially limiting the robustness of any system-based learning.

1.13 The report does meet its own terms of reference, however it is the view of the external Panel that the analysis could have been strengthened by further analysis of:

- missing information, data and reports on the Trust electronic patient record system;
- the level of understanding across teams and agencies regarding each other's statutory roles and responsibilities.

[2] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[3] Department of Health Guidance ECHR Article 2: investigations into mental health incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

1.14 The report makes nine recommendations addressing protocols and procedures, education and training, working conditions, communications, equipment and resources and human factors.

R1 Operational Manager SMS[4] [sic] to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of both organisations are clear with a particular emphasis on ensuring that MAPPA cases are effectively managed and communication is effective.

R2 Achieve Operational Manager to review current provision of Clinical Risk Assessment Training and an action plan to be developed to ensure adequate access to clinical risk training, training in use of STAR[5] [sic], understanding of actuarial and dynamic risk and awareness of MAPPA.

R3 Achieve Operational Manager to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT [multi-disciplinary team] discussion.

R4 Achieve Operational Manager to review the current arrangements for Thomas [sic] House staff accessing PARIS[6] to be reviewed and an action plan agreed with IM&T in order to improve access for Thomas [House] and mobile staff to appropriate clinical information.

R5 Operational Manager Salford District [sic] to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of both organisations are clear with a particular emphasis on ensuring that MAPPA cases are effectively managed and communication is effective

R6 Operational Manager Salford District to review clinical risk assessment training to ensure that the significance of actuarial and historical risk is effectively communicated to staff.

R7 Operational Manager Salford District to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion including the development of a joint pathway to ensure all cases with a known history of conviction for murder or serious sexual offences are discussed with the local Criminal Justice Liaison Teams.

R8 All services to develop agreed protocols to ensure that when a service user with a conviction for murder moves area that local services are informed of the service user's relocation.

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[4] SMS – Substance Misuse Service

[5] STAR – Stop Think Act Review risk assessment

[6] PARIS is the Trust electronic patient record system

R9 The findings from this review will be presented to a trust wide Positive Learning Event within 2 months of the investigation concluding.

1.15 We have identified two additional potential key lines of enquiry:

- The time gap between the GP referral on 13 July and the eventual assessment by the community mental health team on 15 September, and the processes and reasoning that underpinned it were not examined as comprehensively as they could have been.

- Insufficiently detailed appraisal of whether the assessment by the community mental health team worker was sufficiently comprehensive and whether there should have been other assessment options routinely available given what was known about Mr M at the time.

1.16 The analysis does not identify specific care or service delivery problems, nor does it link these problems with relevant contributory factors. The authors have identified 12 root causes each of which map directly to the 12 issues that have been previously rehearsed. In patient safety terms, the root cause of an incident is the earliest point at which system intervention could have prevented the incident from occurring. It is therefore inconceivable that there could be 12 root causes of a problem, although it is entirely possible that there could have been 12 contributory factors.

Action plans arising from the internal investigation and MAPPA Serious Case Review

1.17 In addition to the Trust's internal investigation report the Greater Manchester Strategic Management Board decided that Mr M's case met the criteria for a discretionary MAPPA Serious Case Review. An independent author was appointed, and the review concluded in February 2018.

1.18 The MAPPA Serious Case Review made recommendations for a number of organisations providing services funded by health or social care. The terms of reference for our independent investigation require us to review the progress made by organisations funded by health or social care.

1.19 We have reviewed a number of action plans for the Trust relating to both the internal investigation and the MAPPA Serious Case Review. The Trust had developed separate action plans for each service (the community mental health team and the substance misuse service) and was the conduit for us accessing progress made by THOMAS House (a service that was sub-

contracted by the Trust). In addition to these plans we also reviewed the action plan for Six Degrees Social Enterprise[7].

1.20 Organisations were able to provide some evidence to us that they had addressed recommendations, but largely that evidence did not provide assurance of completeness, embeddedness or impact.

1.21 We also found a lack of robust oversight by commissioners of implementation of organisations' action plans.

Conclusions

1.22 Organisations were able to provide some evidence to us that they had addressed recommendations, but largely that evidence did not provide assurance of completeness, embeddedness or impact. Therefore, there is further work required by all organisations whose action plans we reviewed, to be able to evidence completeness, embeddedness and impact of the implementation of recommendations.

Recommendations

1.23 We have made six recommendations, the majority of these are for the Trust but a small number are directed at commissioners of mental health services and organisations involved in the MAPPA Strategic Management Board.

Recommendation 1: The Trust should review the Incident Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework.

Recommendation 2: Organisations involved in the MAPPA Strategic Management Board should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.

Recommendation 3: Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.

[7] Six Degrees Social Enterprise is a Community Interest Company based in Salford that provides support for people who are experiencing mental health problems.

Recommendation 4: Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.

Recommendation 5: The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.

Recommendation 6: The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a multi-disciplinary team review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess the compliance with and effectiveness of that protocol.

Part 1: Review process

2 Assurance review

Reason for the review

2.1 Following consultation with MAPPA colleagues, NHS England agreed to commission a desk-top assurance review of the internal investigation and action plans associated with that and the MAPPA Serious Case Review.

Approach to the review

2.2 The external quality assurance review has focussed on the internal investigation report, the subsequent action plan and the action plan developed in response to the recommendations in the Serious Case Review that was commissioned by the Greater Manchester Multi Agency Public Protection Arrangements (MAPPA) Strategic Management Board.

2.3 The external quality assurance review was conducted by:

- Ms Naomi Ibbs, Senior Consultant for Niche;
- Dr John McKenna, retired Forensic Consultant Psychiatrist.

2.4 The external review team will be referred to in the first-person plural in the report.

2.5 The report was peer reviewed by Nick Moor, Partner, Niche.

2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[8] It is important to note that we have not reviewed any health care records because this was not within the remit of our review.

2.7 This independent assurance review is working on the basis that the internal serious incident investigation panel reviewed all relevant documents in appropriate detail in drawing their conclusions and developing their recommendations.

[8] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

2.8 We used information from Greater Manchester Mental Health NHS Foundation Trust (the Trust hereafter), Six Degrees Social Enterprise[9], THOMAS House, and their commissioners to complete this investigation.

2.9 We have graded our findings using the criteria set out in Table 1 below.

Table 1: Assurance review grading criteria

Grade	Criteria
A	Evidence of completeness, embeddedness and impact
B	Evidence of completeness and embeddedness
C	Evidence of completeness
D	Partially complete
E	Not enough evidence to say complete

2.10 As part of our investigation we interviewed:

- Team manager for Salford community mental health team (a Trust provided team);
- Service manager for Achieve Salford (a Trust provided team);
- Service manager for Achieve (a Trust provided team);
- Service manager for Salford services (a Trust provided team);
- Public health finance and business support manager, Salford City Council (commissioner of the substance misuse services);
- Operational manager for Six Degrees Social Enterprise;
- Lead nurse quality assurance and improvement for Salford Clinical Commissioning Group;
- Lead investigator for the internal investigation (a Trust employee).

2.11 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview. Interviewees were invited to review the transcript and to "*add or amend it as necessary, then sign it to signify that you agree to its accuracy and return it to Niche*". Interviewees were further advised that if we did not receive the signed transcript within two weeks, we would assume that the interviewee accepted the contents as accurate.

[9] Six Degrees Social Enterprise is a Community Interest Company based in Salford that provides support for people who are experiencing mental health problems.

2.12 We also had less formal telephone discussions with senior staff at the Trust and Six Degrees Social Enterprise.

2.13 The draft report was shared with NHS England, the Trust, Six Degrees, THOMAS House and their commissioners. This provided opportunity for those organisations that had contributed significant pieces of information and those whom we interviewed to review and comment upon the content.

Structure of the report

2.14 The report is separated into three parts:

2.15 Part 1 provides the administrative narrative of the assurance review (this section).

2.16 Part 2 deals with the Trust internal investigation report and the clinical commissioning group oversight and monitoring of the report and action plan (Sections 3, 4 and 5).

2.17 Part 3 deals with progress of the action plans for organisations providing NHS funded services (Sections 6 and 7).

2.18 Part 4 provides a summary of our conclusions and recommendations (Section 8).

Engagement with affected parties

2.19 NHS England wrote to Mr M at the prison where he is detained to inform him that an assurance review had been commissioned and to establish whether he wanted to meet the assurance review team. Mr M advised that he did wish to meet someone from the assurance review team, and we met with him at the end of May 2019. We met with him prior to publication of the report and explained our findings to him.

2.20 NHS England wrote to the victim's son through his advocate to inform him that an assurance review had been commissioned and to establish whether he wanted to meet the assurance review team. The victim's son advised that he did not wish to be involved in the assurance review but that he did wish to see the report.

2.21 NHS England also wrote to the victim's sister to inform her that an assurance review had been commissioned and to establish whether she wanted to meet the assurance review team. The victim's sister advised that she did wish to talk with someone from the assurance review team and this was arranged for early June 2019.

2.22 When we spoke to the victim's sister, we explained the process of our investigation and clarified that we were not re-investigating the facts of Mr M's care and treatment but were reviewing the changes made to services in response to the internal investigation report and the MAPPA Serious Case Review.

2.23 We offered a further telephone discussion on completion of the report. Arrangements are in place to organise this and to answer any questions that the victim's sister has.

Part 2: Analysis of internal investigation report

3 Internal investigation report process

3.1 The Trust was informed that Mr M had been arrested in relation to the death of Mr Z on 4 April 2017. The Trust commissioned an internal investigation report that was completed on 2 August 2017. This indicates that it took 133 days to complete the investigation. The requirement set out in the NHS England Serious Incident Framework is 60 days. However, it is often the case that complex investigations, commissioned at the same time as a criminal investigation that is dealing with the same incident, are delayed.

3.2 The information about the date of completion of the report conflicts with the information provided by the clinical commissioning group (see Section 5) in which the clinical commissioning group states they approved extensions to the report deadline to 30 September, and then 31 October. We have been unable to establish the reason for the different accounts, however it is possible that the stated date of completion on the Trust report is incorrect and this error was not identified by either the Trust or clinical commissioning group.

3.3 The terms of reference for the internal investigation are provided in full at Appendix D. The scope of the investigation was 13 July 2016 to 4 April 2017.

3.4 The internal investigation team comprised:

- Strategic Lead for Health and Justice;
- Consultant Forensic Psychiatrist.

3.5 The internal investigation team interviewed nine members of staff, and a member of staff from the probation service.

3.6 The report recommendations were:

R1 Operational Manager SMS [sic] to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of

both organisations are clear with a particular emphasis on ensuring that MAPPA cases are effectively managed and communication is effective.

R2 Achieve Operational Manager to review current provision of Clinical Risk Assessment Training and an action plan to be developed to ensure adequate access to clinical risk training, training in use of STAR, understanding of actuarial and dynamic risk and awareness of MAPPA.

R3 Achieve Operational Manager to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion.

R4 Achieve Operational Manager to review the current arrangements for Thomas [sic] House staff accessing PARIS to be reviewed and an action plan agreed with IM&T in order to improve access for Thomas [House] and mobile staff to appropriate clinical information.

R5 Operational Manager Salford District [sic] to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of both organisations are clear with a particular emphasis on ensuring that MAPPA cases are effectively managed and communication is effective

R6 Operational Manager Salford District [sic] to review clinical risk assessment training to ensure that the significance of actuarial and historical risk is effectively communicated to staff.

R7 Operational Manager Salford District [sic] to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT [multi-disciplinary team] discussion including the development of a joint pathway to ensure all cases with a known history of conviction for murder or serious sexual offences are discussed with the local Criminal Justice Liaison Teams.

R8 All services to develop agreed protocols to ensure that when a service user with a conviction for murder moves area that local services are informed of the service user's relocation.

R9 The findings from this review will be presented to a trust wide Positive Learning Event within 2 months of the investigation concluding.

4 Analysis of internal investigation report and associated action plan

4.1 The internal investigation report authors note that at the time of writing Mr M was on remand and that criminal proceedings were still ongoing. As a result, they state, "*there are limits to the appropriateness of drawing conclusions and*

making recommendations" [10]. Further, the authors also later state that they were "*unable to identify of any of the following factors are causative or contributory and it would be inappropriate to do so, as the case is subject to a criminal investigation*"[11].

4.2 In 2006 the NHS, Health and Safety Executive and the Association of Chief Police Officers (now replaced by the National Police Chiefs' Council) agreed and signed a Memorandum of Understanding that set out the responsibilities of the three organisations in investigating serious untoward incidents.

4.3 The 2006 Memorandum of Understanding was withdrawn by the Health and Safety Executive and the National Police Chiefs' Council in 2014 and is described as being under review by NHS England. However, the principles and aims of this Memorandum of Understanding continue to be valid and are reflected in current guidance including the Serious Incident Framework[12] and National Police Chiefs' Council guidance for investigating officers[13]. The National Police Chiefs' Council document was developed with significant contributions from the Department of Health and NHS England.

4.4 It is not clear to us why or how this view was taken. As the Serious Incident Framework makes clear (and as the internal investigation's own terms of reference also state) the focus of such investigations is the nature and quality of a service user's care and treatment up to the point of the incident. Any causative or contributory factors identified, and associated recommendations relate to previously established care and/or service delivery problems, and not to any alleged offence.

4.5 These types of investigations "*are not conducted to hold any individual or organisation to account, as there are other processes for that purpose. Investigations should link to these other processes where appropriate*"[14].

4.6 It is conceivable that there could be circumstances where any investigation of this sort might have the potential to be inappropriate pending the completion of criminal proceedings. However, such an issue could be clarified and

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[10] Internal investigation report paragraph 1.1

[11] Internal investigation report paragraph 4.4

12 NHS England. Serious Incident Framework. March 2015. Relevant organisations (i.e. those who co-commission and /or co-manage care) should develop a memorandum of understanding or develop, in agreement with one another, incident investigation policies about investigations involving third parties so that there is a clear joint understanding of how such circumstances should be managed. The Department of Health Memorandum of Understanding: investigating patient safety incidents involving unexpected death or serious untoward harm (2006) provides a source for reference where a serious incident occurs and an investigation is also required by the police, the Health and Safety Executive and/or the Coroner. However this guidance is currently under review.

[13] NPCC 2015 An SIO's Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings. http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf

[14] NHS England Serious Incident Framework

agreed with the Senior Investigating Officer and/or discussions at a senior level within a Trust. There is no evidence of such discussions in this case, and it remains unclear why the investigators took the view that their role in analysis and recommendations directed at future learning was constrained.

4.7 It is our view that this stance reduced the depth of analysis undertaken, hence potentially limiting the robustness of any system-based learning.

General comments

4.8 These comments do not directly relate to the terms of reference for our review, but we have included them for the sake of completeness.

4.9 The Duty of Candour sections on the front page are left blank, we believe this is because the circumstances of the incident do not engage this duty and associated requirements. However, within the report it is recorded that Mr M's next of kin were contacted and asked to contribute (they did not respond), and that the victim's next of kin were also contacted and invited to contribute (they too did not respond).

4.10 There is no executive summary, and no index or contents page. These are recommended in the Serious Incident Framework. The Trust's relevant policy (Incident, Accident and Near Miss Policy and Procedure, implementation date 10 February 2015) includes at Appendix 14 an "*Executive Summary Report Template Required for RCA level 2 reviews*". It is not clear if this exists as a separate document from the report that was provided to us.

4.11 The process and methodology are set out, and a fishbone template was used to inform a root cause analysis.

4.12 In the Trust's report Mr M is consistently described as a "*Category 1 MAPPA case*". This category is used exclusively for registered sexual offenders. Mr M was in fact a Category 2 MAPPA offender, a violent offender who had received a term of imprisonment for longer than 12 months (but with no sexual convictions). Mr M was being managed at MAPPA Level 1 by the National Probation Service, which is where we believe the apparent confusion may have arisen.

4.13 There are two areas where the report authors have not been explicit about the source of information they have relied upon when summarising Mr M's background diagnosis and history.

4.14 Mr M is described as having a history of "*anxiety, depression, PTSD [post-traumatic stress disorder] and substance misuse".* It is unclear to us where the first three of these four diagnoses were derived from. The post-traumatic

stress disorder diagnosis appears to have been entirely self-reported, and there is no evidence it was formally ascribed by way of a clinician establishing all of the relevant diagnostic criteria. Similarly, there is no evidence that anxiety or depressive disorder were formally diagnosed by a mental health practitioner.

4.15 Much of Mr M's early history is described implicitly as if it were factual or objectively based, without the source/s of this information being confirmed. It is our view that the report should have stated that Mr M had reported these matters.

4.16 It appears to us that the matters in the internal report referred to at paragraphs 4.13 to 4.15 above are based entirely on self-report but are not described as such. This can be misleading, or at least lead to a less comprehensive formulation of someone's presentation (and risk) being taken.

4.17 The investigation does not examine the robustness of the given diagnoses, nor the presumed links between Mr M's background and presentation during the period under review, including his assessed risk. This could then make it more difficult for the investigators to confidently or robustly make conclusions about whether the care and treatment offered was appropriate to his difficulties, and proportionate to his risk, as required by their own terms of reference.

Did the internal report meet its own terms of reference?

4.18 We have set out in Table 2 below the terms of reference set out within the report. We have also provided our comments to indicate how the report met these terms.

Table 2: Analysis of whether the internal report met its own terms of reference

Terms of reference		Independent comment
1	To establish a clear and complete Chronology reviewing significant events from the 13/07/2016 leading up to the time of the incident where Mr M was remanded to custody on 04/04/2017	A detailed chronology of significant events is provided.
2	This investigation will review how comprehensive were local care and treatment plans in enabling the team to effectively meet the physical health and mental health needs of the service user in accordance with Trust and National standards with particular focus on the following areas:	
	a. The Trusts' services approach to the assessment, management and communication of any identified risk	The investigation comments in detail on how risk was assessed and

	relating to Mr M's mental health and historic offending behaviour, with consideration given by staff to the safeguarding of Mr M and others.	managed, and this topic is considered further below.
	b. Where relevant the consideration by professionals regarding the incorporating of Positive risk taking into the service users agreed treatment plan	There is no reference to positive risk taking in the report, but this does not appear to us to be inappropriate.
	c. The timeliness of assessment appointments facilitated by the Trust services, including community mental health team services and specialist drug services.	The timeliness of the community mental health team assessment is highlighted in the report and is discussed further below.
	d. To review the clinical appropriateness of the service provision for Mr M at the time of the incident.	In effect, Mr M was not being provided with a service at the time of the incident. He referred himself back to services very shortly before the incident and was then seen very soon after it.
	e. How services within the Trust organisation liaised and communicated with each other and how Trust staff liaised with other professionals/agencies involved with the service users care and treatment, including Mr M's GP.	The issue is covered in detail in the report, as described below.
3	The level of family/Carer involvement by Trust staff throughout the time period under review and where relevant how Trust professionals implemented the stages within the trust Being Open and Duty of Candour policy	The report confirms that Mr M's next of kin, and the victim's next of kin were contacted and invited to contribute. It is not clear within the report whether these communications fulfilled the Trust's Duty of Candour (Being Open) policy.
4	Where this review has identified any concerns in point 2 relating to care delivered by staff the review will explore with individual staff involved as to the reasons to **Why & How these occurred** e.g. *What was the overall, reason for staff deviation from a trust policy or procedure, what was the reason as to why a care plan or risk assessment was not completed, what were the weaknesses found within a local process/protocol* etc. The reviewer will also consider the relevance of staff human factors and human error when exploring concerns found and how circumstances or events reviewed may have influenced individual staff behaviours and actions.	The wording of this term is unusual in that it specifies care delivery problems (care delivered by staff) rather than care OR service delivery problems. The investigation report does consider relevant contributory factors, although the level of analysis of these is considered further below.
5	The review will highlight if any of the concerns found were these deemed to be influential, contributory or causal in any way to the incident occurring.	As indicated above, the authors are unable to comment on contribution causality in respect of an alleged homicide at the time of writing.

		However, in our judgement, there was also a lack of detailed analysis of care and service delivery problems, as explored further below.
6	To make recommendations to address any identified contributory factors or Root causes found.	The report does make recommendations, and we consider below whether these could have been framed more helpfully.

4.19 The template that the Trust staff were required to use contained headings from the Incident Accident and Near Miss Policy, but those headings did not match the contents of the terms of reference. This made it difficult for the report author to clearly demonstrate that the terms of reference were met.

Recommendation 1: The Trust should review the Incident Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework.

Are there any additional key lines of enquiry that would have influenced the recommendations?

4.20 It is the conclusion of the Panel that the analysis underpinning the report's conclusions could have been strengthened in relation to:

- missing information/data/reports on the PARIS system;
- the level of understanding across teams regarding each other's statutory responsibilities and roles.

4.21 The report confirms that SRS1 (Achieve Salford Recovery Services worker) and NPS1 (National Probation Service Offender Manager) agreed that on 17 August 2016, NPS1 sent SRS1 additional information about Mr M, with the intention of this being forwarded by SRS1 to Ramsgate House (community mental health team base). SRS1 recorded the contact and the fact of the sharing on PARIS (the Trust health record system), but the relevant documents appear not to have been uploaded onto this system (by SRS1). Further, the email/s containing the conversation and the attachment/s could not later be located or retrieved by SRS1 or NPS1. The investigation authors describe the "*non-uploading*" of data as an omission on the part of SRS1. However, we believe that two further points should have been considered as part of the investigation:

- The report does not make it clear how far this issue was 'chased' as part of the investigation. We understand that the Trust IT department advised that the email could not be retrieved but no rationale for this is provided. For example, it may have been the case that there was an inherent

problem in the systems used by the different organisation. The probation service used a fully secure (encrypted) email system to send e-mails and attachments to a non-secure e-mail system. It is known that such incompatibilities can sometimes prevent attachments being sent. If that were the case, then such inter-agency communication failure could recur in future.

- On 19 August 2016 (and not specifically noted in the investigation) SRS1 (successfully) made a PARIS entry stating she had received information from NPS1, and that she had emailed Ramsgate House to ask them to action Mr M's referral. The internal investigation does not consider the issue of why community mental health team staff did not then look for the notes or information whose existence was clearly indicated by the email records, or why nobody chased up SRS1 to ask where the information was. We consider this to be particularly relevant because the stated purpose of SRS1 obtaining this information was to expedite the community mental health team assessment (which had been "*put on hold*" because of lack of information). It seems that when Mr M was assessed by the community mental health team, recent PARIS record entries were either not noted, or not acted upon. This could have represented an opportunity to have rectified the above communication failure noted in the bullet above.

4.22 The internal investigation states (at 4.2.1) that Trust staff "*did not have an adequate understanding of the criminal justice system in terms of the likely supervision arrangements for a service user on Lifetime Licence for Murder…*", and (at 4.3.1) that Ramsgate House staff were "*not of the opinion that they were aware that he was under probation supervision*". The investigation also states (at 4.3.9) that CMHT1, the community mental health team staff member who assessed Mr M on 15 September 2016:

> *"did not have a full understanding of the conditions related to a life [sic] licence and therefore did not come to the conclusion that [Mr M] would have had a probation officer to liaise with…"*

4.23 However, it is our view that there were good grounds to have considered in more detail whether it was accurate to state that CMHT1's lack of understanding of supervision arrangements meant that the community mental health team was not aware that Mr M must have had a probation officer.

- Review of the health record shows that when considering Mr M's risk at that time, CMHT1 cited a number of "*protective factors"*. One of these factors was "*offender management*". This seems to us to imply that CMHT1 was aware of probation involvement. It is difficult to see how "*offender management*" could involve anything other than that.

- CMHT1's notes include "*probation service"* as a service currently providing support.

- CMHT1 wrote "*he will always be under licence for 99 years".*

4.24 Therefore, we find it difficult to understand how the authors concluded that the community mental health team staff were not aware, and should not have reasonably anticipated, that Mr M was subject to probation supervision. We explored this during interview with the lead author who said that his impression was that the community mental health team staff member had a lack of knowledge and understanding about the probation service.

4.25 In addition, it is our view that the recommendations limited the potential for assessing the effectiveness of whole organisational learning from this case. Although the Trust has referenced a Trust wide learning event stemming from their internal investigation, the assurance processes we have seen have focussed only on the specific implementation of the action for the named service/s.

Recommendation 2: Organisations involved in the MAPPA Strategic Management Board should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.

4.26 We have also identified two additional potential key lines of enquiry that we believe should have been considered and could have influenced the recommendations stemming from the internal investigation report.

First potential additional key line of enquiry

4.27 Mr M was first referred to Ramsgate House community mental health team, by his GP on 13 July 2016. He was assessed at Ramsgate House on 15 September 2016, meaning that the gap between referral and assessment was nine weeks. It is our view that this time gap, and the processes and reasoning that underpinned it, were not examined as comprehensively as they should have been.

4.28 The GP referral letter refers to "*paranoid thoughts of killing others*". The investigation notes that following discussions within the team, it was felt that "*more information was needed prior to agreeing to an assessment".* Efforts were made to establish obtain more information about Mr M's offending history from his GP. However, when the GP was called on 13 July 2016, they could not provide any further information about past history, including offending. Despite this position, at a referral meeting on 20 July 2016 it was still decided to place the referral on hold pending further information from the GP. On or soon after 1 August 2016, SRS1 established that Mr M was on Ramsgate House's "*pending more information*" list.

4.29 At paragraph 4.4.5, the investigation refers to this sequence of events as a contributory factor "*Ramsgate House could not receive the information they required to process the referral for [Mr M] as the GP did not have this*". In other words, the delay between referral and assessment was concluded to have been due to inadequate risk information being available.

4.30 The investigation offers no comment about the following issues:

- whether an appointment should have been offered on the basis of the original referral;
- whether it was reasonable to expect a GP to have more information about a patient who had very recently newly registered with them after spending years in custody;
- whether it was reasonable to wait for a total of nine weeks (between referral and assessment) once it was clear no more detail would be forthcoming;
- why, having delayed processing the referral because of insufficient information, the community mental health team then did go on to process the referral without obtaining any new information.

4.31 Given that the referral mentioned "*paranoid thoughts of killing others*", it does seem to us that it was an obvious option for the community mental health team to offer an assessment on that basis. In addition, we find it difficult to understand why the team kept the referral on hold even after the GP had stated they could not provide further information.

4.32 The internal investigation does not explore the issue of why an assessment was eventually booked when the team were in possession of precisely the same information as when they had deferred an assessment.

4.33 It is our view that the investigation missed an opportunity to appraise, rather simply describe, the processes for, and decision-making around, managing new referrals within the community mental health team.

Second potential additional key line of enquiry

4.34 In Section 4 of the report, one of the positive practices identified was the "*detailed initial assessment … carried out by the [Ramsgate House] social worker*". It is our view that there should have been a more detailed appraisal of whether the assessment by CMHT1 on 15 September 2016 was sufficiently comprehensive, and whether there should have been other assessment options routinely available given what was known about Mr M at the time, or what was apparent after initial assessment.

4.35 Three issues have not been fully explored in the report (although they are, to varying degrees, described).

- Although the information provided about and by Mr M seems to have clearly signalled probation service involvement, CMHT1 did not consider liaison with the probation service, and neither did a medical practitioner with whom they spoke shortly after the assessment.

- Although the assessment was comprehensive in some domains (including protective risk factors) little if any attention was paid to potential destabilising factors and in particular to exploring how and why two recent prison releases had failed (leading to recall). This seems an unexpected oversight in the case of a convicted murderer who reported ideas of killing other people and who had only quite recently been (again) released from custody. It is our view that formulation around risk was rather limited, as was documentation of current mental state examination findings, particularly regarding exploring likely destabilising factors or risk indicators, Mr M's understanding around risk management, and steps that might be taken should risk be thought to be increasing.

- We accept that community mental health team assessments must be influenced by resource constraints in what is a high turnover service. However, Mr M presented with a combination of unusual or at least unfamiliar features:

    - a significant (albeit unconfirmed) forensic history, in addition to the original index offence of murder (Mr M told CMHT1 that he had previously been charged with threats to kill, assault, robbery and abduction);

    - paranoid thinking, thoughts about harming or killing others;

    - a conviction for murder;

    - two prior recalls to custody; and

    - a significant substance misuse history.

- It is unclear why CMHT1 did not consider further options, or if she did, why they were not used. Other options could have included an extended assessment (further appointments), referral for a second opinion, or prompt discussion with a peer or more senior colleague.

4.36 This issue is described in the investigation "*There is no evidence of any consideration of a referral for a consultant review, forensic opinion, criminal justice liaison referral or any direct contact with offender manager [NPS1]*". However, the consequence of these matters not having been explored further as part of the investigation means that certain deeper issues around care and service delivery within the multi-disciplinary team were not fully considered. These issues might have included the flexibility of assessment procedures

and practice within the team, the availability and accessibility of senior clinical opinion, the allocation and support of assessors, and the practices and cultures of advice-seeking and clinical supervision within the multi-disciplinary team.

Adequacy of the investigation findings and recommendations and resultant action plan

4.37 The findings and analysis set out in the investigation are complicated by the fact the first relevant section of the report (Section 4. Analysis and Review findings) do not map on to the terms of reference set out immediately above it. Consequently, it is difficult to establish in a straightforward way whether and how the terms of reference were addressed. It should be noted that the wording of the subheadings at 4.1 (and 4.2 and 4.3, see below) are set out as mandatory in the Trust's incident procedure (see above).

4.38 To illustrate this issue, the first two headings in Section 4 are as follows:

- *"4.1 Identify where elements of care or service delivery were in accordance with the expected standards and identify where the use of Therapeutic Positive Risk Taking was considered as part of service users agreed care and treatment. Please also highlight where notable practice by individual staff or team was identified".*
- *"4.2 Identify any significant problems / concerns relating to the care delivered by GMMH staff"*

4.39 These subheadings could be confusing. Although they appear to address the terms of reference (eg 4.1 includes two elements of terms of reference 2) they do not address the same issues.

4.40 It appears to us that these subheadings have had the effect that the report authors have not employed the terms of reference as a framework for ordering their analysis and conclusions.

4.41 The 12 issues set out in Section 4 of the investigation are listed in abridged form at Appendix E. It can be seen that these issues do not take the form of:

- identifying specific care or service delivery problems (what?);
- linking these problems with relevant contributory factors ('how?').

4.42 In fact, the analysis either passes immediately to contributory factors, or considers both levels of analysis (problems and factors) side-by-side.

4.43 For example, several listed "*problems/concerns"* (paragraphs 4.2.1, 4.2.2, 4.2.4, 4.2.8) appear to describe contributory factors rather than care or service delivery problems. Paragraph 4.25 comprises both a service delivery

problem (delay in new patient assessment) with a contributory factor (insufficient referral information).

4.44 The third heading in Section 4 aims to consider 'why':

- *"4.3 What were the reasons as to WHY the Care delivery concerns occurred - Identify what were the fundamental reasons e.g. as to why there may have been deviations by staff from trust policies and procedures identified in 4.2 that will then need addressing by the service or Trust (Please consider where Human factors played a role in any staff behaviours relating to any of the concerns found e.g. human error or oversight)"*

4.45 Again, this chosen heading does not directly map to the terms of reference, although it does in part use some phrasing from terms of reference number 4. The use of the question "*why*" and of the phrase "*fundamental reasons*" suggests that the intention behind this heading is to consider fundamental or root causes (presumably from amongst previously identified contributory factors). This would be in keeping with the structure or framework of analysis that the Serious Incident Framework aims to facilitate. However, what follows in the investigation report is further explanation or elaboration about all of the 12 issues identified in the section immediately prior, including some repetition of the findings or opinions previously recorded. This section of the analysis, therefore, does not assess the questions set out in the relevant heading.

4.46 For example:

- paragraph 4.3.3 includes a repetition of paragraph 4.2.3;
- paragraph 4.3.4. rehearses paragraph 4.2.4. with some more detail about service arrangements;
- paragraph 4.3.5 repeats the information in paragraph 4.2.5;
- paragraphs 4.3.6, 4.3.7 and 4.3.12 largely repeat paragraphs 4.2.6, 4.2.7 and 4.2.12; and,
- paragraph 4.3.8 does not develop paragraph 4.2.8.

4.47 The wording of the fourth subheading of Section 4 is again set out in the Trust's incident policy and procedure.

- *"4.4 What were the overall Root Causes found in 4.3 and consider whether these could be deemed to have been contributory or causal in any way to incident occurrence".*

4.48 The authors set out the "*root causes*"[15] that we have listed in full in Appendix F. In patient safety terms, the root cause of an incident is the earliest point at which system intervention could have prevented the incident from occurring. It is therefore inconceivable that there could be 12 root causes of a problem although it is entirely possible that there could have been 12 contributory factors. We have provided a detailed description of root cause at Appendix G.

4.49 Each of the 12 root causes maps directly on to the same 12 issues previously rehearsed in paragraphs 4.2 and 4.3, although in this section they are linked to one of the contributory factor groupings set out in NPSA's contributory factor framework:

- education and training;
- protocol and procedure;
- working conditions;
- communication;
- individual staff factors;
- equipment and resources.

4.50 This reiteration may explain why the numbering in the list in section 4.4 erroneously changes from 4.4.1 to 4.4.8, to 4.3.9 to 4.3.12

4.51 Two of the 12 "*overall root causes*" relate to communication between the probation service and mental health services:

- 4.4.1 notes that there are no written standards underpinning effective communication between the Trust and the National Probation Service.
- 4.4.11 notes that there is no protocol to ensure joint working arrangements around information sharing (including for MAPPA Level 1 cases managed by NPS).

4.52 We find it surprising that the Trust was not already party to a MAPPA policy agreed with the National Probation Service that describes information sharing arrangements and points of contact. These two recommendations also beg the question of covering situations where (as asserted here) the Trust practitioners do not recognise that the probation service or MAPPA are

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[15] *A factor is considered to be a root cause if its removal from a sequence of events would prevent a final undesirable event from occurring. So rather than look at the symptomatic results of a problem, RCA attempts to address the hidden failings of a system or process. It is a fundamental contributory factor which had the greatest impact on the system failure. One which, if resolved, will minimise the likelihood of recurrence both locally and across the organisation.* https://improvement.nhs.uk/resources/root-cause-analysis-using-five-whys/

relevant to the case in the first place. This is referenced in root cause 4.4.9, which states that CMHT1:

- *"did not have a full understanding of the conditions related to a life [sic] licence and therefore did not come to the conclusion that [Mr M] would have had a probation officer to liaise with. There is only limited evidence of any form of robust procedure for ensuring that referrals with such a significant offending history are subject to a review by a senior clinician and/or the multi- disciplinary team within Ramsgate House. The expectation is that staff would escalate concerns but the investigation team feel this is not a robust system".*

4.53 As indicated above it is our view that the reasons why CMHT1 concluded there was no "*probation officer to liaise with*" could have been examined more closely. We have also noted that the wider issue of referral practice and team working could also have been usefully considered by the report (paragraphs 4.16 - 4.20).

4.54 Two listed root causes link to risk assessment:

- 4.4.2 notes that at the time, staff had not accessed clinical risk training;
- 4.4.3 states that Achieve staff did not understand the difference between actuarial and dynamic risk, while CMHT1 focussed on Mr M's day to day presentation (at the expense of historical risk).

4.55 The remaining root causes can be summarised as follows:

- 4.4.4 Working Conditions: limited induction for staff covering at Achieve;
- 4.4.5 Communication: Delayed processing of Ramsgate House referral;
- 4.4.6 Individual Staff Factor: SRS1 did not upload email correctly;
- 4.4.7 Individual Staff Factor: STAR risk assessment not updated;
- 4.4.8 Equipment and Resources: Unreliable THOMAS House IT systems;
- 4.4.10 Protocol & Procedure: No protocols to ensure local services are informed when a service user with a significant offending history moves area;
- 4.4.12 Protocol & Procedure: no agreed protocols with probation to ensure that the service user is picked up by services when resettled.

4.56 It is not clear to us that these issues were always fully interrogated to establish a fundamental issue (for example using the five whys technique. They appear to each have been identified as a major contributory factor linked to an identified problem.

4.57 The recommendations made are listed at in Section 3 of the Trust internal report. There are three noteworthy features of these.

- Although they generally map on to five of the root causes identified in part 4.4 of the investigation (4.4.1, 4.4.2, 4.4.3, 4.4.8, and 4.4.11), seven of the 12 root causes previously listed are not then matched by any recommendation for future action. The reason for this is not clear.

- Separate but very closely similar recommendations are given for different organisations.

- Two of the recommendations refer to actions required for service users specifically convicted of murder.

4.58 Recommendations 1 and 5 are identical, save for being directed at different teams provided by the Trust. Salford mental health and substance misuse services work with the probation service to develop a set of jointly agreed standards around the expectations of each, especially for effective communication in MAPPA cases. While this is undoubtedly an important issue raised by the investigation team, it is our view that a more effective solution would be for the standards to be embedded into a wider organisational approach to the Trust's duty to co-operate responsibilities in general, rather than being restricted to Salford-based services.

4.59 Recommendations 2 and 6 are also twinned, in that both are directed at clinical risk assessment and management training:

- one for Achieve (adequate access to clinical risk training, training in use of STAR, understanding of actuarial and dynamic risk, awareness of MAPPA);

- the other to Salford community services (ensure that the significance of actuarial and historical risk is effectively communicated to staff).

4.60 Again, it is unclear to us why these points are not for consideration by the Trust more widely. It is also unclear why the emphases of the recommendations for the two services are so different. We explored this at interview with the lead reviewer but were no clearer about this issue.

4.61 Recommendations 3, 7 and 8 all relate to service users with a past conviction for murder.

4.62 We have suggested above that this investigation overlooked a potentially important key line of enquiry relating to multi-disciplinary team functioning and norms around supervision, assessment, peer review and 'escalation'. To suggest that escalation and multi-disciplinary discussion are to be specifically (and exclusively) triggered by a murder conviction seems a limited response to the care issues raised by the investigation.

4.63 Furthermore, it is unclear whether there is a valid evidence base that suggests that murder, as opposed to other types of homicide and other serious violent offences (such as wounding with intent), should for risk assessment and management purposes be treated as an entirely separate or discrete behavioural category. This point seems to be alluded to in recommendation 7, which (unlike recommendations 3 and 8) also refers to serious sexual offences.

4.64 We are not convinced that these particular recommendations are in line with the current evidence base for risk assessment practice. We also believe that they miss, or unnecessarily restrict, an opportunity to think about how teams might work in real clinical scenarios more generally: what if someone with a background and history very similar to that of Mr M had presented with a history of a malicious wounding that had been non-fatal, or with persistent and detailed homicidal fantasies but with no history of murder?

Niche Investigation and Assurance Framework

4.65 We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[16] NHS England Serious Incident Framework (SIF)[17] and the National Quality Board Guidance on Learning from Deaths.[18] We also reviewed the Trust's policy for completing serious incident investigations, to understand the local guidance that investigators would refer to.

4.66 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement,[19] 'RCA^2 '(or Root Cause Analysis and Action, hence 'RCA Squared'), which discusses how to get the best out of root cause analysis investigations, and suggests that there are ways to tell if the RCA process is ineffective. We have set these out in Table 3 below and have built them into our assessment process.

16 National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

17 NHS England (2015) Serious Incident Framework Supporting learning to prevent recurrence https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

18 National Quality Board: National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

19 National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analysis and Actions to Prevent Harm - published by Institute of Healthcare Improvement, United States of America

Table 3 Warning signs of ineffective RCA[2]

Warning signs of ineffective RCA[2]
There are no contributing factors identified, or the contributing factors lack supporting data or information.
One or more individuals are identified as causing the event; causal factors point to human error or blame.
No stronger or intermediate strength actions are identified.
Causal statements do not comply with the 'Five Rules of Causation'.
No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
Action follow-up is assigned to a group or committee and not to an individual.
Actions do not have completion dates or meaningful process and outcome measures.
The event review took longer than 45 days to complete.
There is little confidence that implementing and sustaining corrective action will significantly reduce the risk of future occurrences of similar events.

4.67 We also considered the current NHS improvement consultation document on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g. lack of patient/staff involvement;
- inappropriate use of serious incident process e.g. doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g. too much focus on process related stats rather than quality;
- lack of time/expertise e.g. clinicians with little training in investigations trying to do them in spare time; and
- inconsistent use of evidence-based investigation methodology e.g. too much focus on fact finding, but not enough on analysing why it happened.

4.68 It is of note that the content of all current documents was consistent with original guidance issued by the National Patient Safety Agency in 2008, regarding the structure and process to be followed with root cause analysis investigations. For example, the original guidance in 2008 called for the involvement of families and those affected by the incident to have input into developing terms of reference. This is reiterated in the National Quality Board guidance and the RCA[2] guidance.

4.69 We evaluated the guidance available and constructed 25 standards for assessing the quality of serious incident reports based around the three key

themes of credibility, thoroughness and whether the report was likely to lead to change in practice.

4.70 Our assessment against these standards can be found at Appendix H.

5 Clinical Commissioning Group oversight

5.1 Salford Clinical Commissioning Group had responsibility for oversight of the Trust internal investigation report and associated action plan. We can see that the clinical commissioning group took the following actions during the completion of the internal investigation report:

- Extended the completion deadline to 30 September 2017 due to the complexity of the investigation, noting that the deadline was originally extended due to the police investigation that prevented the Trust from progressing.

- Gave a further extension to 31 October 2017 "*given the heavy involvement of the police and then safeguarding etc*".

5.2 The clinical commissioning group received the report on 10 November 2017 and on 1 December provided the following feedback to NHS England:

- One of the key areas seems to be in relation to clinical risk training and the wider recognition of external risk factors so it is good to see specific focus on this in all services within the recommendations.

- The concern around missing emails/ reports / data from the PARIS system was highlighted, however there doesn't seem to be a recommendation to address this?

- The recommendations around joint working and clear information sharing protocols between Achieve, CMHT and Probation are welcomed but perhaps this could go further as there seems to be a lack of understanding across the teams about each other's statutory responsibilities and roles

- None of the recommendations sit with the Psychology team – is it useful to also include them in the wider discussions around joint working with Probation and understanding of Licence terms (e.g. should they have known to notify when appointments were missed?

- The missing information (e.g. emails) was not retrieved – was this clarified? Do we know where the information went / why it is missing?

- Recommendation to include escalation process for service users with forensic backgrounds to be discussed at MDT is welcomed.

- Communication with offender manager – does there need to be a specific learning event to discuss how teams work together and the link with offender managers?

- Following discharge there did not seem to be any follow up / onward referral to GP or other mental health services in the new area of residence. Should this be an area to explore given the knowledge held by services on this person's background?

5.3 We have been unable to clarify with the clinical commissioning group whether this feedback was provided to the Trust or whether the clinical commissioning group obtained answers to the questions they raised, because the clinical commissioning group was unable to locate any evidence to this effect.

5.4 The clinical commissioning group summary provided to NHS England was in response to an email from NHS England in which the issue of commissioning a fully independent investigation was raised. In the clinical commissioning group response of 1 December 2017, the clinical commissioning group stated "*given the omissions and the seriousness of this case*" they would welcome an independent review.

5.5 The clinical commissioning group was unable to provide us with any other evidence relating to their oversight of the Trust internal investigation report, or their oversight and monitoring of the Trust action plans.

5.6 The clinical commissioning group reiterated that one of their concerns was in relation to risk assessment and risk management and the Trust had evidenced that risk management training had been undertaken. However, the clinical commissioning group reported to us that risk assessment and risk management was still a theme within serious incidents being reported.

5.7 The clinical commissioning group confirmed that they shared our concern that the focus of the recommendations was predominantly on services in Salford. The clinical commissioning group told us that the Trust "*do really good learning events*" but that commissioners don't attend the learning events, nor do they get a list of who has attended, which means that the clinical commissioning group is unable to establish how widely learning is being shared within the Trust.

5.8 Salford clinical commissioning group has told us that there were numerous factors that contributed to the lack of clinical commissioning group oversight in this investigation including the long-term absence of both substantive post holders involved in the day to day performance management of serious incident.

5.9 The clinical commissioning group has told us that they have now dealt with the backlog of incidents and is working more effectively with other commissioners and providers.

5.10 Since this incident was reported and investigated health and social care services in Salford have become an integrated care organisation. Therefore, there is opportunity to ensure greater consistency and quality of oversight of serious incidents reports and action plans. There is also a new process for ensuring adequate oversight and assurance from investigations.

Recommendation 3: Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.

Part 3: Review of progress made in implementing organisations' action plans

6 Progress of Trust action plan in response to internal investigation

6.1 The action plan developed in response the internal investigation report that we have reviewed was updated in January 2019. We have provided a copy of the narrative given to us by the Trust at Appendix I.

6.2 The action plan updated in January 2019 shows that at the time three recommendations remained in progress, rather than complete. They were:

- Recommendation 1 & 5: this was waiting for new standards agreed between the Trust, Salford Probation and Achieve to be signed off at a joint meeting. When we conducted interviews in April 2019, we heard that the standards were in the process of being formally agreed and signed off by the Trust (community mental health services and Achieve) and Salford Probation.

- Recommendation 8: this was shown as amber (in progress) because it linked to the development of the standards referred to in the previous bullet point.

6.3 We have reviewed the evidence provided and have graded our assessment based on the following criteria:

- A: Evidence of completeness, embeddedness and impact
- B: Evidence of completeness and embeddedness
- C: Evidence of completeness
- D: Partially complete
- E: Not enough evidence to say complete

6.4 Table 4 below provides a summary of our assessment for each recommendation. We have set out our analysis and rational for the grading in the relevant sections following.

Table 4: Assurance review grading criteria

Recommendation		Assurance grading
1 & 5	Operational Manager SMS to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of both organisations are clear with a particular emphasis on ensuring	D

Recommendation		Assurance grading
	that MAPPA cases are effectively managed, and communication is effective	
2	Achieve Operational Manager to review current provision of Clinical Risk Assessment Training and an action plan to be developed to ensure adequate access to clinical risk training, training in use of STAR, understanding of actuarial and dynamic risk and awareness of MAPPA	C
3	Achieve Operational Manager to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion	C
4	Achieve Operational Manager to review the current arrangements for Thomas House staff accessing PARIS to be reviewed and an action plan agreed with IM&T in order to improve access for Thomas and mobile staff to appropriate clinical information	C
6	Operational Manager Salford District to review clinical risk assessment training to ensure that the significance of actuarial and historical risk is effectively communicated to staff	C
7	Operational Manager Salford District to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion including the development of a joint pathway to ensure all cases with a known history of conviction for murder or serious sexual offences are discussed with the local Criminal Justice Liaison Teams	C
8	All services to develop agreed protocols to ensure that when a service user with a conviction for murder moves area that local services are informed of the service user's relocation	D
9	The findings from this review will be presented to a trust wide Positive Learning Event within 2 months of the investigation concluding	C

Standards for effective management of MAPPA cases (Trust recommendations 1 and 5)

6.5 The Trust has stated that the intention is to develop joint training for Achieve, National Probation Services and Community Rehabilitation Company substance misuse leads to ensure that MAPPA cases are appropriately managed and that communication between organisations is effective. We have not seen a copy of the draft training programme.

6.6 The Trust has also indicated that the jointly agreed standards will provide a framework to strengthen expectations of both organisations. The Trust has indicated that all staff working in Achieve and Probation will be expected to sign to confirm that they have read the jointly agreed standards and that a joint learning event is to be arranged.

6.7 Whilst agreed standards, implemented with the support of a learning event provides the foundation for improved management of cases, we are

concerned that the organisation has not focussed on monitoring the effectiveness of these changes. We would expect to see a range of checks and balances through (for example) staff supervision and case note audits to gain assurance that staff practice has changed.

Recommendation 4: Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.

Clinical risk assessment training (Trust recommendations 2 and 6)

6.8 The Trust has reviewed the provision of clinical risk assessment training within Achieve and Salford services. A plan was developed to ensure that all relevant staff have adequate access to clinical risk training, notably to ensure understanding of:

- use of STAR document;
- actuarial and dynamic risk;
- awareness of MAPPA.

6.9 Training has been provided to staff over a number of dates and in January 2019 the Trust reported that a "*final two dates*" had been set. However the Trust later clarified that it does provide a rolling programme of training and we have seen evidence of planned dates for this training.

6.10 We have also been told that Achieve team managers and leaders will review ten percent of the caseload of recovery coordinators during management supervision to ascertain the completion of appropriate risk assessment in accordance with Trust clinical risk guidance. We have seen the new supervision template that includes references to partnership working (including MAPPA cases) and review of caseload. However, none of the evidence we have seen provides details of the outcome of this approach during management supervision.

Recommendation 5: The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.

Contact escalation protocol for Achieve and Salford services for clients with a murder conviction (Trust recommendations 3 and 7)

6.11 A flow chart and escalation protocol had been developed to ensure that clients with a conviction for murder are subject to a multi-disciplinary team discussion.

6.12 We have not seen any evidence that the Trust is auditing the compliance or effectiveness of this protocol, therefore we are unable to comment upon the degree to which this has been embedded within the Trust. We are concerned about the narrow focus of this protocol as it risks other high-risk clients who do not have an existing offence label of murder (for example, several serious assaults, manslaughter etc) being overlooked.

Recommendation 6: The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a multi-disciplinary team review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess the compliance with and effectiveness of that protocol.

Access to PARIS for THOMAS House staff (Trust recommendation 4)

6.13 THOMAS House staff now have access to PARIS. Access for staff who work peripatetically in the community has been improved and these individuals now have improved access to appropriate clinical information.

6.14 An information sharing agreement is in place between the Trust and THOMAS House which is also outlined in the contract. The Trust has received assurance that THOMAS House is maintaining data security standards in that THOMAS House has registered for the Data Security and Protection Toolkit. This toolkit is an online self-assessment tool that allows organisations to measure their performance against ten data security standards.

6.15 The Trust holds quarterly contract monitoring meetings with THOMAS House where incident reporting and risks are discussed.

6.16 This information provides us with assurance that the recommendation has been implemented.

Information sharing protocol between services for clients with a conviction of murder that move between areas (Trust recommendation 8)

6.17 The Trust has worked with colleagues in the National Probation Service and the Community Rehabilitation Company to develop a multi-agency protocol to ensure that when a client with a conviction for murder moves area that all local services are informed. The protocol sets out:

- what action should be taken if a client is subject to MAPPA;
- who has responsibility to update probation services regarding MAPPA cases;
- a requirement for verbal information to be followed up by written (email) confirmation within 48 hours;
- what action should be taken and by whom, if a client misses two consecutive appointments.

6.18 The protocol was ratified in April 2019 and was due to be launched shortly afterwards. Training for relevant staff was being organised at that time and therefore it was too early for us to see any evidence of how effective the protocol was or how embedded in the organisation.

6.19 We asked the service manager whether any audits were planned to assess the effectiveness and compliance with the protocol and were advised that at the time there were no plans to do so.

6.20 See our Recommendations 2 and 4.

Learning Event (Trust Recommendation 9)

6.21 This recommendation was not present in the Trust action plan. We explored the reason for this, and we understand that this is a standard action for all serious incidents which tends not to get included in associated action plans.

6.22 Despite the absence of this recommendation in the action plan, the Trust provided us with evidence that a learning event took place on 26 January 2018. We do not have information about who attended the event, but we have been provided with a feedback summary that includes further actions to be undertaken:

- Opportunities to improve clinical risk training by including vignettes about high risk presentations such as in this case.

- Development of an e-learning package to educate and inform all front line staff of the interface with criminal justice services and orders (accessed via the learning hub).

- Development of shared protocols between Trust and probation services in Salford to clarify roles, responsibilities and expectations, including when and how to share information.

- Staff from areas other than Salford to raise the issue of joint working with probation within their local forums.

- Staff to be aware of the support available via the risk and safety department.

6.23 We have seen evidence that the shared protocol has been taken forward, but it is important that the Trust commissioners continue to seek assurance that the Trust is implementing and assessing the impact of recommendations.

7 Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review

7.1 The Greater Manchester Strategic Management Board decided that Mr M's case met the criteria for a discretionary MAPPA Serious Case Review. An independent author was appointed, and the review concluded in February 2018.

7.2 The MAPPA Serious Case Review made recommendations for a number of organisations providing services funded by health or social care. The terms of reference for our independent investigation require us to review the progress made by organisations funded by health or social care.

Achieve Salford MAPPA Serious Case Review recommendations

7.3 Table 5 below sets out the MAPPA recommendations for Achieve Salford and our assessment of progress

Table 5: Recommendations from MAPPA Serious Case Review for Achieve Salford

Recommendations for Achieve Salford		Assurance grading
1	Improve communication between all agencies involved in cases subject to MAPPA	D
2	Reference in clinical records identifying service users who are subject to MAPPA	D
3	Service user admitted to THOMAS [House] instigates immediate referral to Achieve SRS [Salford Recovery Service] for a comprehensive assessment	D

4	Completion of a full risk assessment at Achieve SRS [Salford Recovery Service] comprehensive risk assessment process	D
5	Risk assessments reviewed and updated in line with Greater Manchester Mental Health NHS Foundation Trust Clinical Risk Policy	D
6	Documentation to be contemporaneous in Achieve SRS [Salford Recovery Service] comprehensive assessment	D
7	Prompt closure of Achieve SRS [Salford Recovery Service] cases once the service user re-locates outside of Salford	D
8	GMMH PIR (currently in progress)	D

MAPPA Recommendation 1

7.4 Key actions in response to this recommendation were to develop a multi-agency risk sharing protocol and to hold an Achieve Salford Recovery Service partnership learning event.

7.5 The Achieve action plan notes this recommendation as complete in December 2017 yet when we spoke to staff in April 2019, we were told that the protocol had only just been signed off. Therefore, the recommendation could not have been completed in December 2017.

7.6 We have provided narrative on the protocol in Section 6 and will not repeat that here, save to refer to our Recommendation 4: above.

MAPPA Recommendation 2

7.7 The Trust has cited the multi-agency risk sharing protocol as a key action in response to this recommendation. The Trust has also stated that the issue of MAPPA is now included as a standard agenda item for supervision. These actions link to the Trust recommendations 2 and 6 whereby the use of supervision is used to monitor staff understanding and compliance.

7.8 The Trust has provided details of standards staff are expected to comply with and has developed a process for prompting the discussion of MAPPA cases during management supervision. However, without an audit (that includes the results being shared with appropriate agencies, such as commissioners and partners) it is not possible to assess the impact of the actions the Trust has taken. See our Recommendation 4: above.

MAPPA Recommendations 3 and 4

7.9 THOMAS House has developed a referral pathway that guides referrers and THOMAS House staff through different actions dependent upon whether the

service user is not working with Achieve (including those being released from prison) or is already engaged in treatment with Achieve. This should ensure that no service user can be referred to THOMAS House without also being engaged with Achieve.

7.10 This should ensure that all service users have risk assessments and recovery plans developed in a timely fashion, although the referral pathway does not indicate expected timeframes for Achieve to respond if the service user is not already known to them.

7.11 We can see that THOMAS House has a monthly reporting policy that includes reporting on a range of performance measures that includes:

- total number of clients by MAPPA level;
- completion of MAPPA and safeguarding documentation;
- number of admissions and discharges;
- completion of risk assessments.

7.12 However, we have not seen any completed reports and therefore we are unable to comment upon the impact that the new referral pathway has had on the performance measures, or (more specifically) the completion of comprehensive assessments by Achieve for all THOMAS House referrals.

7.13 If the Trust has not already done so, it should audit the effectiveness of the referral pathway and take any remedial action necessary if the intended outcomes are not being achieved.

MAPPA Recommendation 5

7.14 The Trust has indicated that all staff are to be aware of the Trust Clinical Risk Policy and that the detail would be included in the Achieve shared standards. We have seen the policy and the shared standards, and the Trust has confirmed that the Achieve risk assessments have been updated with the new risk information.

7.15 However, the we have not seen any evidence to indicate that risk assessments are now being completed or that the quality of those risk assessments is being assessed.

MAPPA Recommendation 6

7.16 The Trust has stated that all staff are aware of professional record keeping guidance and that this has been the subject of discussion at an Achieve partnership learning event. The Trust has stated that a comprehensive assessment will clearly identify:

- when the information was obtained and recorded;
- clear documentation, if information is current or historical.

7.17 Again, we have not seen any evidence to indicate that the Trust has audited or assessed whether comprehensive assessments now contain the required information.

MAPPA Recommendation 7

7.18 The Trust has reviewed the Achieve closure process and the information has been cascaded to all colleagues within the partnership. The new process has also been included in the Achieve partnership shared standards and discussed at the Achieve partnership learning event.

7.19 We have seen no evidence that the Trust has audited or assessed whether the new closure process is being followed or whether it is ensuring that the detail about a service user's risk is shared with other agencies as is intended.

MAPPA Recommendation 8

7.20 The Trust has stated that the conclusions of the post incident review have been shared with Achieve staff and discussed at the Achieve partnership learning event. The intended outcome is that there will be an improvement in clinical practice, identification of historical and current risks, and appropriate sharing of information. Without appropriate audits being undertaken and shared the Trust will not be able to assess the outcome of the actions taken in response to this recommendation, nor be able to provide assurance to commissioners and other stakeholders.

THOMAS House MAPPA Serious Case Review recommendations

7.21 THOMAS House is commissioned by the Trust as part of a multi-lateral contract issued by Salford City Council to provide substance misuse services. All our contact about THOMAS House actions were through staff employed by the Trust.

7.22 THOMAS House is one of a number of services provided by THOMAS (Those on the Margins of a Society). THOMAS House in Salford provides residential rehabilitation for men and women to address their drug and alcohol problems.

The service also provides move on accommodation, recovery support and runs a recovery café.

7.23 Table 6 below sets out the MAPPA recommendations for THOMAS House and our assessment of progress.

Table 6: Recommendations from MAPPA Serious Case Review for THOMAS House

Recommendations for THOMAS House		Assurance grading
1	Improve monitoring and audit of referral information for all clients subject to MAPPA or presenting high risk	E
2	Improve action planning, case management, review and external reporting for all clients subject to MAPPA or presenting high risk	E
3	Record dates of interviews between client and probation service, where these have been communicated to THOMAS, in client notes in THOAMS case management system	E

MAPPA Recommendations 1 and 2

7.24 THOMAS House reported that a new central risk management and monitoring committee was being implemented, chaired by the Chief Executive of THOMAS House, that would monitor all MAPPA clients ensuring that:

- the client's offender manager is named;
- OASys[20] details present;
- licencing agreements are accurate and up to date.

7.25 The key outcomes for this change were cited as being improvements in the safety of clients and the wider public and ensuring accurate and timely information sharing and retention.

7.26 Evidence of progress was listed as extracts from minutes of meetings. We have not seen copies of the minutes. We requested them on a number of occasions, and therefore we are unable to assess the impact that this recommendation has had.

[20] OASys (Offender Assessment System) is a risk and needs assessment tool

MAPPA Recommendation 3

7.27 THOMAS House reported that discussions about client interactions would take place at regular service meetings and that these would be evidenced in extracts from case management notes.

7.28 We have not seen any extracts, summaries or audits. We requested them on a number of occasions, and therefore we are unable to assess the impact that this recommendation has had.

Six Degrees MAPPA Serious Case Review recommendations

7.29 Table 7 below sets out the MAPPA recommendations for Six Degrees and our assessment of progress.

Table 7: Recommendations from MAPPA Serious Case Review for Six Degrees

Recommendations for Six Degrees		Assurance grading
1	Establish an understanding of the involvement of agencies such as National Probation Service and of processes such as MAPPA, particularly when related to risk assessment to allow for appropriate information sharing between agencies	D
2	Ensure that there is appropriate inquisitiveness and challenge to all information supplied to the service, particularly where this relates to risk	D

MAPPA Recommendations 1 and 2

7.30 Six Degrees has arranged training for supervisory staff to increase awareness and understanding of the National Probation Service and MAPPA. This has ensured that more senior clinicians are able to support front line staff through individual and team supervision, and team meetings.

7.31 Six Degrees has used this case as a case study to encourage staff to be more vigilant to the use of specific language that would indicate that a service user is known to probation services or has recently been released from prison. Staff are then encouraged to discuss the service user with a member of the management team to agree how to manage risks and which agencies in addition to probation should be contacted.

7.32 Staff are actively encouraged to contact the duty manager if anything about a service user's presentation is unusual or odd. This is set out in the policy and discussed in supervision. The advice given by the duty manager is recorded by the clinician and there is no system in place for the duty manager to keep a record of the advice they gave. Six Degrees conduct annual audits to check that duty discussions are documented by clinicians. It is acknowledged

that this does not allow a duty manager to identify in a timely manner if advice recorded was in accordance with that given.

7.33 We have seen the audit template (version dated 2018) but no completed audits and therefore we are unable to comment upon the audit findings.

7.34 We heard that Six Degrees is conscious of the inherent risk that knowledge and understanding is lost during staff turnover and therefore senior staff ensure that the issue is discussed regularly and "*kept alive*".

7.35 Supervision structures are being changed so that clinicians have more time with their manager on a one-to-one basis where a greater focus can be placed on case reviews. Clinicians have a weekly group session (up to six people assigned to each group) that runs for 90 minutes and is mandatory to attend. In addition, a drop-in supervision session running for 60 minutes is available every fortnight.

Part 4: Conclusions and recommendations

8 Conclusions

8.1 The Trust internal investigation report authors noted that they were limited in drawing conclusions and making recommendations because at the time of writing Mr M was on remand and criminal proceedings were ongoing. They also noted that they were unable to identify any causative or contributory factors because it would be inappropriate given the case was subject to a criminal investigation.

8.2 It is our view that this stance reduced the depth of analysis hence potentially limiting the robustness of any system-based learning.

8.3 The report does meet its own terms of reference, however it is the view of the external Panel that the analysis could have been strengthened in relation to:

- missing information, data and reports on the electronic patient record system;
- the level of understanding across teams and agencies regarding each other's statutory roles and responsibilities.

8.4 It is our opinion that there were two additional potential key lines of enquiry:

- The time gap between the GP referral on 13 July and the eventual assessment by the community mental health team on 15 September, and the processes and reasoning that underpinned it were not examined as comprehensively as they could have been.
- Insufficiently detailed appraisal of whether the assessment by the community mental health team worker was sufficiently comprehensive and whether there should have been other assessment options routinely available given what was known about Mr M at the time.

8.5 The analysis does not identify specific care or service delivery problems, nor does it link these problems with relevant contributory factors. The authors have identified 12 root causes each of which map directly to the 12 issues that have been previously rehearsed. The term root cause in a systems/root cause analysis investigation remains as identified by the National Patient Safety Agency (England), the most significant contributory factor. The one that had the most impact on system failure and the one that if resolved would minimise the likelihood of a re-occurrence.

8.6 Salford clinical commissioning group evidence of their oversight of the Trust internal investigation was lacking and they have acknowledged that they experienced a range of factors for this.

8.7 Salford clinical commissioning group have told us that they were concerned about risk assessment and risk management and the Trust had evidenced that risk management training had been undertaken. However, the clinical commissioning group reported to us that risk assessment and risk management was still a theme within serious incidents being reported.

8.8 Since this incident was reported and investigated health and social care services in Salford have become an integrated care organisation. Therefore, there is opportunity to ensure greater consistency and quality of oversight of serious incidents reports and action plans. In addition, there is a new process for ensuring adequate oversight and assurance from investigations.

8.9 Organisations were able to provide some evidence to us that they had addressed recommendations, but largely that evidence did not provide evidence of completeness, embeddedness or impact. Therefore, there is further work required by all organisations whose action plans we reviewed, to be able to evidence completeness, embeddedness and impact of the implementation of recommendations.

Recommendations

8.10 We have made six recommendations, the majority of these are for the Trust but a small number are directed at commissioners of mental health services and organisations involved in the MAPPA Strategic Management Board.

Recommendation 1: The Trust should review the Incident Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework.

Recommendation 2: Organisations involved in the MAPPA Strategic Management Board should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.

Recommendation 3: Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.

Recommendation 4: Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.

Recommendation 5: The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.

Recommendation 6: The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a multi-disciplinary team review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess the compliance with and effectiveness of that protocol.

Appendix A Terms of reference for independent investigations under NHS England's Serious Incident Framework 2015

The individual Terms of Reference for case 2017/10088 are set by NHS England with input from Salford CCG and the Chair of Greater Manchester MAPPA SMB. These terms of reference will be developed further in collaboration with the offeror and affected family members where appropriate. However, the following terms of reference will apply in the first instance.

Terms of Reference

1. Conduct a desk top review of the Trust's internal investigation, in doing so:
    - consider whether the terms of reference set by the Trust were met;
    - analyse and assess the adequacy of its findings, recommendations and the resultant action plan
    - Identify any additional key lines of enquiry which would have influenced recommendation development not considered by the internal investigation such as, but not limited to;
        - missing information/data/reports on the PARIS system
        - the level of understanding across teams regarding each other's statutory responsibilities and roles
        - development of joint working and clear information sharing protocols between Achieve, CMHT, Psychology Team and Probation
        - follow up / onward referral to GP or other mental health services in new area of residence
2. Review and assess the CCG's assurance processes and oversight of Serious Incident management
3. Taking into account the findings and learning from the SCR, identify any additional areas for improvement not covered or fully explored in relation to health services
4. Conduct a multiagency assurance review to take account of the progress made towards implementation of respective action plans. With regards to the Trust,
    - consider the effectiveness/embeddedness of clinical risk training and the wider recognition of external risk factors by all services
    - identify any notable areas of good practice or any new developments in services

- review and assess compliance with local policies, national guidance and where relevant statutory obligations

5. Assess and report on progress made against any partially implemented recommendations and identify possible organisational barriers to full implementation

6. Provide a written report to NHS England that includes measurable and sustainable recommendations

7. Provide a concise case summary and identifying an appropriate mechanism to share the learning opportunities

8. Support the commissioners if required to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.

9. Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England, North.

Appendix B Documents reviewed

Trust documents

- Internal investigation report and associated action plans
- Incident accident and near miss policy and procedure 4.10 March 2017
- Incident accident and near miss policy and procedure 2015
- Being open policy 1.1 2017
- Being open policy 2015
- Closure pathway updated October 2018
- Transcripts of internal investigation interviews
- Correspondence with affected families
- Draft partnership agreement between Achieve, National Probation Service (NPS) and Cheshire & Greater Manchester (CGM) Community Rehabilitation Company (CRC) and GMMH Mental Health District Services
- Salford Adult Community Mental Health Teams Operational Procedure
- Action plans in response to the MAPPA Serious Case Review
- THOMAS House drug and alcohol policy 2018-20
- THOMAS House management reporting policy effective 23 January 2018
- THOMAS House Executive Chair of Risk Management – MAPPA documentation (blank template)
- Email communication

Salford Clinical Commissioning Group documents

- Serious incident management policy
- Email communication

Six Degrees Social Enterprise documents

- MAPPA Serious Case Review action plan
- Minutes of internal meetings
- Referral pathways
- Documentation audit template

- Email communication

Salford City Council

- Achieve Salford Governance Report Quarter 3 2018/19
- Integrated substance misuse treatment and recovery service specifications

Appendix C Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The regulation applies to registered persons when they are carrying on a regulated activity.

CQC can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section of this guidance for more detail.

The regulation in full:

20.—

1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

2. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

    a notify the relevant person that the incident has occurred in accordance with paragraph (3), and

    b provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

3. The notification to be given under paragraph (2)(a) must—

    a be given in person by one or more representatives of the registered person,

    b provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

    c advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

    d include an apology, and

    e be recorded in a written record which is kept securely by the registered person.

4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

    a the information provided under paragraph (3)(b),

    b details of any enquiries to be undertaken in accordance with paragraph (3)(c),

    c the results of any further enquiries into the incident, and

    d an apology.

5. But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —

    a paragraphs (2) to (4) are not to apply, and

    b a written record is to be kept of attempts to contact or to speak to the relevant person.

6. The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

7. In this regulation—
"apology" means an expression of sorrow or regret in respect of a notifiable safety incident; "moderate harm" means—

    a harm that requires a moderate increase in treatment, and

    b significant, but not permanent, harm;

    "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
    "notifiable safety incident" has the meaning given in paragraphs (8) and (9);
    "prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
    "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
    "relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

    a on the death of the service user,

    b where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

    c where the service user is 16 or over and lacks capacity in relation to the matter;

"severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

8. In relation to a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

    a the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

    b severe harm, moderate harm or prolonged psychological harm to the service user.

9. In relation to any other registered person, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

    a appears to have resulted in—

        i) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

        ii) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

        iii) changes to the structure of the service user's body,

        iv) the service user experiencing prolonged pain or prolonged psychological harm, or

        v) the shortening of the life expectancy of the service user; or

    b requires treatment by a health care professional in order to prevent—

        i) the death of the service user, or

        ii) any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

Appendix D Terms of reference for the internal investigation

1. To establish a clear and complete Chronology reviewing significant events from the 13/07/2016 leading up to the time of the incident where AM was remanded to custody on 04/04/2017

2. This investigation will review how comprehensive were local care and treatment plans in enabling the team to effectively meet the physical health and mental health needs of the service user in accordance with Trust and National standards with particular focus on the following areas:

3. GMMH's services approach to the assessment, management and communication of any identified risk relating to AM's mental health and historic offending behaviour, with consideration given by staff to the safeguarding of AM and others.

4. Where relevant the consideration by professionals regarding the incorporating of Positive risk taking into the service users agreed treatment plan

5. The timeliness of assessment appointments facilitated by GMMH services, including CMHT services and specialist drug services.

6. To review the clinical appropriateness of the service provision for AM at the time of the incident.

7. How services within the GMMH organisation liaised and communicated with each other and how GMMH staff liaised with other professionals/agencies involved with the service users care and treatment, including AM's GP.

8. The level of family/Carer involvement by GMMH staff throughout the time period under review and where relevant how GMMH professionals implemented the stages within the trust Being Open and Duty of Candour policy

9. Where this review has identified any concerns in point 2 relating to care delivered by staff the review will explore with individual staff involved as to the reasons to **Why & How these occurred** e.g. *What was the overall, reason for staff deviation from a trust policy or procedure, what was the reason as to why a care plan or risk assessment was not completed, what were the weaknesses found within a local process/protocol* etc. The reviewer will also consider the relevance of staff human factors and human error when exploring concerns found and how circumstances or events reviewed may have influenced individual staff behaviours and actions.

10. The review will highlight if any of the concerns found were these deemed to be influential, contributory or causal in any way to the incident occurring.

11. To make recommendations to address any identified contributory factors or Root causes found.

Appendix E Issues set out in Section 4 of the internal report

Staff were not aware that Mr M was a "*category 1 MAPPA case*". The investigation could not review e-mail correspondence between Achieve and the National Probation Service. It concluded that:

> *"… GMMH [Trust] staff on the ground did not have an adequate understanding of the criminal justice system in terms of the likely supervision arrangements for a service user on Lifetime Licence for Murder..."*

No staff, bar the Ramsgate House social worker, could provide evidence that they had been trained in risk assessment.

Staff foregrounded or excessively relied upon Mr M's day-to-day presentation and functioning rather than actuarial risk factors and the potential relevance of destabilising factors.

This relates to the Achieve assessment on 23 March 2017, which involved staff from another team covering because of shortages and working without an induction. "*This assessment took place after the alleged incident and therefore could not have had any bearing on hat allegedly took place*".

The delay between community mental health team referral and assessment "*was due to there being insufficient information in the referral … the GP was unable to provide the relevant information regarding risk … In the event this information was requested by [Achieve] who then forwarded it to Ramsgate House and the referral proceeded*".

This notes that the information sent to Ramsgate House by Achieve (SRS1) could not be retrieved for the purpose of the investigation.

When Achieve assessed Mr M on 23 March 2017, the STAR risk assessment was not updated.

At the time, Thomas Staff had limited access to PARIS: mobile workers could not access it remotely, and there was a laptop that was "*not always operational*".

CMHT1 did not discuss the case with senior clinicians or managers, and "*there does not seem to have been consideration of the risks associated with destabilising factors … there is no evidence that following this assessment any liaison occurred with Probation but the staff concerned report that they did not have a full understanding of a lifetime licence and that this would indicate the existence of a Probation Officer*".

After Mr M moved to Blackburn, neither Achieve nor primary care psychology made a referral to local services or his new GP.

The National Probation Service did not invite any Trust service to a multi-agency meeting, did not inform health services of any relevant restrictions or licence conditions, and did not specify what issues or events should be reported by Trust staff.

Trust staff were not involved in the National Probation Service plan to resettle Mr M in Salford, and THOMAS House Blackburn did not communicate this information either.

Appendix F Root causes identified in internal investigation report

1. **Protocol and Procedure:** There are no written standards for ensuring effective communication between Achieve and Salford Probation. Similarly, there are no standards for ensuring the same with GMMH services in general.

2. **Education & Training:** While there is a program of Clinical Risk Training implemented at the time of the incident there were insufficient opportunities for staff to access this. The investigating team are led to believe that this has now been rectified.

3. **Education & Training:** Achieve staff are not conversant with the difference and significance of actuarial and dynamic risk and have not received recent training in this area. The assessing clinician at Ramsgate House similarly was focused on the actual presentation of AM on the day. There is a lack of understanding and knowledge of the significance of the risk history of AM and similarly a lack of knowledge related to the criminal justice system and supervision/MAPPA.

4. **Working Conditions:** At the point of the assessment by Achieve on 27/03/17 Trafford AIM staff were supporting Achieve as they faced challenges related to staffing. The investigating team have found little evidence that these staff received a meaningful induction to the service and it is clear that expectations of the assessment process at Achieve were not the same as at Trafford AIM. The investigation team have been assured that this was a short-term staffing issue related to staff sickness and has been resolved.

5. **Communication:** Ramsgate House could not receive the information they required to process the referral for AM as the GP did not have this. In the event Achieve sourced this information and although there was a delay in receiving an assessment at Ramsgate House. AM did receive detailed initial assessment although this was heavily reliant on self-report by the service user.

6. **Individual Staff Factor:** The Achieve Rehab Coordinator communicated information to Ramsgate House via The PARIS email system but did not upload the content of this communication into the clinical notes. The investigating team are of the opinion that this was an omission on the Rehab Coordinators part.

7. **Individual Staff Factor:** The Trafford AIM worker who completed the assessment on 27/03/17 did not update the STAR risk assessment and it therefore only contained historical and not contemporaneous information. They did update other assessment documentation to take into account some of the changes in AM's clinical presentation. However the documentation and clinical information system was the same and the Trafford AIM staff member was an experienced band 6 from the Trafford AIM assessment team. Although the staff member was working in an unfamiliar environment and unfamiliar processes the care documentation is the same at Trafford AIM as Achieve and therefore this is considered by the investigating staff that this is an omission by the Trafford Aim worker.

8. **Equipment and Resources:** The IT systems for Thomas House staff to access PARIS are not robust and reliant on unreliable connections and equipment. While there is no evidence this had a detrimental effect of the care of AM communication via a shared clinical record could be much improved.

9. **Education & Training:** The clinician involved did not have a full understanding of the conditions related to a life licence and therefore did not come to the conclusion that AM would have had a probation officer to liaise with. There is only limited evidence of any form of robust procedure for ensuring that referrals with such a significant offending history are subject to a review by a senior clinician and/or the multi-disciplinary team within Ramsgate House. The expectation is that staff would escalate concerns but the investigation team feel this is not a robust system.

10. **Protocol & Procedure:** There are no protocols in place to ensure that when a service user with a significant offending history moves area that local services are informed.

11. **Protocol & Procedure:** Although the decision to share information for a MAPPA 1 case sits with probation there is not a protocol in place to ensure that joint working arrangements are robust.

12. **Protocol & Procedure:** Although resettlement from Blackburn was not the responsibility of GMMH there are no agreed standards or protocols with probation to ensure that the service user is picked up by services.

Appendix G Definition of the term root cause

The term root cause has been referred to since as early as 1905, where the root cause of a problem with health care in the Rhondda Valley was reported in the Lancet.[21]

Over the years since, the term root cause has been used in investigation methodology, where safety investigations have been conducted using root cause analysis principles. Thinking has developed to move around from simply identifying the root cause as the most basic causal factor to one that, if changed, would have changed the outcome.

The purpose of carrying out root cause analysis investigations is to make improvements so that the chance of error is reduced or removed. In order to do this one cannot simply look for the most basic causal factor but look for the most basic causal factor which could be corrected. As a result, root cause analysis methodology now refers to the root cause being the most basic/earliest causal factor which is amenable to management intervention. There are numerous examples of this available in generic root cause analysis guidance, for example:

- In the 2008 TapRooT® Book, the definition of root cause was changed to: "*A Root Cause is the absence of a best practice or the failure to apply knowledge that would have prevented the problem.*" The 2008 TapRooT® Book is available at this link http://www.taproot.com/store/Books/
- "*A root cause is the deepest cause in a causal chain that can be resolved. If the deepest cause in a causal chain cannot be resolved, it's not a real problem. It's the way things are.*" http://www.thwink.org/sustain/glossary/RootCause.htm
- The most useful definition identified to date is the definition used by Paradies and Busch (1988),[22] that is: the most basic cause that can be reasonably identified and that management has control to fix.
- "*A root cause is the most basic causal factor or factors which, if corrected or removed, will prevent recurrence of a situation*," writes John Robert Dew, EdD, in an article published in the proceedings of the 56th Annual Quality Congress in 2002.
- "*There is honest disagreement as to whether or not an error can be attributed to a single root cause ... or whether there will be a cluster of causes,*" Dew adds. Dew presents five basic root causes:

  1. Putting budget before quality
  2. Putting schedules before quality
  3. Putting politics before quality

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[21] *The Present State of Medical Practice in the Rhondda Valley". The Lancet.18 November 1905*

[22] *HSE (2001) Root causes analysis: Literature review Prepared by WS Atkins Consultants Ltd for the Health and Safety Executive*

4. Arrogance

5. Lack of understanding of knowledge, research, and education.

Applying safety methodology to healthcare was accepted by the National Patient Safety Agency. The National Patient Safety Agency Root cause analysis training tools and guidance refer to the root cause as follows:

- A fundamental contributory factor. One which had the greatest impact on the system failure.
- One which, if resolved, will minimise the likelihood of recurrence both locally and across the organisation.

Some of the anxieties that are experienced about identifying a factor as a root cause stem from our continued problem with approaching investigations in order to learn. The purpose of root cause analysis is to learn what caused something bad to happen and how to stop it from happening in the future. It is predicated on systems theory and should not be used to identify individual culpability.

However, with the increasing chance of litigation it is increasingly difficult for organisations to simply identify learning from an investigation.

In 2016 the American National Patient Safety Forum recommended a new approach to root cause analysis that makes the purpose of the investigation process much clearer. They have produced guidance on the subject, and they have renamed root cause analysis as RCA^2. In the guidance pack[23] they make the following statement:

"*The actions of an RCA2 must concentrate on systems-level type causations and contributing factors. If the greatest benefit to patients is to be realized, the resulting corrective actions that address these systems-level issues must not result in individual blaming or punitive actions. The determination of individual culpability is not the function of a patient safety system and lies elsewhere in an organization.*"

The term root cause in a systems/root cause analysis investigation remains as identified by the National Patient Safety Agency (England):

"*The most significant contributory factor, the one that had the most impact on system failure and the one that if resolved would minimise the likelihood of a re-occurrence.*"

[23] *National patient safety foundation (January 2016) RCA2- Improving Root Cause Analyses and Actions to Prevent Harm, Boston, Massachusetts. www.npsf.org*

Appendix H Niche Investigation and Assurance Framework

Standard		Met Y/N
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident	Y
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	Y
1.3	The person leading the investigation has skills and training in investigations	Y
1.4	Investigations are completed within 60 working days	N
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	Y
1.6	Staff have been supported following the incident	N
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	Y
2.2	The terms of reference for the investigation should be included	Y
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	N
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	Y
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	N
2.6	A summary of the patient's relevant history and the process of care should be included	Y
2.7	A chronology or tabular timeline of the event is included	Y
2.8	The report describes how RCA tools have been used to arrive at the findings	Y
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	N
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	N
2.11	Root cause or root causes are described	N
2.12	Lessons learned are described	Y
2.13	There should be no obvious areas of incongruence	N

2.14	The way the terms of reference have been met is described, including any areas that have not been explored	N
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	N
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	N
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	Y
3.4	Recommendations are written in full, so they can be read alone	Y
3.5	Recommendations are measurable and outcome focused	Y

Appendix I Trust action plan for internal investigation as at April 2019

Recommendation		Actions	Update	Rating
1 & 5	Operational Manager SMS to develop a set of standards jointly with Salford Probation and Achieve to ensure that the expectations of both organisations are clear with a particular emphasis on ensuring that MAPPA cases are effectively managed, and communication is effective.	Develop joint training for Achieve and NPS/CRC substance misuse leads to ensure MAPPA cases are effectively managed and communication is effective Develop joint Achieve and Probation standards to provide a framework to strengthen expectations of both organisations with particular emphasis to ensure MAPPA cases are managed effectively All Achieve and Probation staff to sign they have read the Achieve and Probation joint standards Arrange Joint learning event for Achieve staff and NPS/CRC substance misuse leads	Awaiting sign off at joint meeting between NPS, Achieve & Salford District services	
2	Achieve Operational Manager to review current provision of Clinical Risk Assessment Training and an action plan to be developed to ensure adequate access to clinical risk training, training in use of STAR, understanding of actuarial and dynamic risk and awareness of MAPPA.	SMS - Review current provision of clinical risk assessment training within Achieve Develop an action plan to ensure all Achieve staff have adequate access to clinical risk training to ensure understanding re: 1. Use of STAR document 2. Actuarial and dynamic risk 3. Awareness of MAPPA Achieve team managers & team leaders to review 10% of recovery coordinators caseloads in management supervision sessions to ascertain completion of appropriate risk assessment in line with GMMH clinical risk guidance	SMS - several training days have been delivered and a final 2 dates set for staff Clinical risk is being delivered Refresher training on MAPPA with probation has been delivered	
3	Achieve Operational Manager to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion.	SMS - Develop an escalation protocol and flow chart to ensure individuals with a conviction for murder are subject to an MDT discussion	SMS - MDT for reviewed and developed to be an agenda item with partnership with NPS CRC	

4	Achieve Operational Manager to review the current arrangements for Thomas House staff accessing PARIS to be reviewed and an action plan agreed with IM&T in order to improve access for Thomas and mobile staff to appropriate clinical information.	Review access to PARIS for THOMAS staff based at Thomas Houses and Achieve staff who undertake mobile working Develop an Achieve, THOMAS and GMMH IM&T joint action plan	Reviewing accessing to PARIS Staff have untaken PARIS training, records held with the Trust Learning & Development Team Development of a new IM&T action for the new BST contract	
6	Operational Manager Salford District to review clinical risk assessment training to ensure that the significance of actuarial and historical risk is effectively communicated to staff.	Review of clinical risk assessment training	Review of clinical risk assessment training	
7	Operational Manager Salford District to develop a protocol for the escalation of contact of those with a conviction for murder to ensure all are subject to an MDT discussion including the development of a joint pathway to ensure all cases with a known history of conviction for murder or serious sexual offences are discussed with the local Criminal Justice Liaison Teams.	Salford - Protocol	Salford - Complete	
8	All services to develop agreed protocols to ensure that when a service user with a conviction for murder moves area that local services are informed of the service user's relocation.	Development of multi-agency protocols to ensure when a service user with a conviction for murder moves area that all local services are informed.	The development of this is covered in the joint working protocol with CRC/NPS (Action 16000 & 16017)	