An independent review of the internal investigation and associated action planning into the care and treatment provided to a mental health service user Mr S in Kent

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Our Draft Report has been written in line with the terms of reference as set out in the Terms of Reference on the independent investigation into the care and treatment of Mr S. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

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1 Executive Summary

1.1 Mr S had been under the care of mental health services since 1995 after heavy use of alcohol and drugs.

1.2 On 19 November 2015 Mr S violently assaulted Mrs R, his maternal grandmother, which led to her death. Mr S was subsequently arrested and charged with Mrs R's murder, he admitted to manslaughter by reason of diminished responsibility.

1.3 NHS England (South) 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 a mental health service user Mr S, who received care and treatment from Kent and Medway Partnership NHS Foundation Trust (the Trust hereafter).

1.4 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 Dr Carol Rooney, Deputy Director, Niche.

1.5 The assurance review follows the NHS England Serious Incident Framework (March 2015)[1] and Department of Health guidance on Article 2 of the European Convention on Human Rights[2] and the investigation of serious incidents in mental health services. The terms of reference for this review are given in full in Appendix A.

Mental health history

1.6 Mr S had previously been detained in a secure unit under Section 37/41[3] Mental Health Act (1983) after he attacked his paternal grandmother in June 1996. Although she later died, because of the passage of time between the assault and her death, Mr S was not charged with her murder.

1.7 Mr S was conditionally discharged in March 2000. The conditions required him to take medication to treat his mental health problems[4] and to refrain from drinking alcohol. He was readmitted in July 2001 after drinking alcohol,

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

[2] 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

[3] Section 37/41 of the Mental Health Act is used by a Crown Court (on the advice of two doctors) that instead of going to prison, a person would benefit from going to hospital to receive treatment for a serious mental health problem. Section 37 deals with the treatment of the mental health problem. Section 41 (often called a Restriction Order) means that the Secretary of State (for Justice) decides when a person can be given leave and when they can leave hospital. If it is agreed that a person can leave hospital, conditions will be attached to their discharge. This is called a conditional discharge and means that the person can be brought back to hospital if they do not comply with those conditions.

[4] Source: Domestic Homicide Review Executive Summary paragraph 6.6

contrary to the conditions of his discharge, but was discharged into the community again in September 2001.

1.8 In late September 2001 Mr S began to have thoughts about killing an elderly person in a care home where his girlfriend (at the time) worked, and he was again readmitted to hospital. Around this time Mr S also started to believe that his girlfriend was having an affair with his father.[5]

1.9 Mr S was commenced on clozapine[6] which led to significant stabilisation of his mental health. In December 2001 he was again discharged from hospital but his care was not transferred to the local community forensic mental health team until May 2005.

1.10 In December 2005, despite having no indications of relapse, Mr S attacked his maternal grandfather. Mr S's mother was able to contain him, and he was recalled to hospital. Mr S later admitted that he had intended to kill his grandfather.

1.11 In September 2007 Mr S was sufficiently stable to have overnight leave from hospital (with the condition of no unsupervised access to his grandparents) and in April 2008 a Mental Health Review Tribunal authorised conditional discharge to the community. One of the conditions of Mr S's conditional discharge to be in the community was limited alcohol use.

1.12 Mr S led a "*stable life*" up to 2011 when he asked to have the restriction reduced on his alcohol use. The Home Office consented and allowed Mr S to drink two units per week.

1.13 During 2012 Mr S formed a new relationship with a female whose two children were at the same school as his daughter. Mr S went on to cohabit with them.

1.14 On 29 April 2014 Mr S was granted an absolute discharge by the Mental Health Review Tribunal, despite concerns from his family and an objection from the Secretary of State. In May 2014 responsibility for Mr S's care was transferred to the local community mental health team (CMHT).

1.15 Mr S's dose of clozapine was slightly reduced in November 2014 when the pharmacist noted increased toxicity in Mr S's blood that could have caused a seizure if no action had been taken. In September 2015 Mr S advised his care coordinator that in August he had significantly reduced his medication further. He said this was because of morning drowsiness that had prevented

[5] Source: Domestic Homicide Review Executive Summary paragraph 6.8

[6] Clozapine is a drug used to treat schizophrenia in patients who have been unresponsive to, or intolerant of, conventional antipsychotic drugs. It is also occasionally used off licence in certain other clinical pictures in specialist settings, including severe personality disorders.

him from driving on a family holiday. However, his care coordinator did not arrange for Mr S to be reviewed by a doctor.

1.16 We have seen evidence of limited engagement from Mr S's care coordinator during this period, care plan reviews were overdue and record keeping was poor. There is also evidence that Mr S had started drinking regularly but changes in his behaviour were not explored further by his care coordinator.

Internal investigation and Domestic Homicide Review

1.17 The Trust undertook an internal investigation that was completed on 11 April 2017, the start date is not clear from the information we were provided. The report made ten recommendations. The internal investigation report took over 500 days from the date of the incident to complete and there was a lack of clarity in both the Trust and NHS Swale Clinical Commissioning Group (CCG) about the rationale for the delay. The internal panel did not include an appropriate clinician and did not clearly draw out care and service delivery problems, contributory factors or root cause.

1.18 We have provided an assessment of the internal report against the Niche Assurance Review Standards that we have developed.

1.19 We understand that the internal investigation processes have improved since the time of this report. Therefore, the Trust should be able to provide assurance that recent and future investigations:

- identify all appropriate system learning;
- the roles of investigation panel members are clear and include an appropriate clinician.

1.20 In addition, Kent Community Safety Partnership commissioned a Domestic Homicide Review (DHR) that began on 15 December 2015 and was completed on 7 March 2017. That report indicates that the review team had sight of the draft internal investigation report, and made six further recommendations, one of which was for the Trust, three of which were for NHS England, and two of which were for the Secretary of State, although it does not specify which Secretary of State. We presume it is referring to the Secretary of State for Justice as this is where responsibility rests for mental health patients with restriction orders.

Action plan and clinical commissioning group oversight

1.21 We reviewed the Trust action plan arising from the internal report and the DHR; and the NHS England Specialised Commissioning action plan arising from the DHR.

1.22 Not all of the recommendations in the internal report were present in the action plan and not all actions were addressed. The Trust described that some recommendations had been superseded by new services commissioned by NHS England Specialised Commissioning.

1.23 The evidence provided by the Trust to support their position on progress of all the recommendations was in some cases lacking. We are particularly concerned that the evidence of implementation of Care Programme Approach reviews actually demonstrated that 60% of reviews did not take place within the required six-month timeframe.

1.24 Where we could see that action had been taken to implement the recommendations, we were not always assured that the intended outcomes were being achieved. Where this is the case, we have made further recommendations about appropriate assurance.

1.25 The CCG was able to provide evidence that there was some oversight of the internal investigation report. We have seen no evidence that the CCG challenged the delay in the completion of the report, particularly given we understand the Trust was citing either the fact that a DHR was being undertaken or a police investigation was ongoing as the rationale for the "stop-the-clock". We have heard the CCG processes have improved but the challenge of multiple CCGs in the area covered by the Trust impacts timely progress.

1.26 NHS England has provided us with very high-level information as evidence that recommendations for the organisation have been implemented. We have reviewed this and consider that there is insufficient evidence present to make an informed judgement regarding the progress. In saying this, we are not saying that relevant actions have not been completed, simply that we have not seen sufficient evidence to be able to state that they have been.

Recommendations

1.27 The Trust and their commissioners should work together to ensure that any issues regarding the quality of investigation reports are addressed in a final draft report prior to the report being shared with families.

Recommendation 1:

The Trust must ensure that a process is in place that indicates that family members have been offered the opportunity to see a copy of the report, indicating when this has been completed.

Recommendation 2:

NHS England (South) must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.

Recommendation 3:

The Trust must ensure that all relevant key lines of enquiry are identified and addressed in internal investigation reports (for example in this case, safeguarding issues in relation to Mr S's older relations).

Recommendation 4:

The Trust and their commissioners should work together to ensure that any issues regarding the quality of investigation reports are addressed in a final draft report prior to the report being shared with families.

Recommendation 5:

The relevant department within NHS England must work with the CCGs to facilitate a co-ordinated approach by them that ensures standards are met for all serious incident investigations and associated action plans.

Recommendation 6:

The Trust must assure themselves and their commissioners that the provision of six-monthly reviews to patients in receipt of clozapine is embedded in every-day practice.

Recommendation 7:

The Trust must assure themselves and their commissioners that the arrangements for managing the risks of conditionally or absolutely discharged patients is appropriate, and embedded in every-day practice.

Recommendation 8:

The Trust must undertake further work with Swale Community Mental Health Team to ensure that crisis and contingency plans are in place and fully completed for all patients.

Recommendation 9:

The Trust must ensure that this audit and future related audits undertaken are accompanied by a clear narrative indicating the audit findings and any follow up action required.

Recommendation 10:

The Trust must ensure that the process of managing conditionally or absolutely discharged patients in community mental health teams is set out in the relevant policy/ies.

Recommendation 11:

The Trust must ensure that when new processes are introduced, they are clearly described in relevant policies or procedures and adhered to.

Recommendation 12:

NHS England Specialised Commissioning Team must consider and review the evidence they are using as assurance that recommendations have been addressed.

Recommendation 13:

NHS England (South) should consider overseeing all recommendations made for NHS England by any independent reports.

2 Assurance review

Approach to the review

2.1 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 DHR that was commissioned by Kent Community Safety Partnership.

2.2 The external quality assurance review commenced in January 2019 and was completed in April 2019. It was carried out by:

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

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

2.4 The report was peer reviewed by Dr Carol Rooney, Associate Director, Niche.

2.5 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[7] It is important to note that we have not reviewed any health care records because this was not within the remit of our review.

2.6 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.

2.7 We used information from Kent and Medway Partnership NHS Foundation Trust (the Trust hereafter), NHS Swale CCG, NHS West Kent CCG, Kent Community Safety Partnership, NHS England and Mr S's family to complete this investigation.

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

2.8 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

2.9 As part of our investigation we interviewed:

- Assistant Medical Director for the Trust.
- Community Mental Health Team Service Manager for the Trust.
- Community Care Recovery Group Patient Safety and Risk Manager for the Trust.
- Lead Investigator for the internal investigation, formerly employed by the Trust.
- Deputy Chief Nurse for NHS West Kent CCG, in the absence of any relevant staff from NHS Swale CCG still being in post.

2.10 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.

2.11 The draft report was shared with NHS England, the Trust, Kent CCG, and Kent Community Safety Partnership. 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

2.12 Section 2 describes the process of the review.

2.13 Section 3 provides a summary of the contact we have had with Mr S and his wider family.

2.14 Section 4 provides an overview of Mr S's history and mental health treatment.

2.15 Section 5 describes the Trust's execution of its Duty of Candour and Being Open Policy.

2.16 Section 6 provides a summary of the Trust internal investigation report and CCG oversight.

2.17 Section 7 sets out the recommendations from the DHR.

2.18 Section 8 describes in detail the actions planned in response to the internal investigation report and the DHR, and the progress the Trust has made in making and embedding change.

2.19 Section 9 sets out our conclusions and recommendations.

3 Engagement with affected parties

Contact with Mr S

3.1 NHS England (South) wrote to Mr S's Responsible Clinician at the high secure hospital where Mr S is detained. The purpose of the correspondence was to inform the doctor that an independent investigation had been commissioned and to establish whether Mr S was sufficiently well to be informed about it.

3.2 NHS England (South) did not receive a response until November 2019 at which time arrangements were made to meet with Mr S in December 2019. We gave Mr S an overview of our report findings and advised that we would also be meeting separately with his parents and his aunt. NHS England (South) agreed to send a copy of the report to Mr S's consultant psychiatrist when it had been finalised, so that Mr S was able to access a copy of the report in the future.

Contact with Mr S's family

Mr S's parents

3.3 NHS England (South) and Niche met with Mr S's parents to explain the process of the investigation and discuss the terms of reference.

3.4 Mr S's parents told us that they were concerned that no disciplinary proceedings had been taken in connection with the clinician who was Mr S's care coordinator at the time of Mr S's offence. They also expressed concern that Mr S's restriction order has been rescinded and that they believed this had ultimately led to the reduction of Mr S's dose of medication.

3.5 Mr S's parents also told us that Mr S's girlfriend had not known much about his mental health history. They believed that she only knew he had to take medication for an illness but that she did not know about his previous attacks on older family members.

3.6 We discussed the Trust internal investigation report with Mr S's parents, and they told us that they had not seen a copy. We do not know why the Trust had not shared the report at an earlier date. NHS England (South) therefore agreed to liaise with the Trust to arrange for a copy to be shared with them.

Recommendation 1:

The Trust must ensure that a process is in place that indicates that family members have been offered the opportunity to see a copy of the report, indicating when this has been completed.

Mrs R's daughter (Mr S's aunt)

3.7 NHS England (South) and Niche met with Mrs R's daughter (Mrs A) at the start of the investigation to explain the process and invited her to contribute to the terms of reference. Mrs A did not wish to make any changes to the terms of reference.

3.8 Mrs A told us that she had not been informed of the Trust internal investigation and had not seen a copy of their report. Mrs A described the difficulty in the family dynamics since Mrs R's death.

3.9 Mrs A talked to us about the occasion when Mr S had assaulted his maternal grandfather and his parents had taken him to hospital. Mrs A said that she had wanted to make sure that hospital staff were fully aware of the circumstances around the assault on her father. Mrs A reported to us that Mr S had tipped his grandfather out of his chair, kicked and punched him, and tried to strangle him. Mrs A told us that when she provided this information to hospital staff they indicated that it was different from the information that Mr S's parents had provided.

3.10 Mrs A told us that she had three key concerns:

- every time Mr S attacked, he had done so partly because he had been enabled to access potential victims;
- when Mr S had been given overnight leave prior to the attack on his grandfather, the people at risk (his grandparents) were not informed that he was on leave (if Mr S had stayed with his parents, he would have been 200 yards from his grandparents' home);
- she should have been given more information in order to better protect her mother from Mr S.

4 Summary of Mr S's mental health care and treatment

4.1 Mr S had previously been detained in a secure unit under Section 37/41 Mental Health Act (1983) after he attacked his paternal grandmother in June 1996. Although she later died, because of the passage of time between the assault and her death, Mr S was not charged with her murder.

4.2 Mr S was conditionally discharged in March 2000. The conditions required him to take medication to control his mental health problems. He was readmitted in July 2001 after drinking alcohol, which was contrary to the conditions of his discharge, but was discharged into the community again in September 2001.

4.3 In late September 2001 Mr S began to have thoughts about killing an elderly person in a care home where his girlfriend (at the time) worked, and he was again readmitted to hospital. Around this time Mr S also started to believe that his girlfriend was having an affair with his father.

4.4 Mr S was commenced on clozapine which led to significant stabilisation of his mental health. In December 2001 he was again discharged from hospital, but his care was not transferred to the local community forensic mental health team until May 2005.

4.5 In December 2005, despite having no indications of relapse, Mr S attacked his maternal grandfather. Mr S's mother was able to contain him, and he was recalled to hospital. Mr S later admitted he had had intended to kill his grandfather.

4.6 In September 2007 Mr S was sufficiently stable to have overnight leave from hospital (with the condition of no unsupervised access to his grandparents) and in April 2008 a Mental Health Review Tribunal authorised discharge to the community.

4.7 Mr S led a "*stable life*" up to 2011 when he asked to have the restriction reduced on his alcohol use. The Home Office consented and allowed Mr S to drink two units per week.

4.8 On 29 April 2014 Mr S was granted an absolute discharge by the Mental Health Review Tribunal, despite concerns from his family and an objection from the Secretary of State. In May 2014 responsibility for Mr S's care was transferred to the local CMHT.

4.9 Mr S's dose of clozapine was slightly reduced in November 2014 when the pharmacist noted increased toxicity in Mr S's blood that could have caused a seizure if no action had been taken. In August 2015 Mr S reduced his

medication further, to enable him to share the driving on a family holiday. His care coordinator was informed of this in September 2015. However, his care coordinator did not arrange for Mr S to be reviewed by a doctor.

4.10 We have seen evidence of limited engagement from Mr S's care coordinator during this period of time, care plan reviews were overdue and record keeping was poor. There is also evidence that Mr S had started drinking regularly but changes in his behaviour were not explored further by his care coordinator.

5 Duty of Candour and Being Open

Duty of Candour

5.1 Duty of Candour applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred.

5.2 We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour, introduced in April 2015. The Regulation is also a contractual requirement in the NHS Standard Contract.

5.3 In interpreting the regulation on the Duty of Candour, the Care Quality Commission (CQC) uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- ***"Openness*** *– enabling concerns and complaints to be raised freely without fear and questions asked to be answered.*
- ***Transparency*** *– allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.*
- ***Candour*** *– any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."*

5.4 To meet the requirements of Regulation 20, a registered provider has to:

- *"Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.*
- *Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.*
- *Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.*
- *Advise the relevant person what further enquiries the provider believes are appropriate.*
- *Offer an apology.*
- *Follow up the apology by giving the same information in writing, and providing an update on the enquiries.*

- *Keep a written record of all communication with the relevant person."*

5.5 We have included the full excerpt of the regulations at Appendix C.

5.6 The regulations are clear that the "*relevant person*" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

5.7 We asked the Trust to provide us with copies of any correspondence or clinical entries relating to the execution of the Duty of Candour responsibilities. We received an extract from Mr S's clinical records relating to communications by senior Trust staff with Mr S's partner, Mr S's parents, and Mr S himself.

5.8 We have not received copies of any correspondence, despite asking for this information twice, and indicating that the Trust's internal investigation report states that a letter was sent to Mr S's family explaining what Duty of Candour means. The Trust has advised that they have been unable to locate the original correspondence but that current practice is that all Duty of Candour correspondence is uploaded onto the relevant serious incident record.

Communication with Mr S

5.9 Mr S fulfils the criteria of "*relevant person*" because the Trust failed to properly and effectively monitor him, this led to a deterioration in his mental health and known early warning signs being missed. This in turn led to an increase in his risk of harm to older relatives.

5.10 This constitutes a notifiable patient safety incident under Regulation 20. As a person using services, he and his family or next of kin are defined as a 'relevant person' in the Regulations. Furthermore, point 7b) states:

- *"moderate harm includes 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****);"*

5.11 Mr S is now in a secure hospital and will remain there for some considerable time. This suggests that Mr S sustained at least moderate harm as he will require prolonged hospital treatment as a result of this incident.

5.12 We have seen evidence that the Trust met with Mr S in a high secure hospital on 27 April 2016. However, there is no indication from the associated clinical entry that this visit related to the Trust execution of Duty of Candour responsibilities. The clinical entry specifically references the purpose of the meeting with Mr S being to introduce his new care coordinator in the CMHT

and to see how he was settling onto the ward in the secure hospital. There is no mention in the record of any discussion in relation to Duty of Candour or Being Open.

5.13 The Trust Duty of Candour policy states that 48 hours after an incident a verbal apology should be offered to the patient or relevant person. In addition, within ten working days of the notifiable safety incident being known, the patient or relevant person must be notified in writing that the incident has been identified and provide:

- '*a meaningful apology;*
- *details of the process for providing updates to the patient or family/carer;*
- *details for a lead contact to enable the patient or family/carer to raise any questions'*.

5.14 We therefore consider that the Trust did not discharge its responsibility in relation to Duty of Candour.

5.15 The Trust should consider whether Duty of Candour should have been applied at the point when either:

- they commissioned an investigation into Mr S's care and treatment; or
- the investigation report was finalised and there were recommendations made about the care and treatment provided to Mr S.

5.16 We also recommend that NHS England (South) clarifies the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.

Recommendation 2:

NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.

Being Open with Mr S's family

Mr S's parents

5.17 Mr S's parents do not strictly fulfil the criteria of the definition of a "*relevant person*" within the regulations. However, the Trust did contact them and provided us with a copy of the associated clinical entries as evidence that they had fulfilled their Duty of Candour and Being Open responsibility towards them. Although technically the Trust did not owe Mr S's parents a Duty of Candour, we consider that communicating with them was appropriate and within the spirit of the regulations.

Mr S's partner

5.18 Again, Mr S's partner does not strictly fulfil the criteria of the definition of a "*relevant person*" within the regulations. However, the Trust did contact her and provided us with a copy of the associated clinical entries as evidence that they had fulfilled their Duty of Candour and Being Open responsibility towards her. Again, although technically the Trust did not owe Mr S's partner a Duty of Candour, we consider that communicating with her was appropriate and within the spirit of the regulations.

Mr S's aunt (Mrs A)

5.19 Mr S's aunt (Mrs A) is another family member that does not fulfil the criteria of the definition of a "*relevant person*" within the regulations. Mr S's grandmother (Mrs A's mother) was not a service user of the Trust and therefore the Trust had no direct responsibility for her wellbeing.

5.20 The Trust did not make contact with Mr S's aunt. This is the sister of Mr S's mother and the other daughter of his grandmother. The Trust has advised that the manager that met with Mr S's girlfriend and parents was not aware that there was another family member.

5.21 It would have been appropriate for the Trust to have made contact with Mrs A, not as Mr S's aunt, but as the bereaved daughter of Mr S's victim (his grandmother).

5.22 Mrs A told us that she had previously contacted the Trust following a previous assault on her father for which Mr S was responsible. However, there is no mention in the records that the Trust shared with us that Mr S's family made any reference to Mrs A in their meetings with the Trust.

6 Internal investigation report

Internal investigation report process

6.1 The Trust commissioned an internal investigation report shortly after the incident was reported, that was completed on 11 April 2017. It took 509 days to complete the investigation (1 year, 20 weeks, and 4 days). The requirement set out in the NHS England Serious Incident Framework is 60 days.

6.2 We have explored the reasons why the investigation took so long to be completed and it appears that there was confusion about whether an internal investigation report was required because a DHR was being commissioned, and there was mention of NHS England commissioning an independent investigation.

6.3 The full terms of reference for the internal investigation can be found at Appendix D. The scope of the investigation was 9 December 2013 to 19 November 2015. The key questions that the investigation team were asked to address were:

- Was the risk of relapse managed adequately?
- Did services respond appropriately when the patient informed them that he had reduced his medication?

6.4 The internal investigation team comprised:

- Patient Safety Manager;
- Community Recovery Service Line, Service Manager Patient Safety/Quality;
- Service Manager Swale Community Mental Health Team.

6.5 The internal investigation team interviewed three members of staff, received a medical review from a fourth member of staff, and were unable to interview a fifth member of staff because they had taken early retirement.

6.6 The internal investigation team had access to Mr S's electronic patient record and developed a chronology from this information.

Internal investigation report findings

6.7 The internal investigation team identified nine care and service delivery problems:

- "*There was a lack of Care Coordination, when the patient was transferred to the Swale CMHT, including not seeing the patient, not making contact with his family and carers.*

- *When the Care Coordinator was made aware that the client had reduced his medication, he was not proactive in following the client up and trying to engage him and monitor his mental state.*
- *The patient was primarily cared for by the nurse in the clozapine clinic and did not have adequate contact with other members of the multi-disciplinary team.*
- *The relapse indicators and the risks that the patient posed to older people when unwell were well known to services. This risk was not adequately managed by the care coordinator or the service when the patient reduced his medication.*
- *At this time, there was no local risk forum established in CMHTs.*
- *The crisis and contingency plan was not robust or explicit enough as to what to do if the patient stopped or reduced his medication.*
- *Information about the patient's past and current mental health problems had never been shared with the patient's current partner, nor did the care coordinator attempt to facilitate in achieving this communication with the partner.*
- *The use of the Mental Health Act was never considered. When the patient was last seen, he was not showing any psychotic symptomology. However, there could have been consideration for detention due to the nature of his mental illness and consequences of his known and well documented history.*
- *There was* [sic] *no local management arrangements of the oversight of (ex) forensic patients."*

6.8 The internal investigation team identified eight contributory factors:

- *"There was a lack of Care Coordination when the patient was transferred to the Swale CMHT, including not seeing the patient, not arranging Multi-Disciplinary review and not making contact with his family and carers.*
- *When the Care Coordinator was made aware that the client had reduced his medication, he was not proactive in following the client up and trying to engage him and monitor his mental state.*
- *The patient was primarily cared for by the nurse in the Clozapine clinic and did not have adequate contact with other members of the multi-disciplinary team.*
- *The relapse indicators and the risks that the patient posed to older people when unwell were well known to services. This risk was not adequately managed by the care coordinator or the service when the patient reduced his medication.*
- *The use of the Mental Health Act was never considered. When the patient was last seen, he was not showing any psychotic symptomology. However, there could have been consideration for detention due to the nature of his mental illness and consequences of his known and well documented history.*

- *Information about patient's past and current mental health problems had never been shared with patient's current partner, nor did the care coordinator attempt to facilitate this.*
- *There were no discussions or consideration by the Community Mental Health team to include Forensic Services in the discussions or management of this patient when it was known he had reduced his Clozapine medication.*
- *The care team did not follow the direction for the Absolute Discharge which stipulates that contact should be made with the family whilst this patient was in the community."*

6.9 The report goes on to state that the internal investigation team found that the root causes (defined in the report as fundamental care and service delivery problems that led to the incident happening) were the same as the contributory factors. These were:

- *"There was a lack of Care Coordination, when the patient was transferred to the Swale CMHT, including the care coordinator not seeing the patient, not making contact with his family and carers.*
- *When the Care Coordinator was made aware that the client had reduced his medication, he was not proactive in following up the client and trying to engage him and monitor his mental state.*
- *The patient was primarily cared for by the nurse in the Clozapine clinic and the patient did not have adequate contact with other members of the multi-disciplinary team.*
- *The relapse indicators and the risks that the patient posed to older people when unwell were well known to services. This risk was not adequately managed by the care coordinator or the service when the patient reduced his medication."*

6.10 Three lessons learned were identified:

- "*The consultant psychiatrist was new in post and had never met the patient before. She was very well aware of the risk indicators which were not present when he was seen; however there was no formal handover.*
- *The Trust did not have an accurate list, or register of, Conditionally or Absolutely Discharged patients or a list of patients on Community Treatment Orders.*
- *The Trust did not have a policy for the management of Conditionally or Absolutely Discharged patients."*

6.11 The conclusions of the internal investigation team were that the management of Mr S's care and treatment whilst under the care of the CMHT had a number of inadequacies, and, on the evidence that the internal investigation team saw, the care coordinator and the service failed in their duty of care to the patient and their family.

6.12 The report recommendations were:

R1 *"All patients receiving Clozapine to be reviewed via the CPA process twice a year, as per CPA policy.*

R2 *All Conditionally and Absolutely Discharged patients should be discussed in the team's Risk Forum when there is significant changes or concerns.*

R3 *Crisis and contingency plans should be clear and explicit, including the use of the Mental Health Act and involvement of the forensic service line.*

R4 *All clients who are either Absolutely or Conditionally Discharged from a forensic section and are under the care of the Clozapine or Depot Clinic should be seen and reviewed in between these sessions by the Care Coordinator or the wider multi-disciplinary team. This includes contact with the patient's family.*

R5 *Depot or Clozapine clinics must not be the only point of contact for patients who are Absolutely or Conditionally Discharged from a forensic section.*

R6 *A handover process should be developed for new consultants so they are familiar with; high risk and Conditionally or Absolutely Discharged forensic patients.*

R7 *The development of specialist practitioner roles for the care of forensic patients within the community mental health teams.*

R8 *The RiO electronic record system has the ability to add a 'notice' (flag/alert) and should be used in these instances so that all staff are aware of key information.*

R9 *The trust should develop guidance for forensic patients who are being cared for by Community Mental Health Teams.*

R10 *The community Mental Health Team to ensure that they have staff who have attended the Think Family Training Programme."*

Analysis of internal investigation report – Niche Investigation and Assurance Framework

6.13 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,[8] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[9] We also reviewed the Trust's policy for completing serious incident

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

[9] 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

investigations, to understand the local guidance to which investigators would refer.

6.14 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement,[10] 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 root cause analysis process is ineffective. We have built these into our assessment process.

6.15 The warning signs of an ineffective root cause analysis investigation include:

- 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.

6.16 We also considered the current NHS improvement consultation document[11] 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 statistics rather than quality;

[10] National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analyses and Actions to Prevent Harm –published by Institute of Healthcare Improvement, United States of America.

[11] NHS Improvement (2018) The future of NHS patient safety investigation https://improvement.nhs.uk/documents/2525/The_future_of_NHS_patient_safety_investigations_for_publication_proofed_5.pdf

- lack of time/expertise e.g. clinicians with little training in investigations trying to do them in spare time;
- inconsistent use of evidence-based investigation methodology e.g. too much focus on fact finding, but not enough on analysing why it happened.

6.17 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.

6.18 We evaluated the guidance available and constructed 25 standards for the 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. Below, we set out the standards and the source of the guidance, which we have developed into our own '**credibility, thoroughness and impact**' framework.

6.19 Our assessment against these standards can be found at Appendix E.

6.20 As we have referred to above, the internal investigation report was completed more than 500 days after the incident took place. This is an exceptionally long time, particularly for reviewing such a short period of care and treatment. Trust staff have described to us a "*myth*" being held by the Trust that if an independent DHR was going to take place, then the Trust should not do a serious incident investigation because this would interfere with the DHR. Other staff told us that the internal investigation was delayed because of the criminal investigation and trial processes.

6.21 The Trust Director of Nursing has told us that the previous Head of Safeguarding had expressed the view that the Trust could not start an internal investigation until safeguarding processes had concluded. The Director of Nursing has acknowledged that this view was inaccurate and has confirmed that she rectified this when she took on responsibility for safeguarding and serious incidents. The Director of Nursing has also confirmed that the Trust now has a "*much improved process*" that allows the Trust to progress as soon as police clearance is given, as long as the internal investigation does not interfere with criminal proceedings.

6.22 We understand that the Trust sought permission from the CCG for a "*stop the clock*" to be in place (a suspension of the deadline until an agreed point) and the Trust advised NHS England (South) of this in March 2016.

6.23 The internal investigation team did not include anyone who was employed as a clinician. We have sought to understand what advice or consultation was available to the panel from an appropriate clinician and have established that there was no direct medical input or advice to the investigation. We acknowledge that members of the panel included mental health nurses and an occupational therapist. However, no member of the panel was medically qualified.

6.24 The lack of input from an appropriate clinician limited the ability of the panel to fully interpret the records reviewed. A risk manager cannot interpret records in the same way a senior medical clinician will do. We have been advised that the Trust has now changed the process for allocating an internal investigation team and that an appropriate clinician is now always involved in the panel. The Director of Nursing told us that in a recent serious incident investigation involving a homicide, a Non-Executive Director chaired the panel in addition to a senior medical representative being a panel member.

6.25 During interview we sought to understand who undertook what role in the internal investigation:

- Patient Safety Manager – responsible for the investigation including interviews and report writing, but he told us that he was not responsible for the final version as it was completed after he left the Trust.
- Community Recovery Service Line Service Manager, Patient Safety/Quality – this person told us that at the time the role of the second person was not structured (as it is now) and that she and the Patient Safety Manager had some discussions about the findings and she was given a copy of the draft report for review. This member of staff told us that the Patient Safety Manager and the Service Manager for Swale CMHT were the "*two individuals that were involved in what you would consider to be the pure investigation of the case*".
- Service Manager for Swale CMHT – newly appointed into the role on an interim basis, three days after the incident occurred. This member of staff told us that she had minimal input to the investigation, other than discussing it with the Patient Safety Manager.

6.26 It is unusual for there to be such lack of clarity about the roles of members of an internal investigation panel. We have heard that the way that internal investigations are allocated and organised has improved since the time that this report was written.

6.27 There are a number of key facts that have not been drawn out in the internal investigation report that are present in the DHR report:

- that Mr S reported to staff that he had thoughts of killing his father;
- concerns about Mr S's family not appearing to appreciate the risk he presented;

- that the Secretary of State objected to Mr S's absolute discharge.

6.28 It is of concern to us that it appears that the internal investigation report has not identified a notable amount of what we consider to be relevant information, available in the DHR report. However, because we have not reviewed the records, it is difficult for us to identify how much other information has not been drawn out in the internal investigation report.

6.29 We have been able to identify some omissions from reading the DHR, but it is possible that there are 'unknown unknowns', i.e. that because we have not reviewed the clinical records, we do not know what relevant information is missing from the internal investigation chronology.

6.30 It is of concern to us that the internal report did not consider the safeguarding issues in relation to Mr S's older relations. The risks to his grandparents were well evidenced in his previous attack on his paternal grandmother in 1996 (ultimately resulting in her death) and the attack on his maternal grandfather in 2005. This history should have prompted a far more assertive and clear response from the Trust regarding Mr S's risks and triggers, and we would have expected this to have been addressed in the internal investigation report.

Recommendation 3:

The Trust must ensure that all relevant key lines of enquiry are identified and addressed in internal investigation reports (for example in this case, safeguarding issues in relation to Mr S's older relations).

6.31 The Trust identified care and service delivery problems without clarifying which category applied to the problem. The Trust then identified eight contributory factors which repeated the same content as the care and service delivery problems. The service delivery problems and care delivery problems should have been identified and the contributory factors should have described what influenced the service and care delivery problems.

6.32 The Trust identified four root causes that reiterate the first four care and service delivery problems and the first four contributory factors. The root cause should be identified as the earliest issue that, had it been different, would have resulted in a different outcome.

NHS Swale Clinical Commissioning Group oversight of internal report

6.33 We asked NHS Swale CCG to provide us with:

- notes of the meetings and copies of any formal correspondence between them and Trust regarding the incident report and development of the associated action plan;
- notes of meetings between them and the Trust whereby the action plan was monitored;
- details of any actions taken to share and embed learning across the local health and/or social care system.

6.34 All information relating to the CCG oversight of this case was sourced by the Deputy Chief Nurse for NHS West Kent CCG, in the absence of any relevant staff from NHS Swale CCG still being in post.

6.35 From the documents provided it appears that the incident was discussed only once, on 20 June 2017. At this meeting, the CCG agreed that the additional assurance was required prior to the report being resubmitted for closure. The formal feedback to the Trust was sent on 13 July 2017 and the CCG received a response on 19 July 2017.

6.36 NHS Swale CCG used a Non Closure Form to provide the feedback to the Trust. We have summarised the issues and responses in Table 2 below.

Table 2: CCG comments and Trust responses

CCG queries	Trust response
Clarification about whether the care co-ordinator was still in post and what action was being taken regarding the member of staff in relation to the incident.	The care coordinator no longer works for the Trust. The case was reported to the Health & Care Professions Council[12] and heard by the Conduct and Competence Panel in May 2017. The Panel found that the breaches identified "*did not meet the seriousness necessary for them to be categorised as misconduct*". They found that neither misconduct nor lack of competence had been established.

[12] The Health & Care Professions Council is the organisation that regulates health, psychological and social work professionals who are not medical doctors or nurses. https://www.hcpc-uk.org

CCG queries	Trust response
Clarification about whether the process was followed regarding titration of medication.	The titration of medication was not agreed because the client did not want to increase his medication. It was agreed to monitor his mental state regularly and for his plasma levels to be checked regularly.
Clarification of the safeguarding input to the investigation report regarding the family concerns.	There were no safeguarding issues with the case. The client's partner and former partner had no concerns regarding the client's contact with his step-children or his own child. The "Jacob's Ladder" issue was that the client wanted a baby but his partner at the time did not. The client's parents did not have concerns about him having contact with his daughter or his partner's children. Staff considered all of these relationships to be positive.

6.37 Following receipt of this information the CCG confirmed on 23 August that the incident had been formally closed.

6.38 As we have indicated in the previous section, we would have expected that the safeguarding concerns about Mr S's grandparents would have been drawn out in the internal report. The CCG was correct to draw attention to this in their feedback to the Trust, but this went no further on receipt of the above information from the Trust in response to the CCG's question.

6.39 We find it particularly concerning that the Trust response appears to place responsibility for identifying concerns about safeguarding issues on the family, rather than Trust staff undertaking proactive risk assessments and referrals based upon known risks.

6.40 The process of clearly setting out queries about the report from the CCG provides a robust audit trail. However, we would have expected this to have led to the issues being addressed within an amended serious incident report. For example, we are aware that Mr S's family remains concerned that no action was taken in relation to the concerns about the care coordinator's actions that were set out in the report. Had the report detailed the explanation given in the Trust response to the CCG Non Closure Form, Mr S's family would have had a clearer understanding of the reasons for this.

6.41 We are aware that commissioners are keen to implement a process whereby:

- the relevant CCG has opportunity to review and comment upon a serious incident report, prior to it being shared with the family;
- any feedback results in appropriate amendments being made to the report.

6.42 The Serious Incident Framework is clear in stating that commissioners have a responsibility to "*quality assure the robustness of their providers' serious incident investigations and the action plan implementation undertaken by their providers*".

6.43 It goes on to say, "*Commissioners do this by evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of serious incidents.*"

6.44 In order for commissioners to discharge these duties effectively there should be opportunity to review reports prior to them being shared with families. It would also be reasonable for commissioners to expect that any issues regarding missing key lines of enquiry, sub-standard analysis or other quality related issues are addressed by the Trust in a final draft report.

Recommendation 4:

The Trust and their commissioners should work together to ensure that any issues regarding the quality of investigation reports are addressed in a final draft report prior to the report being shared with families.

6.45 We have heard the CCG processes have improved, but the challenge of multiple CCGs in the area covered by the Trust, impacts timely progress of these improvements.

Recommendation 5:

The relevant department within NHS England must work with the CCGs to facilitate a co-ordinated approach by them that ensures standards are met for all serious incident investigations and associated action plans.

7 Domestic Homicide Review findings

7.1 The Kent Community Safety Partnership commissioned a DHR following a meeting of the DHR Core Panel on 17 December 2015. We have had access to the report from this review for the purposes of understanding the context of the ensuing recommendations.

7.2 The DHR Panel made six recommendations for three different agencies. Table 3 below sets out the recommendations and which organisation was responsible for completing the associated actions.

Table 3: Recommendations from DHR report

Recommendation		Agency
1	Secure Units and other similar establishments should ensure that there is a process of effective communication between them, the Police and other appropriate agencies regarding reporting assaults in their establishments. This must include the local authority where assaults occur in hospitals between patients.	NHS England
2	Whenever there is a significant change of circumstance, such as a change of relationship, or any significant change of circumstance for those under supervision on conditional discharge, then a multi–agency meeting should be initiated and as a result to take and record any action that is required, the person(s) responsible for actions and time scale for completion.	NHS England
3	Where there are concerns in regard to family members raised within a team meeting or any other internal setting then those issues should be clarified. The proposed course of action to manage this position should be set out in the form of an action plan, which should indicate the action required, the responsible member of staff, timescale for action and thereafter feedback on the engagement with the family and the outcomes recorded.	Trust
4	That the process of Mental Health Tribunal Review hearing applications for Absolute Discharge be reviewed to ensure that current arrangements are adequate to provide the panel with the appropriate breadth of information needed to reach their decision.	Secretary of State

Recommendation		Agency
	Such changes should also consider how best to receive intelligence/information from the family.	
5	Where an agency expresses a view as to the decision a Mental Health Tribunal should consider, then, such a view must be supported with a rationale, either in person or in the form of documentary evidence.	Secretary of State
6	That the NHS Trust, in light of the findings of their investigation, further consider whether the management and governance arrangements currently in place were effective and consider how lessons learnt from this review can be applied for the future.	NHS England

7.3 We have spoken to the Chair of the DHR who has advised that the decision about which agency should be responsible for each of the actions was taken by the Panel.

7.4 The Community Safety Partnership is responsible for working with relevant agencies to monitor progress of the implementation of recommendation from DHRs.

7.5 As part of our terms of reference we are required to review the progress made against recommendations for NHS organisations. Therefore, we have addressed progress against Recommendation 3 in Section 7.6 and Recommendations 1, 2 and 6 in Section 8.58.

7.6 We have not assessed the progress of recommendations made for the Secretary of State.

8 Trust action plans

8.1 The Trust developed two action plans:

- one in response to their internal investigation report;
- one in response to the DHR report.

Internal investigation report action plan

8.2 The action plan developed in response the internal investigation report that we have reviewed was updated on 15 October 2018. We have provided a copy of the narrative given to us by the Trust at Appendix F.

Care Programme Approach reviews for clozapine clients

Trust recommendation 1		Grade
1	All patients receiving Clozapine to be reviewed via the CPA process twice a year, as per CPA policy.	D

8.3 The Trust undertook an audit of the clients on clozapine on the caseload of the Swale CMHT in May 2018. The audit was undertaken by the Service Manager and it identified 26 patients who met the criteria for the audit.

8.4 The audit looked at the presence and timing of the previous three Care Programme Approach (CPA) reviews for each patient. We have reviewed the information to identify:

- whether the patient had a CPA review within six months of the previous review, worked from the earliest review listed;
- whether the patient had a future CPA review booked if one was due within one month of the date of the audit;
- whether the patient had a named worker.

8.5 We have set out our key findings in Table 4 below.

Table 4: CPA reviews for Swale CMHT patients who are on Clozapine

Patient	Review 2 Duration between reviews	Review 3	Named worker	Narrative or post audit update
Patient 1	<1month	5 months	✓	
Patient 2	n/a	11 months	×	No review since December 2017
Patient 3	7 months	9 months	✓	Review booked for July 2018, 9 months after previous review
Patient 4	6 months	8 months	✓	Post audit: Seen by psychiatrist 23/07/18
Patient 5	n/a	6 months	✓	

Patient	Review 2 Duration between reviews	Review 3	Named worker	Narrative or post audit update
Patient 6	8 months	×	✓	No review since August 2017 Post audit: Seen by psychiatrist July 2018
Patient 7	9 months	8 months	✓	Most recent review May 2018, but no outcomes noted Post audit: review held 21/06/18, last saw psychiatrist March 2017.
Patient 8	×	1 year, 4 months	×	Canterbury & Coastal client
Patient 9	2 months	2 months	×	Horizon rehab client
Patient 10	8 months	6 months	✓	
Patient 11	8 months	×	✓	No review since October 2017 Post audit: seen by psychiatrist 23/07/18
Patient 12	4 months	×	✓	No review since October 2017 Post audit: seen by psychiatrist 24/09/18
Patient 13	11 months	4 months	✓	Next review due May 2018 Post audit: Post audit: seen by psychiatrist 24/07/18
Patient 14	1 year, 4 months	6 months	✓	Post audit: patient currently receiving inpatient treatment, last review 4/12/18
Patient 15	2 months	5 months	✓	Most recent review January 2018, but no outcomes noted
Patient 16	1 year, 1 month	1 year, 1 month	✓	First review noted May 2016, only 1 review taken place since then Post audit: patient DNA [did not attend] review 24/7/18, seen by psychiatrist 6/9/18
Patient 17	9 months	×	✓	Next review was due March 2018
Patient 18	6 months	6 months	✓	
Patient 19	6 months	6 months	✓	Post audit: review due 16/10/18 cancelled due to staff sickness but not rescheduled. Last saw psychiatrist December 2018. New review booked 7/3/19
Patient 20	1 year	5 months	✓	
Patient 21	8 months	5 months	✓	
Patient 22	7 months	7 months	✓	Post audit: seen by psychiatrist 31/7/18
Patient 23	5 months	3 months	✓	

Patient	Review 2 Duration between reviews	Review 3	Named worker	Narrative or post audit update
Patient 24	11 months	10 months	✓	Post audit: seen by psychiatrist 11/10/18, 6 months after last review
Patient 25	12 months	11 months	✓	Post audit: review in February 2018 did not go ahead (reasons unknown). No new review date noted.
Patient 26	×	×	✓	No review since November 2015 Post audit: seen by psychiatrist 6/11/17, 4/12/17,12/1/18, 6/8/18

8.6 The audit identified that across all 26 patients, over the 18-month period, 30 (60%) CPA reviews did not take place within six months of the previous review. This affected 19 of the 26 patients on at least one occasion.

8.7 The Trust provided us with an update (received in January 2019) on the outcomes for those patients who had reviews outstanding. From this we can see that two patients have still not had a CPA review within six months of their previous review.

8.8 We asked the Trust to clarify whether the audit was part of an ongoing audit and assurance programme. The Trust has advised that there have been no other serious incidents relating to conditionally discharged patients that would suggest that specific ongoing audit of such cases is required.

8.9 The Trust has however implemented regular CliQ checks (clinical quality checks) in each of the CMHTs. These quality checks are carried out by a senior Quality Lead and areas such as CPA documentation, risk assessments, follow up when patients have not attended for appointments etc are audited against quality standards. Each CliQ check is fed directly back to the team on the same day and an individual team action plan is produced for completion.

8.10 We asked for copies of CliQ checks early on in the investigation but did not receive these until the report was circulated for factual accuracy checks. We received a completed CliQ check relating to July 2019 and CliQ overview information for monthly checks completed between August 2018 and July 2019.

8.11 In terms of assurance that all patients in receipt of clozapine have six monthly reviews, we have not seen evidence that this is yet embedded in every-day practice. It remained the case that there were patients who were still not receiving a review every six months and we have not seen any evidence that any further audits are planned.

8.12 The Trust indicated this action as complete on 19 May 2018. We do not agree that the recommendation has been implemented and recommend that the Trust implements a system to audit completion of six-monthly reviews until there is assurance that there are no delayed reviews and that timely reviews are embedded in everyday practice.

Recommendation 6:

The Trust must assure themselves and their commissioners that the provision of six-monthly reviews to patients in receipt of clozapine is embedded in everyday practice.

Use of Risk Forum for Conditionally and Absolutely Discharged patients

Trust recommendation 2		Grade
2	All Conditionally and Absolutely Discharged patients should be discussed in the team's Risk Forum when there is significant changes or concerns.	D

8.13 The Trust identified all patients who had been conditionally or absolutely discharged and who were on CMHT caseloads. The intention was to discuss and review the register for clients on Section 37 or Section 37/41 at monthly Risk Forum meetings.

8.14 The Trust has noted that in November 2017 the Service Manager reviewed the four patients in her team that had been conditionally or absolutely discharged from Section 37/41. At that time, it was noted that there was no evidence that they had been discussed at the Risk Forum. In February 2018 the Service Manager ensured that this was a regular agenda item and gave assurance to the Trust that each of the patients had been discussed in February and March 2018.

8.15 We have reviewed the minutes of those meeting and can see that four patients were discussed, but there is no evidence of discussion about their risks at either meeting.

8.16 We have also seen minutes of Risk Forum meetings held in July and September 2018. We can see evidence of more discussion for three patients in July, one of whom it was noted was waiting to be transferred to another team. There was no discussion of how the team planned for his risks to be clearly articulated to his new team. It appears that there was no meeting in August 2018 because the September minutes refer to July being the last meeting. There was no follow up discussion about any of the patients discussed at the previous meeting and only one patient was discussed for whom it was noted they had been "*discharged*". It is unclear from the minutes whether this was discharged from the team caseload or where clinical responsibility for the patient was subsequently transferred.

8.17 The Trust noted that this action had been completed on 11 May 2018.

8.18 It is not clear to us how the discussions about the conditionally or absolutely discharged patients at the Risk Forum is improving the overall management of the risks of these patients.

Recommendation 7:

The Trust must assure themselves and their commissioners that the arrangements for managing the risks of conditionally or absolutely discharged patients is appropriate, and embedded in everyday practice.

Crisis and contingency plans

Trust recommendation 3		Grade
3	Crisis and contingency plans should be clear and explicit, including the use of the Mental Health Act and involvement of the forensic service line	C

8.19 The Trust undertook an audit of crisis and contingency plans for clients who had been either conditionally or absolutely discharged from Section 37/41 Mental Health Act.

8.20 The audit was undertaken in November 2017 and an update was provided in May 2018. The audit covered four patients all of whom were noted as having:

- a crisis contingency plan;
- no involvement with the forensic service;
- Trust staff contact with the patient's family;
- the presence of a flag/alert;
- had a six-monthly review.

8.21 There was one patient for whom the Mental Health Act was not "*used*" in their care plan.

8.22 The audit does not discuss the quality of the crisis and contingency plans or whether they are "*clear and explicit*".

8.23 The Trust noted that this action had been completed on 7 February 2018.

8.24 We expressed concern that there appeared to be only one audit that assessed the presence of crisis and contingency plans. The Trust has advised that crisis and contingency plans are included in the monthly CliQ checks. We can see from the information provided in the CliQ check completed in July 2019 that the following information is assessed:

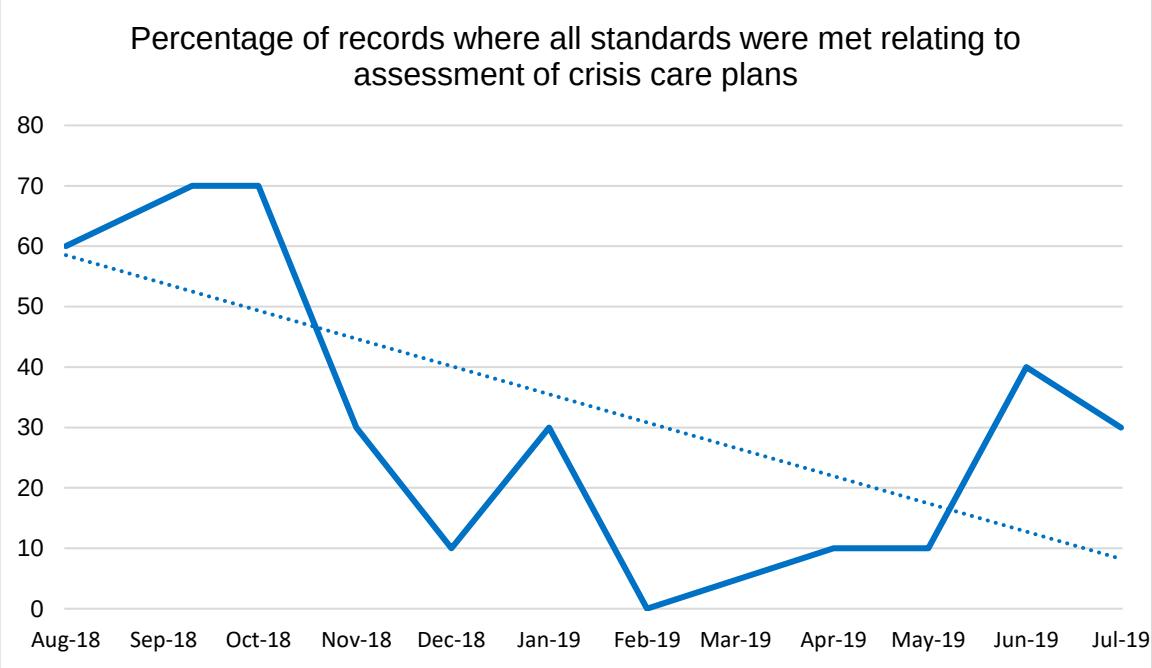
- Details of symptoms / relapse indicators;

- Details of coping strategies;
- Support options – telephone numbers and names;
- Dependents;
- Admission preference;
- Presentation description when ready for discharge;
- View on crisis care plan;
- Evidence of recent client involvement (& carer if appropriate), i.e. in date.

8.25 The CliQ check that we have reviewed covers ten patients. Only three of the ten patient records that were audited contained all of the information being assessed. One patient record had none of the information being assessed.

8.26 We can see that the ongoing assessment of the quality of crisis and contingency plans is in place and for the period August 2018 to July 2019 there has been a downward trend in the number of all standards being met in the review of a client's record. See Figure 1 below.

Figure 1: CliQ check data relating to assessment of crisis care plans August 2018 to July 2019



8.27 This data indicates that there is further work required to ensure that crisis and contingency plans are in place and fully completed for all patients in Swale CMHT.

Recommendation 8:

The Trust must undertake further work with Swale Community Mental Health Team to ensure that crisis and contingency plans are in place and fully completed for all patients.

Management of conditionally or absolutely discharged clients

Trust recommendations 4&5		Grade
4	All clients who are either Absolutely or Conditionally Discharged from a forensic section and are under the care of the Clozapine or Depot Clinic should be seen and reviewed in between these sessions by the Care Coordinator or the wider multi-disciplinary team. This includes contact with the patient's family.	D
5	Depot or Clozapine clinics must not be the only point of contact for patients who are Absolutely or Conditionally Discharged from a forensic section.	D

8.28 The Trust noted that the clozapine or depot clinics should not be the only point of contact with Trust services for these clients. The intention was that a system would be created for tracking conditionally or absolutely discharged clients who were seen in such clinics, and that a case note audit would be conducted to check that they had been reviewed by a care coordinator or multi-disciplinary team.

8.29 We can see that a case note audit was conducted on the records of four patients. This audit looked at the following information:

- presence of a crisis contingency plan;
- whether the Mental Health Act was used in the care plan;
- whether the forensic service was involved in the patient's management;
- whether the patient was seen in the clozapine/depot clinic;
- whether there was contact with the patient's family;
- whether the patient was seen outside of the clinic;
- whether a flag/alert was present.

Table 5: Audit of conditionally and absolutely discharged patients and Section 37/41 patients, Swale CMHT

Standard	Patient 1	Patient 2	Patient 3	Patient 4
Crisis contingency plan	✓	✓	✓	✓
Mental Health Act used in care plan	✓	✓	×	✓

Standard	Patient 1	Patient 2	Patient 3	Patient 4
Forensic service involvement	×	×	×	×
Clozapine/depot clinic	×	×	×	×
Family contact	✓	✓	✓	✓
Seen outside of clinic	✓	✓	✓	✓
Flag/alert	×	×	×	×

8.30 There is no narrative indicating whether the findings of the audit are considered appropriate or whether actions are expected to be taken in response to the findings.

Recommendation 9:

The Trust must ensure that this audit and future related audits undertaken are accompanied by a clear narrative indicating the audit findings and any follow up action required.

8.31 The Trust has advised that Swale CMHT holds a list of conditionally or absolutely discharged patients regardless of whether they are seen in a clinic setting or not. Any new patients transferred to the team are added to this list at the point of the referral. The list is held in the team room and discussed in the monthly team meeting.

8.32 At interview we asked the Assistant Medical Director whether the process had been written into the team's operational policy. She clarified that it had not and agreed that it should be.

Recommendation 10:

The Trust must ensure that the process of managing conditionally or absolutely discharged patients in community mental health teams is set out in the relevant policy/ies.

Handover process for new consultants

Trus recommendation 6		Grade
6	A handover process should be developed for new consultants so they are familiar with; high risk and Conditionally or Absolutely Discharged forensic patients.	E

8.33 The Trust indicated that the intention was to develop a protocol for the handover of conditionally and absolutely discharged clients. As of October 2018 this recommendation was not complete.

8.34 At that time the Associate Medical Directors for the Community Recovery Care Group and the Forensic Services were developing a jointly agreed process for managing clients who moved between different services.

8.35 In addition, a forensic psychiatrist was leading a review of the risk assessment summary tool. Following consultation with colleagues working in community teams it had been agreed that the new risk assessment would include "*a static box*" at the beginning of the form that will list all historically significant risk history.

8.36 The Trust told us in April 2019 that they consider this action to be complete.

8.37 We asked whether the handover process had been written into any team policies or operational procedures and were advised that it had not been. Therefore, the risk remains that a member of staff could be unaware of the expectations of the handover process.

Recommendation 11:

The Trust must ensure that when new processes are introduced, they are clearly described in relevant policies or procedures and adhered to.

Development of specialist practitioner roles

Recommendation		Grade
7	The development of specialist practitioner roles for the care of forensic patients within the community mental health teams.	E

8.38 This recommendation was not present in the Trust action plan so when we interviewed the Assistant Medical Director, we asked her to clarify the reasons for this. We remain unclear why this was not present in the action plan.

8.39 However, the Assistant Medical Director told us that the Trust had identified some specialist forensic practitioner roles within the CMHTs, but this became unsustainable due to the turnover of staff.

8.40 We understand that the Trust hopes that the new care model of an enhanced Forensic Outreach and Liaison Service that was established in April 2019 will provide the necessary support for CMHTs. It is therefore too early to indicate whether the new Forensic Outreach and Liaison Service is able to sufficiently fulfil the gap that the specialist practitioner role was intended to fill.

Amendment to electronic patient record system

Trust recommendation 8		Grade
8	The RiO electronic record system has the ability to add a 'notice' (flag/alert) and should be used in these instances so that all staff are aware of key information.	C

8.41 The Trust has indicated that the RiO electronic patient record system has been modified to include ability to add a 'notice' (flag/alert) for use when a patient who is either conditionally or absolutely discharged from Section 37/41 Mental Health Act, used in these instances so that all staff are aware of key information.

8.42 The Trust action plan stated that the Trust would agree a system on RiO for flagging conditionally or absolutely discharged clients, but we have not been provided with an amended protocol or policy reflecting this change.

8.43 The Trust had told us that the Service Manager has ensured that all conditionally and absolutely discharged clients and clients on Section 37/41 have an alert on their front page of RiO. We have now seen evidence of this, but we have not seen evidence of how new members of staff are informed that this practice must be followed.

8.44 We have however seen a copy of the Trust-wide Learning Bulletin that includes a reminder to staff that they must ensure an alert is placed on RiO for patients who are conditionally or absolutely discharged.

8.45 The Trust has also advised that a case note audit has been conducted to ensure this has been completed. We presume that this is the same case note audit that we were provided with as evidence for other actions. If this interpretation is correct, we can see that an audit of four clients initially showed that an alert was not present (the date of the audit is not stated on the document we have received). However, what we presume must be a later audit (dated 11 May 2018) the same four patients did have an alert in place.

Guidance for CMHTs managing forensic patients

Trust recommendation 9		Grade
9	The trust should develop guidance for forensic patients who are being cared for by Community Mental Health Teams.	D

8.46 The Trust has reported that the initial stages of the process have been completed. Clinical Risk Forums have been reviewed and revised across all of the CMHTs. We have been provided with a copy of the updated terms of

reference and can see that the Clinical Risk Forums provide a multi-disciplinary clinical review of high-risk cases where the care coordinator requires additional support or guidance with the management of risk.

8.47 The Clinical Risk Forums are supported by an administrator who is responsible for taking notes and for updating the risk forum spreadsheet. However, in section 8 of the terms of reference it states that the care coordinator is responsible for recording the outcomes of the risk management review on the patient record and for updating the risk assessment following the meeting. It is not clear to us whether the information the care coordinator uses to update the patient record comes from the administrator's notes of the meeting or whether the care coordinator is expected to take their own notes. If it is the latter the Trust needs to be assured that the records are triangulated (formal notes of the meeting and entry into the client record).

8.48 The Trust told us that an audit was underway in October 2018 and that associate medical directors were working to create an agreed process. This will be part of the remit of the new community forensic service funded and being actioned.

8.49 When we interviewed the Assistant Medical Director, we asked about progress of the implementation of the guidance. She told us that the guidance in place is more physical, real-time support, rather than a formal written guidance document. The Trust had availability for weekly video conference calls with the forensic services for forensic referrals, for support and guidance to CMHTs. However, it was not regularly used and so it has "*faded out*". The guidance for how to manage patients will very much be communicated in clinical meetings, weekly multi-disciplinary meetings and clinicians being able to seek advice on specific patients.

8.50 The Trust noted that the new Forensic Outreach Liaison Service would also be a source of support to staff in CMHTs.

8.51 In January 2019 the Trust reported that this action that could not be closed at that time.

Think Family training programme

Trust recommendation 10		Grade
10	The community Mental Health Team to ensure that they have staff who have attended the Think Family Training Programme	C

8.52 The Trust has stated that all relevant staff would be booked on the training programme and that uptake would be monitored in supervision and team performance meetings.

8.53 The Trust indicated that this action was completed on 7 February 2018.

8.54 We have seen a copy of the sign in sheet for a training event held on 28 June 2017. From this we can see that 21 members of staff attended. However, we have not been provided with any information indicating whether all staff that should have completed this training have done so.

8.55 We have seen no evidence that the Trust is providing this training on a rolling programme and therefore there is a risk that the learning will be lost with staff turnover. The Trust has also not provided us with an assessment of the impact that the training has had on the practice of those staff who have attended. If no assessment has been undertaken, then we would suggest that the Trust undertakes this in order to be assured that the actions have had the desired impact.

Domestic Homicide Review action plan

Trust recommendation 3		Grade
3	Where there are concerns in regard to family members raised within a team meeting or any other internal setting then those issues should be clarified. The proposed course of action to manage this position should be set out in the form of an action plan, which should indicate the action required, the responsible member of staff, timescale for action and thereafter feedback on the engagement with the family and the outcomes recorded.	E

8.56 The Trust has reported that family members' attendance at CPA meetings is to be "*conducted in a manner that allows both sides to challenge the understanding of what has been discussed*". The aim of this approach is to ensure that:

- No one leaves a meeting confused;
- No one feels their point of view was negated in any way;
- Opportunity is given to summarise each action agreed;
- A written copy of the agreement is given to the client and their relatives;
- Time is set aside for family members to question decisions before any meeting is concluded;
- Actions are reviewed at the following meeting before any new items are set;
- Advocates are engaged for relatives if necessary.

8.57 We have not seen any evidence indicating what progress the Trust has made in implementing this approach and therefore are unable to comment upon how effectively this recommendation has been implemented.

8.58 If the Trust has not already done so, we would suggest that a robust audit is undertaken to understand what impact this has had on families.

9 NHS England Specialised Commissioning Team action plan in response to Domestic Homicide Review

9.1 The recommendations for NHS England refer to NHS England Specialised Commissioning Team, rather than NHS England (South) . The latter being the commissioners of this independent assurance review.

9.2 NHS England Specialised Commissioning Team provided us with a spreadsheet setting out the progress of their actions from the DHR. NHS England Specialised Commissioning Team also provided us with a copy of the service specification dated June 2018 for the Forensic Outreach and Liaison Service and the suite of key performance indicators for that service.

9.3 NHS England Specialised Commissioning Team provided no factual accuracy response at the time that the report was circulated to contributing organisations. However, just prior to publication arrangements being made, the organisation provided additional evidence that we reviewed. We have provided more detail of the delays later in this section.

NHSE recommendation		Grade
1	Secure Units and other similar establishments should ensure that there is a process of effective communication between them, the Police and other appropriate agencies regarding reporting assaults in their establishments. This must include the local authority where assaults occur in hospitals between patients.	E

9.4 NHS England Specialised Commissioning Team has confirmed that an audit took place on 11 July 2017 that confirmed liaison links were in place with key agencies including prisons, the courts, local authority social care, primary care trusts, the strategic health authority, education and housing providers, employers and voluntary agencies, to facilitate the care pathway and the provision of a comprehensive mental health service. We have received a copy of an audit undertaken on 11 July 2017, along with a copy of a letter dated 21 July 2017 from NHS England Specialised Commissioning Team to the Service Director for the secure unit for the Trust. The audit is detailed and covers a range of topics. We found one audit reference that we considered to be relevant to this recommendation.

Audit reference	Finding
C19 The provider should ensure that clinical teams and service/ provider managers contribute to relevant local networks, including strategic,	Kent forensic psychiatry service – criminal justice system liaison meetings at least four times a

Audit reference	Finding
operational and mentally disordered offenders' networks	year at which police, probation and MAPPA[13] are represented

9.5 NHS England Specialised Commissioning Team has confirmed that the same audit found that the service was "*fully compliant*" noting that the Trust had reported that "*Kent Forensic Psychiatry Service – Criminal Justice System liaison meetings at least 4 times a year, at which Police, Probation and MAPPA are represented and CPS [Crown Prosecution Service] are invited (this is in addition to the CJLADS [Criminal Justice Liaison and Diversion Service] governance arrangements which involves close working with the Kent Criminal Justice Board)*".

9.6 NHS England Specialised Commissioning Team also reported that frequent meetings took place between social work staff and named police officers in the public protection unit with responsibility for the medium secure service, and that there were regular meetings between the Social Work Team and the Victim Liaison Service.

9.7 We were advised that consultant forensic psychiatrists attend Level 2 MAPPA meetings for their patients and when invited otherwise and that a consultant forensic psychiatrist attends every relevant Level 3 MAPPA meeting and the MAPPA Strategic Management Board. We have not seen minutes of the MAPPA meetings so have not been able to confirm this independently.

9.8 NHS England Specialised Commissioning Team reported a number of regular meetings between agencies and networking events as evidence of the recommendation having been implemented. We have also reviewed minutes of contract review meetings and supporting documentation, however none of these documents provided evidence of assurance that the recommendation above had been fully implemented.

NHSE recommendation		Grade
2	Whenever there is a significant change of circumstance, such as a change of relationship for those under supervision on conditional discharge, then a multi–agency meeting should be initiated and as a result to take and record any action that is required, the person(s) responsible for actions and time scale for completion.	E

9.9 NHS England Specialised Commissioning Team referred us to the evidence for Recommendation 1 and stated that all patients are required to have an

[13] Multi Agency public protection panel. https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

updated risk assessment and management plan where there had been significant changes in the patient's presentation or circumstances. Additionally, NHS England Specialised Commissioning Team stated:

- 'all patients are required to have up to date HCR- 20 V3 Risk Assessments and START (short term assessment of risk and treatment) assessment;
- CPA meetings are mandatory within the secure services, to have a completed care plan within three months of admission and six monthly thereafter'.

9.10 We understand that these requirements are monitored by NHS England Specialised Commissioning Team through the contract monitoring process and the more detailed audit completed in July 2017. NHS England Specialised Commissioning Team informed us that they were satisfied following the review of a random selection of clinical care records that the forensic services could evidence that multi-agency meetings take place and that risk assessment and care plans are updated in liaison with all involved agencies where significant changes to care and treatment are occurring.

9.11 A contract report for 2016/17 was provided as additional evidence of assurance of completion of this recommendation. Review of this audit indicates that:

- the percentage of patients with an HCR-20 completed within three months of admission increased from 86% in quarter 1 to 100% for the remainder of that financial year;
- the percentage of patients with a stay of longer than nine months with an HCR-20 and HoNoS secure assessment completed within the previous six months was at 97% for quarter 1 and 3, and 98% for quarter 2 and 4.

9.12 This provides assurance that risk assessments are being undertaken in a timely fashion but does not provide relevant evidence that the specific recommendation from the DHR has been implemented.

9.13 We reviewed a number of other documents provided:

- audit undertaken on 11 July 2017;
- 2016/17 Commissioning for Quality and Innovation year-end report;
- performance and contract monitoring meeting issues and actions log;
- contract report 2016/17.

9.14 However, none of these documents provided us with information specifically relevant to the DHR recommendation.

NHSE recommendation		Grade
6	That the NHS Trust, in light of the findings of their investigation, further consider whether the	E

NHSE recommendation		Grade
	management and governance arrangements currently in place were effective and consider how lessons learnt from this review can be applied for the future.	

9.15 NHS England Specialised Commissioning Team has not provided any evidence in regard to this recommendation. We have discussed the issue with the commissioners of this independent review and have agreed that it is reasonable to conclude that this recommendation is being met through the provision of this independent assurance review.

9.16 There was significant delay in the initial receipt of information from NHS England Specialised Commissioning Team which was compounded by their provision of additional information on 19 December 2019, following a meeting to plan the publication of the report.

Recommendation 12:

NHS England Specialised Commissioning Team must consider and review the evidence they are using as assurance that recommendations have been addressed.

Recommendation 13:

NHS England (South) should consider overseeing all recommendations made for NHS England by any independent reports.

10 Conclusions and recommendations

10.1 The Trust internal investigation omitted to include some key lines of enquiry and therefore it is our view that not all relevant learning was identified. Of particular concern is the focus on individual rather than system learning, and the lack of reference to safeguarding issues.

10.2 We understand that the internal investigation processes have improved since the time of this report. Therefore, the Trust should be able to provide assurance to their commissioners that recent and future investigations:

- identify all appropriate system learning;
- the roles of investigation panel members are clear and include an appropriate clinician.

10.3 The evidence provided by the Trust to support their position on progress of all of the recommendations was in some cases lacking. We are particularly concerned that the evidence of implementation of Care Programme Approach reviews actually demonstrated that 60% of reviews did not take place within the required six-month timeframe.

10.4 The clinical commissioning group was able to provide evidence that there was some oversight of the internal investigation report. We have seen no evidence that the clinical commissioning group challenged the delay in the completion of the report, particularly given we understand the Trust was citing either the fact that a DHR was being undertaken or a police investigation was ongoing as the rationale for the “stop-the-clock”. We have heard the clinical commissioning group processes have improved but the challenge of multiple clinical commissioning groups in the area covered by the Trust impacts timely progress. We have therefore made our Recommendation 5 to ensure that the barriers to progressing this work are removed.

10.5 NHS England has provided us with very high-level information as evidence that recommendations for the organisation have been implemented. We have reviewed this and consider that there is insufficient evidence present to be able to make an informed judgement regarding the progress. In saying this we are not saying that relevant actions have not been completed, simply that we have not seen sufficient evidence to be able to state that they have been.

Recommendations

10.6 We have made a number of recommendations for the Trust, their commissioners and NHS England (South).

Recommendation 1:

The Trust must ensure that a process is in place that indicates that family members have been offered the opportunity to see a copy of the report, indicating when this has been completed.

Recommendation 2:

NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.

Recommendation 3:

The Trust must ensure that all relevant key lines of enquiry are identified and addressed in internal investigation reports (for example in this case, safeguarding issues in relation to Mr S's older relations).

Recommendation 4:

The Trust and their commissioners should work together to ensure that any issues regarding the quality of investigation reports are addressed in a final draft report prior to the report being shared with families.

Recommendation 5:

The relevant department within NHS England must work with the CCGs to facilitate a co-ordinated approach by them that ensures standards are met for all serious incident investigations and associated action plans.

Recommendation 6:

The Trust must assure themselves and their commissioners that the provision of six-monthly reviews to patients in receipt of clozapine is embedded in every-day practice.

Recommendation 7:

The Trust must assure themselves and their commissioners that the arrangements for managing the risks of conditionally or absolutely discharged patients is appropriate, and embedded in every-day practice.

Recommendation 8:

The Trust must undertake further work with Swale Community Mental Health Team to ensure that crisis and contingency plans are in place and fully completed for all patients.

Recommendation 9:

The Trust must ensure that this audit and future related audits undertaken are accompanied by a clear narrative indicating the audit findings and any follow up action required.

Recommendation 10:

The Trust must ensure that the process of managing conditionally or absolutely discharged patients in community mental health teams is set out in the relevant policy/ies.

Recommendation 11:

The Trust must ensure that when new processes are introduced, they are clearly described in relevant policies or procedures and adhered to.

Recommendation 12:

NHS England Specialised Commissioning Team must consider and review the evidence they are using as assurance that recommendations have been addressed.

Recommendation 13:

NHS England (South) should consider overseeing all recommendations made for NHS England by any independent reports.

Appendix A Terms of reference

Independent Review of the Level 2 Trust RCA investigation and associated action planning by Kent and Medway Partnership NHS Foundation Trust following the Kent Community Safety Partnership and Medway Community Safety Partnership Domestic Homicide Review "Joan"

Purpose of the Review

1. To independently assess the quality the Trusts action plan resulting from the Kent Community Safety Partnership and Medway Community Safety Partnership Domestic Homicide Review and the embedding of learning across the trust and identify any other areas of learning for the trust and/or CCG

2. The outcome of this review will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

Terms of Reference

3. Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

    - If the investigation was completed in a timely manner.
    - If the investigation satisfied its own terms of reference.
    - If all root causes and lessons have been identified, actions identified and shared.
    - Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and root causes.
    - Review whether the action plan reflects the identified root causes, and that actions are comprehensive.
    - Review progress made against the action plan.
    - Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.
    - Review whether the Trust Clinical Governance processes in managing the RCA were appropriate and robust.
    - Comment on the CCG involvement and monitoring of any actions.

4. Domestic Homicide Review:

    - Review the Trust and CCG action plans developed from the Kent Community Safety Partnership and Medway Community Safety Partnership "Domestic Homicide Review: Joan" and assess their quality.
    - Review progress made against the action plan.
    - Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.
    - Review whether the Trust Clinical Governance processes in managing the DHR Action Plan were appropriate and robust.
    - Make further recommendation for improvement as appropriate.

5. Review the trusts (sic) application of its Duty of Candour to the family of the perpetrator and the victim's family.

6. Review the CCGs (sic) quality assurance processes in relation to this incident with particular reference to:

    - the development of appropriate recommendations;
    - the monitoring of resulting action plans and the embedding of learning across the Trust;
    - any actions taken to share and embed learning across the local health and/or social care system.

Timescale

7. The review process starts when the investigator receives the Trust documents and the review should be completed within 3 months thereafter.

Initial steps and stages

8. NHS England Independent Investigations Review Team will:

    - Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.
    - Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

Outputs

9. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

10. A summary learning document that can be shared internally and with partner organisations.

11. At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

12. A final presentation of the review to NHS England Specialised Commissioning Team, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

13. We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

14. The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

Appendix B Documents reviewed

Trust documents

- Action plan as of 15 October 2018
- Clozapine audit evidence
- Risk forum review evidence
- Review by care coordinator evidence
- Learning bulletin evidence
- Risk forum terms of reference
- Think Family training attendees
- Serious incident review panel minutes
- Serious incident process for Community Recovery Care Group
- Serious incident review panel terms of reference
- Domestic Homicide Review action plan
- Independent management report submitted to the Domestic Homicide Review
- Duty of Candour evidence
- Serious incident policy

Clinical commissioning group documents

- Policy for managing serious incidents
- Minutes from meetings
- Emails between the clinical commissioning group and the Trust

NHS England Specialised Commissioning documents

- Action plan
- South East Forensic Outreach Liaison Service standardised monthly key performance indicator suite Version 1
- Kent, Surrey and Sussex Forensic Outreach and Liaison Service specification
- Audit undertaken on 11 July 2017
- Contract monitoring reports
- Correspondence

Other documents

- Domestic Homicide Review overview report
- Domestic Homicide Review executive summary
- Home Office quality assurance letter dated 6 December 2017

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

Purpose

To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients.

Objectives

To establish the facts

To establish whether failings occurred in care or treatment

To look for improvements rather than to apportion blame

To establish how recurrence may be reduced or eliminated

To formulate recommendations and an action plan

To provide a report and record of the investigation process and outcome

To provide a means of shared learning from the incident

To identify routes of shared learning from the incident

Key questions/issues to be addressed

1. Was the risk of relapse managed adequately?
2. Did services respond appropriately when patient informed them that he had reduced his medication?

Appendix E Niche Investigation and Assurance Framework (NIAF)

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)	N
1.6	Staff have been supported following the incident	Y
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	Partial
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	N
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	Partial
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	Partial
3.4	Recommendations are written in full, so they can be read alone	Y
3.5	Recommendations are measurable and outcome focused	N

Appendix F Internal investigation action plan as of 15 October 2018

Recommendation		Action	Details	Complete
1	All patients receiving Clozapine to be reviewed via the CPA process twice a year, as per CPA policy.	Audit to be carried out of clients that attend the Clozapine Clinic to see if these clients having a review every 6 months.	Audit of Clozapine Clients in Swale to review if they have had reviews every six months over an 18-month period. Audit uploaded to Datix.	19/05/2018
2	All Conditionally and Absolutely Discharged patients should be discussed in the team's Risk Forum when there is significant changes or concerns.	Identify all clients on CMHT caseload who are conditionally or absolutely discharged. Discuss and review the register for clients on S.37 or S.37/41 at monthly Risk Forums This will include those conditionally discharged from these sections or absolutely discharged.	In November (2017) the Service Manager reviewed the four clients on the list in her team who were conditionally or absolutely discharged from S.317/41. At this time there was no evidence they had been through the Risk Forum, but in February and March 2018 the Service Manager has ensured that this is an agenda item on the minutes and can evidence that each of these patients had been discussed in February and March 2018. Evidence is uploaded on the documents section of Datix.	11/05/2018
3	Crisis and contingency plans should be clear and explicit, including the use of the Mental Health Act and involvement of the forensic service line.	Audit crisis and contingency plans for clients who have been either conditionally or absolutely discharged from S. 37/41.	Evidence submitted in old format and signed off by care group in incident review panel 7th February 2018. Evidence uploaded to Datix.	07/02/2018
4	All clients who are either Absolutely or Conditionally Discharged from a forensic section and are under the care of the Clozapine or Depot Clinic should be seen and reviewed in between these sessions by the Care Coordinator or the wider multi-disciplinary team. This includes	Responding to R4 and R5 Create a system for tracking Conditionally or Absolutely Discharged and seen in depot or clozapine clinic. Conduct a RiO case note audit of the above clients to check review by with Care Coordinator or MDT.	Responding to R4 and R5 Service Manager has reviewed all the clients who have been Conditionally or Absolutely Discharged and found none of these clients attend the Clozapine Clinic or Depot Clinic and can confirm they are all Care Coordinated with a named worker within the team.	11/05/2018

Recommendation		Action	Details	Complete
	contact with the patient's family.			
5	Depot or Clozapine clinics must not be the only point of contact for patients who are Absolutely or Conditionally Discharged from a forensic section.			
6	A handover process should be developed for new consultants so they are familiar with; high risk and Conditionally or Absolutely Discharged forensic patients.	Develop a protocol for the handover of conditionally and absolutely discharged clients.	Interim AMD CRCG is working with Forensic AMD to create an agreed joint process for working with clients who move between Forensic and specialist care group and Community Recovery Care Group. Red board meetings held each morning in every CMHT - now include daily discussion of clients of high risk, CTO, Sec 37/41 for example. Risk assessment summary tool is being reviewed and re designed - This is being led by a Forensic Psychiatrist, supported by key members of each Care Group. A workshop has taken place with an agreement that the new form will hold a static box at the top that will list all historical significant risk history. 14.09.18 - Interim AMD CRCG is arranging for conditionally discharge/absolutely discharged patients to be added to the 'CTO' list for each area (this list managed by the MHA office) so that they can be held on the red board and so all are aware and progress reviewed within the red board process.	Not complete
7	The development of specialist practitioner roles for the care of forensic patients within the community	Recommendation not present in action plan		

Recommendation		Action	Details	Complete
	mental health teams.			
8	The RiO electronic record system has the ability to add a 'notice' (flag/alert) and should be used in these instances so that all staff are aware of key information.	The RiO electronic record system has the ability to add a 'notice' (flag/alert) and should be used in these instances so that all staff are aware of key information. Agree a system on RiO for flagging Conditionally or Absolutely Discharged clients. Communicate and implement this change across the Trust. Audit case notes of these clients to check effectiveness of system.	Service Manager has ensured that all Conditionally and Absolutely Discharged client and clients on S.37/41 have an Alert on their front page of RiO Patient Safety and Risk Manager has requested that the Trust Wide Learning Bulletin includes information for all staff with a direction that they use the RiO Flag system to identify any Conditionally or Absolutely Discharged clients in the team Case notes have been audited to ensure this has been completed.	11/05/2018
9	The trust should develop guidance for forensic patients who are being cared for by Community Mental Health Teams.	Develop and implement practice guidance.	Initial stages of process completed: Clinical Risk Forums reviewed and revised across all of the CMHTS. Most up to date terms of Reference uploaded onto Datix. Risk Forum audit underway October 2018. Interim AMD CRCG is working with - Forensic AMD - to create an agreed joint process. Additional monies and service development for Community Forensic Teams is being developed- led by the Forensic and Specialist care group. This is an on going action that at this stage can not be closed. Once completed will result in this issue being solved and action can then be closed. This will be part of the remit of the new community forensic service funded and being actioned.	Not complete
10	The community Mental Health Team to ensure that they have staff who have attended the Think Family Training Programme	Book all relevant staff on training. Monitor uptake in supervision and team performance meeting.	Evidence submitted in old format and signed off by care group in incident review panel 7th February 2018. Evidence uploaded to Datix.	07/02/2018