An independent quality assurance review Isle of Wight NHS Trust

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Sancus Solutions wish to particularly thank Keziah's mother for her ongoing contribution to the quality assurance review.

Sancus Solutions' investigation team would also like to acknowledge the contribution from both the Isle of Wight NHS Trust and Hampshire, Southampton and Isle of Wight CCG
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Contents

1 The incident ... 4
2 Sancus Solutions' investigation ... 4
3 Contact with the family of Darren and Keziah ... 8
4 Quality assurance methodology ... 9
5 The Trust's governance process ... 10
6 Recommendation 1 ... 11
7 Recommendation 2 ... 12
8 Recommendation 7 ... 15
9 Recommendation 8 ... 16
10 Recommendation 3 ... 19
11 Recommendation 9 ... 20
12 Recommendation 10 ... 22
13 Recommendation 12 ... 24
14 Recommendation 5 ... 26
15 Recommendation 4 ... 28
16 Recommendation 6 ... 30
17 Recommendation 11 ... 31
18 Family involvement ... 32
19 Concluding comments ... 34

1 The incident

1.1 On 1 June 2016 Darren, aged 44 years killed his six-year-old daughter, Keziah, and then took his own life.[1]

1.2 At the time of the incident Darren was receiving cognitive behavioural therapy (hereafter referred to as CBT)[2] from the Isle of Wight NHS Trust's (hereafter referred to as the Trust) Access to Psychological Therapies Plus Service (hereafter referred to as IAPT)[3]. The last session Darren attended was on 25 May 2016.

1.3 Darren's GP was prescribing him the antidepressant medication mirtazapine[4] (45mg). The last prescription issued was on 20 May 2016.

2 Sancus Solutions' investigation

2.1 In March 2017 NHS England (South) commissioned Sancus Solutions to undertake an independent investigation under their Serious Incident Framework.[5]

2.2 In summary Sancus Solutions' investigation identified a number of areas of concern and significant deficits with regard to:

- The accessibility of the literature provided to patients by IAPT service.
- The HoNOS risk assessment tool used by the IAPT service.
- Lack of communication and involvement of Darren's wife.
- Lack of safeguarding action taken when Darren made a disclosure, to his IAPT therapist, about the contents of a dream he had recently where he reported that he had harmed Keziah.
- Lack of action taken to Darren's disclosures that there was escalating psychologically controlling and coercive behaviours within his relationship with Keziah's mother.

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[1] Next of kin requested that Sancus Solutions investigation uses the forenames of both Darren and Keziah.
[2] Cognitive behavioural therapy *(*CBT*)* is a talking therapy. It is most commonly used to treat anxiety and depression, CBT
[3] Provides evidence based talking therapies to adults with anxiety disorders and depression IAPT
[4] Mirtazapine (Remeron) is an antidepressant used to treat major depressive disorder Mirtazapine
[5] The criteria for NHS England's commissioning of an independent mental health homicide investigation are: "When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event." NHS Serious Incident

- The Think Family Agenda[6] did not underpin any of the practitioners' responses to Darren's assessment, disclosures or treatment/therapy plan.
- There was no documented evidence that either Darren's wife or mother were provided with information about what support was available to them as carers.
- Post incident: Sancus Solutions' investigation team concluded that the Trust met their Duty of Candour [7]with regard to involving Keziah's mother but not Darren's family.

Sancus Solutions utilised the civil standard of the balance of probabilities[8] in order to assess the following:

- **Predictability:[9]** Sancus Solutions' investigation team concluded that it was not predicable that on 1 June 2016 he would harm his daughter. There was, however, enough evidence to suggest that Darren was a significant risk of ending his own life by suicide.

- **Preventability:[10]** Sancus Solutions' investigation team concluded that the incident on 1 June 2016 that led to the tragic death of Keziah and the suicide of Darren was not preventable.

Keziah mother's comments: Having read the investigation report Keziah's mother reported that she disagreed with the conclusion reached by Sancus Solutions' investigation team. She believes that if Darren had been offered the support from mental health services that he needed both his suicide and the death of Keziah would have been prevented.

2.3 Sancus Solutions made 12 recommendations:

[6] The Think Family agenda recognises and promotes the importance of a whole-family approach –offers an open door into a system of joined-up support at every point of entry. Looks at the whole family and co-ordinate care. Provides support that is tailored to need. Builds on family strengths. Think Family

[7] CQC Regulation 20 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. Regulation 20 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. Duty of Candour

[8] Civil standard of balance of probabilities means that it is more likely than not to have occurred – that is, the probability that some event happens is more than 50%. Balance of probabilities

[9] Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. Predictability

[10] Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. Preventability

Isle of Wight NHS Trust's Improving Access to Psychological Plus Therapies service (IAPT)

Recommendation 1: To ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to meet the diverse needs of the population the IAPT therapist must, at the initial assessment, assess what support and aids may be required by the patient.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 2: Isle of Wight NHS Trust IAPT service must either develop a bespoke IAPT service risk assessment or utilise the community mental health risk assessment tool.

The IAPT risk assessment must include the identification and assessment of:

- All potential risk, including the patient's risk to self and others.
- Documentation of all historical risks.
- A narrative of all risk(s) identified.
- A risk management plan should be agreed with the patient based on all current risk(s) identified:
- The risk management plan should identify a contingency and crisis plan.
- Risk(s) identified must be reviewed at subsequent sessions.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 3: The IAPT service's operating procedure (SOP) need to be revised to include:

- A specific section on the assessment and monitoring of risk.
- A hyperlink to Isle of Wight NHS Trust's clinical risk and Care Programme Approach (CPA) policies.
- A section that clearly outlines the IAPT therapist's responsibilities with regard to safeguarding adults and children and the trust's Think Family

Agenda. This section should have hyperlinks to the relevant safeguarding policies and the Think Family Joint Working Protocol.

Isle of Wight NHS Trust

Recommendation 4: A review should be undertaken to ascertain why the Named Nurse for Safeguarding Children does not always receive all CA/12 Child and Young Person at Risk forms (now referred to as Public Protection Notices). Any issues identified should be promptly addressed.

Isle of Wight NHS Trust Improving Access to Psychological Therapy (IAPT) and Single Point of Access services (SPA).

Recommendation 5: The involved IAPT and SPA practitioners and managers must receive additional bespoke safeguarding and domestic violence training. Safeguarding and domestic violence should be a standing agenda item within both IAPT and Single Point of Access' supervision and team meetings.

Isle of Wight NHS Trust

Recommendation 6: As part of all primary and secondary mental health practitioners and service /operational managers' recruitment interviews the interviewee should be asked to demonstrate how the Think Family Agenda underpins their practice.

Isle of Wight NHS Trust

Recommendation 7: Isle of Wight NHS Trust should consider adopting an assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC), within its primary and secondary mental health services, including the IAPT service.

Isle of Wight NHS Trust, Clinical Commission Group (CCG) and NHS England (South)

Recommendation 8: Isle of Wight NHS Trust should redesign the current IAPT service's assessment proformas to ensure that they are adequately identifying risk(s) and potential safeguarding issues.

The CCG and NHS England (South) should seek assurance and evidence from the Isle of Wight NHS Trust that the IAPT risk assessment adequately addresses any potential safeguarding issues.

Isle of Wight NHS Trust

Recommendation 9: Isle of Wight NHS Trust should develop a Carer's Support Policy.

Isle of Wight NHS Trust and Isle of Wight Safeguarding Adults and Children Boards

Recommendation 10: A joint protocol should be developed between Isle of Wight NHS Trust and the local Safeguarding Adult and Children Boards that identifies how and in what circumstances joint investigations will be undertaken.

Isle of Wight NHS Trust

Recommendation 11: Isle of Wight NHS Trust should consider recruiting a family liaison post who would be the single of point of contact and support for families throughout the Serious Incident investigation process.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT) and secondary community mental health services

Recommendation 12: The IAPT referral information requires further amendments in order to clarify the criteria of referrals, including any prohibitive risk histories.

2.4 At a meeting on 27 February 2019, attended by Keziah's mother and Darren's mother, the Trust and Hampshire and Isle of Wight Partnership of Clinical Commissioning Group (hereafter referred to as CCG), Sancus Solutions' recommendations were accepted.

2.5 Due to delays in obtaining information and the ongoing challenges of the Covid 19 pandemic there has been a significant delay in completing the quality assurance review.

3 Contact with the family of Darren and Keziah

3.1 Sancus Solutions has maintained contact with Keziah's mother providing her with updates on the process of the quality assurance review.

3.2 Sancus Solutions are very grateful for both her on going patience and for the information that she has provided that has greatly assisted the review.

4 Quality assurance methodology

4.1 As part of NHS England's (South) Terms of Reference (hereafter referred to as ToR) Sancus Solutions was asked to:

"Undertake an assurance follow up and review, six months after the report has been published to ensure all key recommendations have been implemented by the Provider Trust." [11]

4.2 Sancus Solutions' quality assurance process (hereafter referred to as Q&A) provides a structure for obtaining evidence and evaluating information/data which enables an analysis of:

- Compliance with action plans.
- Deficits in the evidence and /or implementation of actions so that further action(s) can be identified.
- Effects of actions at an operational, and practitioner level and on the service user's experience.
- Areas of good practice.

4.3 Sancus Solutions' QA utilises the following numerical grading system to assess both qualitative and quantitative evidence/data supplied by the relevant provider/stakeholder of the progress that has been made on the implementation of action plan(s).

Score	**Assessment criteria**
0	Insufficient evidence of implementation
1	Evidence of some implementation
2	Evidence of significant progress in implementation
3	Evidence of implementation but no evidence of an impact assessment
4	Evidence of implementation and impact assessment completed

4.4 On acceptance of Sancus Solutions' report the Trust categorised the recommendations into the following subgroups:

- Recommendations which relate to risk assessments.
- Recommendations which relate to standard operating procedures /guidance/policies.

[11] ToR p2

- Recommendations which relate to education, knowledge, skill and competencies.

- Recommendations which relate to staffing.

4.5 Sancus Solutions have reviewed and commented on the Trust's implementation of their action plan using the same subgroupings.

4.6 Sancus Solutions' quality assurance review is based on the latest version of the trust's action plan that was provided dated October 2020.

4.7 It should be noted that the QA review was based on information that was provided at the time, however, due to the delay in publication the Trust has provided a further update on the progress they have made on implementing and monitoring their action plan. This will be published alongside Sancus Solutions' QA report.

Structure of Sancus Solutions' assurances review report

4.8 The Trust's action plans grouped the recommendations into the following categories:

- Lessons which relate to risk assessment: recommendations 1,2,7,8.1 and 8.2.

- Lessons which relate to standard operating procedures/guidelines/policies: recommendations 3,9,10 and 12.

- Lessons which relate to access to information and electronic records system: recommendation 4.

- Lessons which relate to staffing: recommendations 6 and 11.

4.9 Sancus Solutions' report has used these categories to address the progress the Trust has made on implementation of the individual recommendations.

4.10 Sancus Solutions has reviewed the evidence that is cited against each recommendation.

5 The Trust's governance process

5.1 Sancus Solutions were provided with the following:

- The Trust's action plan (October 2020) with evidence.

- The Trust's governance monitoring processes-Mental Health and Learning Division Board – 11 April, 6 August and 20 November 2019.

Lessons that relate to risk assessments

6 Recommendation 1

"To ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to meet the diverse needs of the population the IAPT therapist must, at the initial assessment, assess what support and aids may be required by the patient."

6.1 **Lead Director:** Improving Access to Psychological Therapies (IAPT) Service Manager.

6.2 **Issue/ lesson learned/action**

"As part of the initial assessment process patients should be asked if they have any particular needs which might prevent them from accessing the written literature. If a patient discloses that they have specific needs the Improving Access to Psychological Therapies (IAPT) therapist should then undertake an assessment and access the support/adaptations, they require so that they can fully participate in their therapy."

6.3 **Implementation**

"Any communication difficulties are discussed during the IAPT assessment process and addressed at that point. In addition, the Mental Health and Learning Disabilities (MHLD) services are currently working with Information Systems to ensure that all areas of the service are fully accessible to people with additional communication needs."

6.4 **Evidence** the action plan reported:

- IAPT template- rolled out that prompts the IAPT practitioner to consider a person's accessibility to the service- personalised care text box within the front screen of a patient's assessment form which records any additional needs.

- "The recent audit of records shows that this is completed in the majority of cases and when additional considerations are needed, they are addressed."[12]

- Update September- "work is ongoing aligning this action with the green light toolkit task and finish group, which is working across all mental health services, so it is not just a commitment to IAPT accessibility but a division wide commitment."[13]

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[12] Updated Family G action plan October 2020 p1
[13] Action plan p1

6.5 **Additional action:** the updated action plan documented the following additional actions that have been triggered by this recommendation.

- "The Mental Health and Learning Disability (MHLD) Division now has a group of clinicians and service users/carers working though the Green Light Toolkit. Using the Basic, Better and Best audit tools in the toolkit we will be identifying any accessibility deficits across all services and addressing them. This work will be monitored at the MHLD Quality Improvement Committee which reports to Divisional Board.

- The product design workshops that have been held as part of the MHLD transformation, has captured further feedback from service users and carers which will be taken forward into the implementation phase."[14]

6.6 **Timescale:** 31 May 2019- completed.

6.7 **Conclusion:**

- Sancus Solutions were satisfied that there was evidence of implementation and impact assessment completed.

- It was also noted that the Trust has utilised the learning from Sancus Solutions' investigation to review the accessibility of all services within MHLD division.

Sancus Solutions have scored the Trust **4-** evidence of implementation and impact assessment completed**.**

7 Recommendation 2

"Isle of Wight NHS Trust IAPT service must either develop a bespoke IAPT service risk assessment or utilise the community mental health risk assessment tool."

The IAPT risk assessment must include the identification and assessment of:

- All potential risk, including the patient's risk to self and others.

- Documentation of all historical risks.

- A narrative of all risk(s) identified.

[14] Updated Family G action plan October 2020 p1

- A risk management plan should be agreed with the patient based on all current risk(s) identified:

- The risk management plan should identify a contingency and crisis plan.

- Risk(s) identified must be reviewed at subsequent sessions.

7.1 **Lead Director:** Improving Access to Psychological Therapies (IAPT) Service Manager.

7.2 **Lesson learned/action**

"The trust should consider either introducing the mental health risk assessment that is used by the community mental health services to their IAPT service or develop a bespoke IAPT risk assessment."[15]

7.3 **Evidence** the action plan reported:

- The risk assessment template that was used by the Single Point of Access Service has now been used by the IAPT service. This ensures that there is a "robust assessment of risks undertaken and appropriate plans to manage identified risks put in place."[16]

- The IAPT team is "engaging with the national IAPT team to share learning, and request changes to the national IAPT template.

- IAPT's Service Operational Policy (SOP) had been revised and directs practitioners to undertake a review of a patient's risk assessment every time a patient attends an appointment.

7.4 **Monitoring/ compliance**

- "An audit has been carried out specifically into the quality of risk assessment with results showing over 90% compliance with audit standards.

- To ensure that lessons have been learned across all teams, as part of the annual Audit Plan a Division wide Family Approach audit is planned for Q4 20/21.

- A 'Survey Monkey 'was developed for staff with 50% response rate at the time of the first audit, due to the pandemic there has been a delay in this being sent to staff again. The Team leader will ensure that the comments made by staff

[15] Action plan p1
[16] Updated Family G action plan October 2020 p1

from the initial survey have been addressed and provide further evidence of this.

- Service user feedback: "shows a high level of satisfaction." [17]

- IAPT team feedback "concerns raised being the interface between IAPT and SPA with regard to type of referrals being received from Single Point of Access Service. It was reported that the "planned transformation of service pathways will ensure that this issue is addressed by bringing the teams within the same pathway and under the same service manager."[18]

7.5 **Timescale** 31 May 2019- completed.

7.6 **September 2019 update** "Mandatory IAPT risk training now in place -either face to face or e-learning- The latest progress update provided to Sancus Solutions reported that by January 2020 there was "expected compliance levels … however due to some training being stepped down as a result of Covid19 this is now not the case. The team leader has been asked to focus on compliance improving over the next month."[19]

7.7 **Conclusion**

- Although the complete roll of out of the mandatory IAPT's risk assessment training has been delayed, due to the Covid 19 pandemic, Sancus Solutions were satisfied that there was evidence of the implementation of the action plan.

- Additionally, the Trust has demonstrated that they have undertaken several impact assessments at service, practitioner and servicer user levels.

- Sancus Solutions were satisfied that there was evidence of implementation and impact assessment completed.

Sancus Solutions have scored the Trust **4-** evidence of implementation and impact assessment completed**.**

[17] Action plan p2
[18] Updated Family G action plan October 2020 p2-3
[19] Updated Family G action plan October 2020 p1

8 Recommendation 7

"Isle of Wight NHS Trust should consider adopting an assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[20], within its primary and secondary mental health services, including the IAPT service. "

8.1 **Lead Director** IAPT Service Manager/ Mental Health & Learning Disability (MH/LD) Head of Nursing & Quality (HONQ).

8.2 **Issue/ lesson learned/action**

"The Isle of Wight NHS Trust should consider adopting a risk assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC). Consideration is given to implementing in the assessment tool the IAPT's practitioner to consider the effects that a parent's mental health may be having on their children and to consider what support both the parent and child might require."[21]

8.3 **Evidence** the action plan reported:

- The IAPT team has undertaken level 3 safeguarding training.
- **September 19 update** "IAPT team are at 86% compliance with Safeguarding Children level 3 training. The remaining 3 staff are booked to attend."[22]
- The PAMIC assessment tool has been added to the revised IAPT's Standard Operating Procedure.
- There is now a specific question in the IAPT assessment template that directs the practitioners to ask and consider the patient's "ability to undertake caring responsibilities."[23] As part of IAPT's ongoing risk assessment this is considered at every contact with a patient.
- The action plan update reported that since the introduction of the PAMIC tool "there is evidence of increased contact and referrals with the Children's safeguarding team through data figures from the IOW NHS Trust Children's Safeguarding team. Historically there has been difficulty in collecting accurate data however the Trust's Children Safeguarding lead has communicated with

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[20] This procedure is to be used when considering the likelihood and severity of the impact of an adult's mental ill health on a child. It involves the practitioner thinking about the nature of risk and also the protective factors for the child PAMIC.
[21] Trust action plan p 2
[22] Trust action plan p 2
[23] Trust action plan p 3

all staff to ensure that any referrals are captured on the Trust's incident reporting system so that there is a clear audit trail of referrals." [24]

- It was reported that "following discussion at the Trust's Joint Safeguarding Steering Group this [assessment tool] has also been shared with the Trust Children's Safeguarding Lead for wider learning. "[25]

- Evidence of the change in culture within the IAPT service with regard to the use of PAMIC and assessment of the potential risk and support needs of patients with caring responsibilities are being identified in the ongoing risk and training audits that are taking place at the service.

8.4 **Timescale** May 2019 and September 2019 completed.

8.5 **Conclusion**

- Sancus Solutions were satisfied that there was evidence of introduction of PAMIC tool kit alongside the ongoing assessment of IAPT's patients who have caring /parental responsibilities.

- There was also evidence that the PAMIC tool is being rolled out throughout the Trust.

- Sancus Solutions were satisfied that there was evidence of implementation and impact assessment completed.

Sancus Solutions have scored the Trust **4**- evidence of implementation and impact assessment completed**.**

9 Recommendation 8

Isle of Wight NHS Trust

"Isle of Wight NHS Trust should redesign the current IAPT service's assessment proformas to ensure that they are adequately identifying and risk(s) and potential safeguarding issues."

9.1 **Lead Director:** IAPT Service Manager.

9.2 **Issue/ lesson learned/action**

[24] Updated Family G action plan October 2020 p2-3
[25] Updated Family G action plan October 2020 p2-3

"The assessment proforma used at the time of the incident did not adequately identify potential safeguarding issues." [26]

9.3 **Evidence the** action plan reported:

- The IAPT assessment has been amended to direct the assessor to ask patients about any children and vulnerable adults that they care for.
- The assessor is required to record details about any children the patient has responsibility for e.g. names and date of birth.
- The assessor is also asked to discuss with the patient and consider the "capacity of the person to provide safe care to any dependents."[27]

9.4 **Timescale** completed May and September 2019.

9.5 **Conclusion**

Sancus Solutions have scored the Trust **4**- evidence of implementation and impact assessment completed**.**

CCG and NHS England South

"The CCG and NHS England South should seek assurance and evidence from the Isle of Wight NHS Trust that the IAPT risk assessment adequately addresses any potential safeguarding issues."

9.6 **Lead Director** Clinical Commissioning Group (CCG) Safeguarding Lead/ NHS England (NHSE).

9.7 **Issue/ lesson learned/action**

"The assessment proforma used at the time of the incident did not adequately identify potential safeguarding issues."[28]

9.8 **Evidence** the action plan reported:

- The most updated action plan documented the following:

  "CCG Safeguarding lead reports that the Wessex Regional NHSE team were notified of the concerns and escalated this to the national team. The position

[26] Trust's action plan p 3
[27] Trust's action plan p2
[28] Trust action plan p4

of the National Team is that local services adapt their own proformas for assessment and those proformas should reflect local safeguarding procedures and risk assessment procedures, the responsibility for having robust assessment tools being with local services.
This work has been progressing locally, but in the meantime, NHSE Wessex has identified that there is a need to identify how much of an issue this is also at a regional and southern level.

The Lead contacted NHSE to see if any progress has been made on this at national level.

The manual only makes one reference to safeguarding and that is in the context of clients under 18 and not parents with mental health conditions/presentations with children under 18."[29]

The Trust's action plan concluded that "with the local use of PAMIC, the recommendation should now be sufficiently met."[30]

9.9 **Time scale** completed May and September 2019.

9.10 **Additional information** the following information in the initial action plan forwarded to Sancus Solutions but was not documented in the updated action plan October 2020:

"A number of other reports have been undertaken prior to and in conjunction with this independent report that note lessons learned relating to the theme of risk assessments. These reports include: the Serious Incident (SI) report from the Isle of Wight NHS Trust, the SI report from the Isle of Wight Clinical Commissioning Group (CCG) and the local Safeguarding Children's Board (LSCB) published Serious Case Review (SCR). These lessons learned and actions required have been addressed through specific plans which are monitored through each organisation and Board. Completed actions include multi-agency lessons learned training across health services to explore the concept of protective factors within safeguarding, clinical risk training and added communication, the review and embedding of the Joint Working Protocol by the LSCB, easier access to information for GP consultations to ensure child and adult risks are in one place and practice based safeguarding training for primary care services." [31]

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[29] Trust action plan p4
[30] Trust action plan p4
[31] Trust action plan p 5

9.11 **Conclusion** Sancus Solutions were satisfied that there was evidence of implementation and impact assessment completed.

Sancus Solutions have scored the Trust **4**- evidence of implementation and impact assessment.

Lessons that relate to standard operating procedures /guidance/policies

10 Recommendation 3

"The IAPT service's operating procedure (SOP) need to be revised to include:

- A specific section on the assessment and monitoring of risk.
- A hyperlink to Isle of Wight NHS Trust's clinical risk and Care Programme Approach (CPA) policies.
- A section that clearly outlines the IAPT therapist's responsibilities with regard to safeguarding adults and children and the trust's Think Family Agenda. This section should have hyperlinks to the relevant safeguarding policies and the Think Family Joint Working Protocol."

10.1 **Lead Director** IAPT Service Manager.

10.2 **Issue/ lesson learned/action**

"IAPT Standing Operating Procedure (SOP) does have hyperlinks to various national IAPT guidance and cites that "The Isle of Wight Primary Care Mental Health Team/IAPT team adhere to the Isle of Wight NHS Trust policies, guidelines and protocols." However, it does not make any reference to any specific Isle of Wight NHS Trust's policies, such as safeguarding adults and children."[32]

10.3 **Evidence** the action plan reported:

- **May 2019**: The IAPT SOP has been reviewed to include the required changes, and a more comprehensive revision is planned to ensure the SOP aligns with other changes in the Single Point of Access and Community Mental Health Service.
- **September 19 update**
  "IAPT team are aware of the Family Approach online resource toolkit, which includes a range of parenting capacity assessment tools https://www.hampshirescp.org.uk/toolkits/adopting-a-family-approach-joint-

[32] Trust action plan p4

toolkit/. as well as the policies and procedures available on the Local Safeguarding Adult and Children Board website: LSAB: https://www.iowsab.org.uk/ LSCB: http://www.iowscp.org.uk/ "[33].

10.4 **Timescale** 30 September 2019.

10.5 **Conclusion**

Sancus Solutions were satisfied that there was some evidence of implementation but to date there has been no impact assessment completed.

Sancus Solutions have scored the Trust **3** -evidence of implementation. No evidence of an impact assessment.

11 Recommendation 9

"Isle of Wight NHS Trust should develop a Carer's Support Policy."

11.1 **Lead Director:** Isle of Wight NHS Trust.

11.2 **Issue/ lesson learned/action**

"The investigation team were concerned that the mother was not directed to a carer's assessment and support services, as she was clearly under significant pressure supporting her ex-partner."[34]

11.3 **Evidence:** the action plan reported:

- **30 June 2019**: Work around engaging with families and carers have been developed within the Trust. Provision of the Carers Lounge within St Mary's has been facilitated by the team from Carers IW. Within MHLD services the development and recruitment to three Service User and Family Engagement coordinator Posts has occurred, as has the Development of a Carer support group within inpatient MH Services. Policy development remains outstanding and will be taken forward in the Trust. Upon the final report being confirmed and publically available, this will be shared with the Local Safeguarding Children Board. It will then be possible to consider this recommendation in combination with the recommendations of the Wood report (2016), Working Together 2018 and future changes which are imminent to national, regional and local serious

[33] Trust action plan p3
[34] Trust action plan p3

case review processes."[35]

- **September 19 update** "On 29 June 2018, local areas began their transition from Local Children's Safeguarding Boards (LSCBs) to the local safeguarding partner arrangements set out in Working together to safeguard children 2018 (Department for Education, 2018a). This guidance also sets out the new process for child safeguarding practice reviews, replacing the previous process for conducting serious case reviews. Therefore, national guidance is now in place which local partnerships need to align with."[36]

- **October 2020 update** "Due to capacity within the service there had been a delay in getting this strategy completed. The pandemic resulted in a further delay however this has not prevented progress within related improvement work within services. The planned discovery event in March was cancelled due to the pandemic however the product design workshops used as part of service transformation has used technology to ensure that a high number of service users, carers and families have been involved with any discussions and planned changes in the MHLD Division. This feedback will steer the content of the strategy to ensure that it is a truly collaborative document.

  A draft document is in progress and will be discussed at the service user and carer forum in October 2020. The service, CarersIW and individual service users and their families will review and approve the draft strategy.

  In addition to the engagement work noted above the acute MH service now has a carers facility based within the inpatient service. This has resulted in increased engagement with families and carers and additional support for them. "[37]

11.4 **Timescale** on going.

11.5 **Conclusion**

- The Trust has opened a carer's drop in centre located within the inpatient unit. Keziah's mother reported that she had been invited to visit the centre.

- As yet there has been no impact assessment undertaken as to the experiences of this facility for carers.

[35] Trust action plan p4
[36] Trust action plan p4
[37] Updated Family G action plan October 2020 p3

- Based on the most up to date information supplied to Sancus Solutions it was reported that due to challenges of the Covid 19 pandemic the implementation of the Carers Strategy remains outstanding.

Sancus Solutions have scored the Trust **2**- evidence of some implementation. No evidence of an impact assessment.

12 Recommendation 10

"A joint protocol should be developed between Isle of Wight NHS Trust and the local Safeguarding Adult and Children Boards that identifies how and in what circumstances joint investigations will be undertaken."

12.1 **Lead Director:** Local Children's and Adults Safeguarding Boards.

12.2 **Issue/ lesson learned/action**

"Upon the final report being confirmed and is available, this will be shared with the Local Safeguarding Children Board. It will then be possible to consider this recommendation in combination with the recommendations of the Wood report (2016), Working Together 2018 and future changes which are imminent to national, regional and local serious case review processes."[38]

12.3 **Evidence** the updated action plan October 2019 reported -

- "On 29 June 2018, local areas began their transition from Local Children's Safeguarding Boards (LSCBs) to the local safeguarding partner arrangements set out in Working together to safeguard children 2018 (Department for Education, 2018a). This guidance also sets out the new process for child safeguarding practice reviews, replacing the previous process for conducting serious case reviews. Therefore, national guidance is now in place which local partnerships needs to align with."[39]

- A joint protocol (8 November 2018) was published and "applies to any partner organisation working with children, adults with care and support needs and their families in and across Pan-Hampshire."[40]

- The protocol states:

[38] Trust's action plan p3
[39] Updated Family G action plan October 2020 p4
[40] A Family Approach Protocol 8 November 2018 p1

"Agencies should note that the likelihood of the risk and harm to children and an adult with care and support needs increases when they live with a family member with one of the following vulnerability factors:
Domestic abuse - Parental/familial mental ill-health - Learning disabilities - Substance misuse - Sexual exploitation."[41]

- The protocol recommends that a "Multi-agency, flexible and coordinated services, with an underpinning 'think family' ethos, are most effective in improving outcomes. This includes staff in adults' services being able to identify children's needs, and staff in children's services being able to recognise needs of adults with care and support needs. Such services are viewed positively by families and professionals alike."[42]

The protocol also highlights the need for all practitioners to work toward:

- Restorative Practice.[43]
- Strength based approach[44]
- Person centred working.[45]
- Mental Capacity Act 2005.[46]
- Professional curiosity.[47]

The Protocol outlines the following review process:

"The 4LSCPs and 4LSABs will review the Think Family protocol as a part of the reviews of their strategic plans. This protocol should be used in conjunction with the 4LSAB Safeguarding Adults Escalation Protocol …. and the 4LSAB Multi Agency Risk Management Framework." [48]

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[41] A Family Approach Protocol 8 November 2018 p2-3
[42] A Family Approach Protocol 8 November 2018 p6
[43] "Restorative Practice is about building and maintaining relationships. It's about working 'with' people at every opportunity and in doing so" P11
[44] "Strengths-based practice is a collaborative process between the person / family supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's / families strengths and assets "P12
[45] "The person centred approach reflects the core values and practice which are understood to be valued by service users." P13
[46] "A person's mental capacity should be considered regularly. Where a person is found to lack capacity in any area of decision-making, a best interest decision will be made and this must take into account the child / adult's views and wishes in accordance with the MCA Code of Practice."
[47]"Professional curiosity is a mind set and is about the capacity and communication skill to explore and understand what is happening within an environment rather than making assumptions or accepting things at face value." p16
[48] A Family Approach Protocol 8 November 2018 p19

12.4 **Conclusion**

Sancus Solutions concluded the following:

- The Think Family Protocol provides a pathway for referral, developing practice and communication to key agencies such as children's and adult services.
- The protocol states "Provide opportunities for shared learning from relevant board activity, for example, Serious Case Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews, audits."[49] There is, however, no reference to "how and in what circumstances joint investigations will be undertaken." Therefore, Sancus Solutions have concluded that the Trust and Isle of Wight Safeguarding Adults and Children Boards have not implemented this recommendation.

Sancus Solutions have scored the Trust and Isle of Wight Safeguarding Adults and Children Boards **0** - insufficient evidence of implementation.

13 Recommendation 12

The IAPT referral information requires further amendments in order to clarify the criteria of referrals, including any prohibitive risk histories.

13.1 **Lead Director** IAPT Service Manager/CCG.

13.2 **Issue/ lesson learned/action**

"People are still being referred to the service who have considerable risk factors and therefore are unsuitable to be managed by the IAPT service."[50]

13.3 **Action and evidence**

- The referral criteria have been reviewed and amended and is in the revised IAPT SOP.
- There is a new triage system to review all referrals into the team to ensure their suitability against the criteria.

13.4 **Timescale** September 2019.

[49] Think Family Protocol p9
[50] Action Plan p 4

13.5 **Conclusion**

- Sancus Solutions have reviewed the revised IAPT SOP and noted that the referral criteria have been strengthened.
- It was reported to Sancus Solutions by an IAPT practitioner that the service was still receiving referral of unsuitable patients who either had too high risks or support needs.
- Based on the information provided there was no evidence that the Trust has undertaken an impact assessment in order to assess the impact of the new referral criteria outlined in IAPT SOD.

13.6 **Additional information** the following information was reported in the initial action plan forwarded to Sancus Solutions but was not documented in the updated action plan 2020:

"A number of other reports have been undertaken prior to and in conjunction with this independent report that note lessons learned relating to the theme Standard Operating Procedures, Guidance and Policies. These reports include: the Serious Incident (SI) report from the Isle of Wight NHS Trust, the SI report from the Isle of Wight Clinical Commissioning Group (CCG) and the local Safeguarding Children's Board (LSCB) published Serious Case Review (SCR). These lessons learned and actions required have been addressed through specific plans which are monitored through each organization and Board. Actions completed. Further collaboration to enable clearer understanding of referral protocols between the Local Authority, Police and Safeguarding Teams, amending Standard Operating Procedures (SOPs) for electronic recording, a written protocol for liaison and referral between IAPT and SPA teams, having universal procedures in primary care IT systems for flags and alerts, an Early Help audit to identify referrals into Barnardos utilised by GP's. Ongoing improvements include the Mental Health Transformation programme work."[51]

Sancus Solutions have scored the Trust **3**-evidence of implementation. No evidence of an impact assessment.

[51] Action Plan p 4

Education, knowledge, skill and competencies

14 Recommendation 5

The involved IAPT and Single Point of Access practitioners and managers must receive additional bespoke safeguarding and domestic violence training.

Safeguarding and domestic violence should be a standing agenda item within both IAPT and Single Point of Access' supervision and team meetings.

14.1 **Lead Director** Isle of Wight NHS Trust IAPT and Single Point of Access Service Managers.

14.2 **Issue/ lesson learned/action**

"It is not solely the role of the individual practitioners to make the assessment of whether a child or adult may be at potential risk, because such a decision requires considerable skill and sensitivity. However, it is all practitioners' responsibility to seek the advice and/or to inform the appropriate safeguarding team of any possible concerns regarding the welfare and safety of children and/or domestic abuse."[52]

14.3 **Evidence**

- "There is agreement for the Safeguarding lead to attend an IAPT team meeting to provide a bespoke session. An additional session will be arranged with the Team Leader for the Single Point of Access team. The MHLD Head of Nursing is currently liaising with the newly appointed Trust Adult Safeguarding Practitioner for the service regarding the format and roll out of safeguarding supervision.

September 2019 update

- "Approximately a third of Division staff have attended the Family G workshop. Keziah's mother attended this workshop.
- Further dates are in the process of being arranged to ensure all staff have an opportunity to attend.
- All Single Point of Access staff have completed some element of Safeguarding children training, Team compliance currently sits at level 1: 94%, level 2 100% and level 3 100%"[53]

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[52] Action Plan p4
[53] Action plan p 4

Evidence

- Training database

- Safeguarding supervision model[54] still to be negotiated for adult mental health with the adult and child safeguarding leads within the Trust.

October 2020 update

- “There are increased resources on the Trust intranet pages for all staff to access. The Safeguarding pages have a direct link to resources and information regarding domestic violence.

- All MHLD staff have been made aware of this and the link has been recirculated in Jan 2020.

- Level 3 DV training is being provided by the Local Authority. These training dates are circulated to all teams in the Division.”[55]

14.4 **Additional information**: the following information was reported in the initial action plan forwarded to Sancus Solutions but was not documented in the updated action plan 2020:

“A number of other reports had been undertaken prior to and in conjunction with this Independent Report that note lessons learned relating to the themes of Education, Knowledge, Skills and Competency**.** These reports include: the Serious Incident (SI) report from the Isle of Wight NHS Trust, the SI report from the Isle of Wight Clinical Commissioning Group (CCG) and the local Safeguarding Children's Board (LSCB) published Serious Case Review (SCR). These lessons learned and actions required have been addressed through specific plans which are monitored through each organisation and Board. Actions completed include: The IOW Local Safeguarding children’s Board (LSCB) has contributed to and is a partner in the development of the Think Family Approach Protocol commissioned across the four LSCB's across Hampshire, Portsmouth, Southampton and the IOW. Transformation of services in the Single Point of Access to develop good practice and review and audit of this. Access and completion of Level three safeguarding children training at the IOW NHS Trust has greatly improved.”[56]

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[54] Safeguarding supervision is a facilitative process that enables the supervisor and supervisee to reflect on, scrutinise, challenge and evaluate the work undertaken. This includes assessing risk and protective factors for the child in question as well as the strengths and areas for development of the practitioner. Safeguarding supervision model

[55] Updated Family G action plan October 2020 p5

[56] Action Plan p4

14.5 **Conclusion**

- It is evident that the Trust has undertaken an extensive training programme to improve practitioners' understanding understating and their roles in safeguarding

- There was, however, one area that Sancus Solutions noted which was highlighted in the action plan in September 2019- Safeguarding supervision model- was not commented on in the trust's updated action plan – October 2020. It is therefore not clear if this action has been implemented.

- Sancus Solutions would suggest that such a model of supervision is an essential tool as it not only provides practitioners with a regular opportunity to not only review their individual case management but also their safeguarding responsibilities and further training needs.

Sancus Solutions have scored the Trust **2-**evidence of some implementation. No evidence of an impact assessment.

Lessons which relate to access to information and the electronic record system

15 Recommendation 4

Recommendation 4: A review should be undertaken to ascertain why the Named Nurse for Safeguarding Children does not always receive all CA/12 Child and Young Person at Risk forms (now referred to as Public Protection Notices). Any issues identified should be promptly addressed.

15.1 **Lead Director** Trust Children's Safeguarding Lead Nurse.

15.2 **Issue/ lesson learned/action**

"The Isle of Wight NHS Trust's safeguarding nurse for adults and children reported that her department does not always receive copies of the CA/12 forms. Sancus Solutions' investigation team would suggest that it is essential that this department receives all CA/12 forms in order for them to be able to take appropriate action(s)."[57]

[57] Action plan p5

15.3 **Evidence**

- "The Named Nurse does receive PPN1 notifications now which have replaced the CA12 and Children and Young People (CYP) forms.
- All known adult and child risks are included on the one notification which is far more efficient and supports a family approach to risk assessment and therefore supports appropriate referrals.
- Report shows that there has been a marked increase (almost x 4) in PPN1 reporting captured since December 2018. "[58]
- **September 2019 update** evidence data report and email regarding new process.

15.4 **Additional information** the following information was reported in the initial action plan forwarded to Sancus Solutions but was not documented in the updated action plan 2020:

"A number of other reports had been undertaken prior to and in conjunction with this Independent Report that relate to the themes of Access to Information and the Electronic Patient Systems. These reports include: the Serious Incident (SI) report from the Isle of Wight NHS Trust, the SI report from the Isle of Wight Clinical Commissioning Group (CCG) and the local Safeguarding Children's Board (LSCB) published Serious Case Review (SCR). These lessons learned and actions required have been addressed through specific plans which are monitored through each organization and Board. Actions completed include: A new Template for the Care Programme Approach (CPA) has been rolled out with guidance and risk consideration for dependents, improvements in the SPA to capture risks to children or dependents through developed risk assessments, access to differing IT systems to ensure join up of clinical risk assessments, improved information sharing in GP practices regarding functionality to map family members on practice IT systems."[59]

15.5 **Conclusion**

- Sancus Solutions were satisfied that there was evidence of implementation and impact assessment completed.

Sancus Solutions have scored the Trust **4**- evidence of implementation and impact assessment completed**.**

[58] Action plan p4
[59] Action plan p4

Lessons that relate to staffing

16 Recommendation 6

As part of all primary and secondary mental health practitioners and service /operational managers' recruitment interviews the interviewee should be asked to demonstrate how the Think Family Agenda underpins their practice.

16.1 **Lead Director** MHLD Head of Nursing and Quality.

16.2 **Issue/ lesson learned/action**

"The Think Family Agenda did not underpin any of the practitioners' responses to the service user's assessment, disclosures or treatment/therapy plan."[60]

16.3 **Action and evidence**

- "Initial discussion with Human Resources lead for the MHLD Division. This needs to be disseminated to all staff with responsibility for recruitment."[61]
- **September 2019 update "**MHLD Interim Head of Nursing has confirmed that a Think Family Question has been incorporated into a number of recruitment and selection processes."
- The MHLD team worked with Human Resources to ensure that all recruitment paperwork sent to recruiting managers has the clear and highlighted instruction to ensure that a family approach question is included within all clinical interviews."[62]
- "Standard recruitment paperwork is provided as an example of the prompt for staff."
- Assurance will be sought that this is routinely happening through the planned Family approach audit this year."[63]
- **Evidence** Data report and email regarding new process.

[60] Action plan p6
[61] Action plan p6
[62] Action plan p5
[63] Updated Family G action plan October 2020 p5

16.4 **Conclusion**

Sancus Solutions were satisfied that there was evidence of implementation but there is no evidence that they have undertaken a quality assurance exercise in order to review the impact of the changes introduced.

Sancus Solutions have scored the Trust **3-** evidence of implementation. No evidence of an impact assessment.

17 Recommendation 11

" Isle of Wight NHS Trust should consider recruiting a family liaison post who would be the single point of contact and support for families throughout the Serious Incident investigation process."

17.1 **Lead Director** the Isle of Wight Trust Quality Governance Team.

17.2 **Issue/Lesson learned/Action**

"The investigation team would suggest that in order to minimise intrusion with families at such a complex and traumatic time the Isle of Wight NHS Trust considers recruiting a family liaison post."[64]

17.3 **Evidence**

- "The MHLD Division are currently working with the Corporate Quality Team and the Patient safety lead to develop more robust processes and effective engagement with families and carers following a serious incident. This process will identify an individual at an early stage in the process to work with the family as the liaison and support throughout the investigation process."

- **September update**

  Due to service capacity the pilot has not progressed however there has been clearer governance processes put in place around serious incidents, duty of candor, and awareness of the right support for families. These elements are routinely discussed at the Trust wide Weekly Patient Safety Summit (WPSS) at the time that incidents occur or are reported."[65]

[64] Action Plan p 5
[65] Action plan p5

- **October 2020 update**

  "Improved governance in the Trust around clinical incidents and the weekly Patient Safety Summit ensures that all incidents of moderate or above status are reviewed and that the appropriate person is identified to make contact with service users and families to both undertake duty of candour and offer appropriate support.

  In addition to the process above senior clinicians within the MHLD Division and the Clinical Commissioning Group are members of the system wide Suicide Prevention Group and the Mental Health Alliance.

  Part of the suicide prevention work is focussing on post intervention following potential incidents of suicide.

  Real time surveillance data and partnership working with the Police, Public Health and the Samaritans will ensure that the right support is offered to families from the right services."[66]

17.4 **Conclusion** Sancus Solutions are satisfied that

- The Trust has revised their both Duty of Candour and support provided to families post incident.
- There is no evidence to indicate that they have undertaken a quality assurance that involved families who are being supported after a serious incident, in order to review the impact of the changes.

Sancus Solutions have scored the Trust **3-** evidence of implementation. No evidence of an impact assessment.

18 Family involvement

18.1 Keziah and Darren's' mothers attended the pre-publication meeting (27 February 2019) where members of the Trust and CCG were present:

18.2 The minutes from this meeting reported the following:

- "As chair of the [Hampshire and Isle of Wight] health system] quality board …assured that she can take the learning across the wider [Hampshire and

[66] Updated Family G action plan October 2020 p5

Isle of Wight] health system inviting [Keziah's mother] to be part of this when and if she felt ready.

- [The trust's chief executive officer] stated that the trust would welcome [Keziah's mother] support and input in so many ways but acknowledged that it had to be the right time and in a way which was helpful to her.

- [Keziah's mother] stated that she was happy to do this and was relatively free with time and would love to help others understand the impact Keziah and Darren's death has had on her and the wider family and community, whatever that support and input looked like."[67]

18.3 As part of the quality assurance review Sancus Solutions have been in contact with Keziah's mother on several occasions to discuss her experiences of the actions agreed at the pre-publication meeting.

18.4 Keziah's mother reported the following:

- Head of Safeguarding and Designated Nurse for Adults, Children and Looked After Children and Interim Head of Nursing/Service Manager, Acute Mental Health visited Keziah's mother. At this meeting [Keziah's mother] reported that she had not received any updated action plans. This was no followed up and at the time of this report [Keziah's mother] has not received any progress action plans.

- She was invited to attend one meeting where there were about 15 participants from different services. At this meeting she spoke of her experiences.

- She offered to be involved in further training, but apart from one occasion, when she was unable to attend due to it being near a very difficult anniversary, her offer was not taken up. Keziah's mother reported that she had made extensive preparations, such as pictures etc. in the expectation that she would be invited to other training events.

- She was invited to visit the new carers lounge, but as it was not a formal invitation Keziah's mother reported that she had felt unable to just drop in by herself.

- At the meeting with Head of Safeguarding and Designated Nurse for Adults, Children and Looked After Children and Interim Head of Nursing/Service Manager, Acute Mental Health there was a discussion about the trust planning to develop a life experience post. Keziah's mother reported that she

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[67] Mental Health Homicide Report Briefing Meeting 27th February 2019 p9-10

was very excited about this post as she saw it as a real opportunity however she has not heard anything more about the post.

18.5 Keziah's mother reported to Sancus Solutions that following the meeting on 27 February 2019 she had felt really hopeful that there was a real commitment to improve future services for patients with similar support needs and risks as Darren and their families. She felt that it had been recognised that she could make a significant contribution to developing and improving services. She reported that she had now "lost faith"[68] in the process.

18.6 Sancus Solutions accept the unprecedented pressures that the Covid pandemic has placed on the trust and CCG since March 2020, however they are very concerned about Keziah's mother's experiences.

19 Concluding comments

19.1 It was evident to Sancus Solutions that the Trust has made some significant progress and were able to provide evidence of the implementation of a significant number of their actions.

19.2 Sancus Solutions continue to be concerned that despite it being part of successive governmental carers' strategies since 2008[69] and it being nearly two years since the pre-publication meeting the Trust has made little progress in developing and implementing a carer's strategy. Sancus Solution would recommend that the Trust's CCG should seek a definitive time scale from the Trust as to when this strategy will be implemented.

19.3 Sancus Solutions also had concerns about Keziah's mother's reported experiences since the action planning meeting. Sancus Solution would suggest that the Trust needs to meet with Keziah's mother to restore her confidence in the progress of the Trust's actions, to agree how she can contribute to improving services and to identify what on-going support she requires.

19.4 Although Sancus Solutions have identified some actions that require further implementation they have concluded that no further quality assurance review is required.

[68] Keziah's mother telephone interview December 2020
[69] Department of Health and Social Care Carers Action Plan 2018 -2019