# An independent quality assurance review relating to the investigation and associated oversight of StEIS 2018/16725

## Sussex Partnership NHS FT and Sussex NHS Commissioners

**January 2023**

Final report

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Niche Health & Social Care Consulting ('Niche') is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance, and quality, including undertaking independent investigations following very serious incidents.
This report was commissioned by NHS England and cannot be used or published without their permission.

Our final report has been written in line with the terms of reference issued by NHS England on 13 September 2021 ("Independent Quality Assurance Review of Sussex Partnership NHS Foundation Trust's action plan following the Level 2 RCA of R's Care and Treatment: STEIS: 2018.16725"). This is a limited scope review and has been written 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Events which may occur outside of the timescale of this review will render our report out-of-date.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 draft 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. However where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

This is a confidential report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the 'Final Report' should be regarded as definitive.

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# 1 Executive summary

### Overview and context

1.1 R was first referred to Sussex Partnership NHS Foundation Trust (hereafter 'the Trust' or 'SPFT') in April 2016, having been remanded at HMP Lewes for aggravated vehicle taking, assault by beating and dangerous driving. A Consultant Psychiatrist prescribed depot medication, judging that he was likely showing symptoms of an acute psychotic illness and presenting high levels of risk to others. He was then monitored by the Integrated Mental Health Team (IMHT) in HMP Lewes until his release in November 2016 whereupon he was taken onto the caseload of the Community Forensic Outreach Service (CFOS) and also seen by the Community Rehabilitation Company (CRC). He was not subject to multi-agency public protection arrangements (MAPPA) or the Mental Health Act (MHA) at this time.

1.2 In April 2017, his depot medication was reduced by half due to its side effects. In June 2017 it was stopped entirely, and he was discharged from CFOS back to general practice (GP). In October 2017, R attacked a member of the public outside of his GP surgery, where he was waiting for an ambulance for further mental health assessment. R was arrested, and then detained under the MHA at the Hellingly Centre where he required long-term seclusion until 7 November 2017.

1.3 R received a prison sentence for these offences and was sent to HMP Lewes in November 2017. Prior to his release in February 2018, R agreed to oral medication (Olanzapine) after refusing further depot injections. This was R's right given that he was not subject to any legal restrictions under the MHA and was receiving care freely.

1.4 Interaction with the Trust following his release was mostly through the CFOS service via telephone appointments. Planned face-to-face engagements with CRC did not take place as part of his licence conditions, due to R's cancelling appointments.

1.5 On 4 July 2018, R reported low mood, sleep disturbance and changes to his appetite and a mental health assessment with CFOS was scheduled for the following day. Within the next few hours, it was alleged that R murdered his partner. R was arrested and assessed under the MHA while in custody, but was not detained under the MHA at that time.

1.6 The Trust undertook an internal investigation into R's care and treatment which reported in December 2018. A Domestic Homicide Review (DHR) was also undertaken, the findings from which have yet to be published and have not been made available to the review team as part of this report.

### Scope

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

1.8 In September 2021 Niche were commissioned by NHS England to undertake an independent quality assurance review relating to the investigation and associated oversight of StEIS 2018/16725 at SPFT and Sussex NHS Commissioners.

1.9 The terms of reference (ToR) for this review were to:

- Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan.
- Review the Trust's application of its Duty of Candour (DoC) with the families of the perpetrator and the victim, identifying any unintended limitations to that application imposed by the General Data Protection Regulation (GDPR).

- Review the CCG's quality assurance processes in relation to this incident.
- Review progress made against the action plan resulting from the DHR.

1.10 We have been unable to complete the latter part of these ToR due to the delay in the publication of the DHR.

**Approach**

1.11 The review commenced in December 2021 and was completed in August 2022. It was carried out by Danielle Sweeney, Director, and Carol Rooney, Director from Niche. Quality oversight and final review was provided by Kate Jury, Partner. The external review team will be referred to in the first-person plural in the report.

1.12 The method comprised a review of documents provided to us by the Trust and Sussex Commissioners ('the ICB', and formerly 'the CCG'). We also undertook a series of telephone interviews with the following members of staff from both organisations:

- Deputy Chief Nurse, Sussex Commissioners
- Deputy Director of Quality and Infection Prevention and Control Lead, Sussex Commissioners
- Serious Incidents (SI) Lead, SPFT
- Associate Director of Nursing, SPFT
- Clinical Nurse Specialist in the Community Forensic Outreach Service (CFOS, now Forensic Outreach Liaison Service (FOLS)), SPFT
- Service Manager in the CFOS (now FOLS), SPFT

**Conclusions**

1.13 A detailed internal investigation report was provided by a trained and experienced investigator at the Trust, which provides significant contextual history about R's background and care. Staff involved were engaged in the investigation process and, in our opinion, good levels of support were offered to staff in the service following this incident.

1.14 The ToR agreed by the Trust Serious Incident (SI) Panel were not fully adhered to in the investigation and the report itself. This means that there are some areas of learning which may not have been identified and acted upon following the investigation, including adherence to relevant policies, and partnership arrangements in place with criminal justice agencies.

1.15 There is a tendency in the report to describe events that occurred, without fully exploring the underlying causes of these (the 'why'), in order to enable the correct identification of contributory factors (CFs), care and service delivery problems (CDPs and SDPs) and root causes. This in turn may have reduced the impact of the associated action plan.

1.16 Throughout the report, some key facts remain unclear, including the extent of knowledge the service had about R's recent history of domestic violence, and which risk assessment tools had been used and when. In addition, the use of technical language reduces the clarity of the report to the lay reader.

1.17 Considerable progress has been made in relation to all actions arising from the investigation, apart from recommendations 3 and 7 (relating to GP registration and carer engagement respectively), where further assurance is required to demonstrate that actions are having the required impact. Audits are showing positive progress in some areas, and regular testing should continue in order to demonstrate ongoing impact and embeddedness.

1.18 That said, while efforts have been made to recognise CFs, CDPs and SDPs, these have not all been identified or classified accurately or appropriately. This has limited the extent to which the correct root cause(s) has been identified, and therefore the required actions to ensure that learning is properly embedded.

1.19 The Trust engaged the affected families in the investigation as much as possible, given the police instruction not to contact R's adult children While the victim's family chose not to be involved, the Trust answered in the report their question submitted through the Police Family Liaison Officer (PFLO) about the perpetrator's medication.

1.20 There was scope to demonstrate more fully how the Duty of Candour Regulation was considered, including documentation of all verbal and written apologies made, and more explicit consideration of whether R himself was owed a DoC as a relevant person under the Regulation. We have been told that DoC was considered for R, but given that he remained very unwell, he would have been unable to engage in these discussions.

1.21 Significant structural, governance, personnel changes have been made to commissioning in Sussex since the date of this event, including the introduction of the 2022 Health and Care Act nationally. While at the time of this incident being reviewed, there were clear processes in place to ensure the robustness of SI reports from the Trust, these were not all carried out effectively to assure the quality of this report.

1.22 In particular, we found that not all first line triage comments were addressed, safeguarding arrangements had not been fully investigated (despite the number of CCG queries and comments raised in this area), and not all SI closure criteria were met despite the Panel commending the quality of the report. The latter is a particular area of progress since the time of this incident.

**Recommendations**

1.23 This independent review has made nine residual recommendations (RR) to be addressed in order to improve learning from this event.

**RR 1:** Amend the Trust SI template to include an appendix in which the investigation ToR are provided, and the author identifies where findings on each part of these can be found in the report.

**RR 2:** Ensure that Root Cause Analysis (RCA) tools are used effectively to consistently explore why certain events occurred when investigating an SI.

**RR 3:** The Trust and the ICB should ensure that their reviews of SI reports have a consistent focus on ensuring that the 'why' is fully explored in SI reports, as opposed to simply describing the timeline of events.

**RR 4:** SI report authors should ensure that reports are subject to peer review before submission to the relevant Service Director in order to identify, at an early stage, any quality improvement opportunities.

**RR 5:** Verbal and written apologies should be given to those owed an apology, even if they have expressed a wish not to be involved in the investigation itself.

**RR 6:** SI reports should outline how DoC was enacted with all relevant persons. In cases such as these, explicit consideration should be also given to whether the perpetrator is owed a DoC.

**RR 7:** The ICB should update its quality assurance processes for SI reports, to ensure that all first line triage and comments from other sources of review (e.g., specialist teams) are tracked, responded to fully, and incorporated into the report before receipt at the Serious Incident Surveillance Group (SISG), or equivalent forum in the new ICB.

**RR 8:** The Trust should ensure that specialist teams in the CCG / ICB have an opportunity to shape the ToR for SI investigations, where this is proportionate and appropriate. The same teams should then review the draft report to ensure that the ToR have been properly addressed.

**RR 9:** Ensure clarity in the new ICB quality governance structure about how and where themes and actions arising from serious incidents will be monitored. There should be a particular focus on outcomes of action plans and learning.

# 2 Quality of the Trust's internal investigation

### Investigation process

2.1 The incident occurred on 5 July 2018. Initial learning was identified by the service on 7 July, with the initial management review agreed on the 9 July. An internal investigation was then commissioned, which was allocated to the Trust SI Lead. This individual brought previous experience of undertaking SI investigations within the Trust's Forensic services and had received RCA training.

2.2 The report was signed off internally by the Service Director on 27 December 2018, then the Deputy Chief Nurse on 2 January 2019. We have been told that the reason for the delay between the incident date and final reporting was due to the pace at which relevant information was being shared with the lead investigator. Formal extensions were agreed with the CCG during this time period.

2.3 The CCG (now Integrated Care Board, or ICB[1]) undertook it's 'first line triage' review on 5 February 2019, following which it was shared with the CCG Safeguarding team for comment. Due to a backlog of cases to review, the report was not discussed at the CCG's SI Panel (SISG) until 25 April 2019, around three months later. The incident was closed on first submission to the CCG, with positive feedback provided on the strength of the report and its underpinning investigation.

### Our assessment of the internal investigation report

2.4 We have developed a 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, the NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths. We also considered the introductory version of the Patient Safety Incident Response Framework on how to improve learning from investigations.

2.5 Our assessment of the internal investigation against these 25 standards is as follows:

| Rating | Description | Number |
|---|---|---|
| | Standards met | 10 |
| | Standards partially met | 6 |
| | Standards not met | 9 |

2.6 In the table below, we describe the report's compliance with each of the 25 standards

| Standard | | Niche commentary | |
|---|---|---|---|
| **Theme 1: Credibility** | | | |
| 1.1 | The level of investigation is appropriate to the incident | An RCA level 2 ("comprehensive RCA") investigation was undertaken. This is in line with the Trust's Incidents and Serious Incidents Policy and Procedure, which states that a comprehensive RCA L2 investigation can be undertaken for cases of homicide.<br>There was, in addition, a parallel process of investigation through the Domestic Homicide Review. | |

[1] As part of the Health and Care Act 2022, CCGs were dissolved and their statutory functions taken over by ICBs. As such Sussex NHS Commissioners is now Sussex Health and Care ICB.

| Standard | | Niche commentary | |
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| 1.2 | The investigation has terms of reference that include what is to be investigated, the scope and type of investigation | The ToR set out eight aims of the investigation, including to establish the root causes, to establish how risk of a recurrence may be reduced and to share learning. These are reflective of good practice set out in the SIF.<br>They do not detail the scope of the investigation – i.e., if the investigation commences from the patient's first contact with SPFT services. Given the extensive summary provided in the report, it would have been helpful to clarify the timeframe in scope. | |
| 1.3 | The person leading the investigation has skills and training in investigations | The Trust SI Lead undertook the investigation. This individual has had internally and externally provided RCA training, and has frequently led on investigations in Forensic services. | |
| 1.4 | Investigations are completed within 60 working days | The incident occurred on 5/7/2018.<br>Initial learning was identified by the service on 7 July, with the initial management review agreed on the 9 July. The final report is dated 21/12/2018.<br>We have been told that this was due to new evidence becoming known during the course of the investigation. | |
| 1.5 | The report is a description of the investigation, written in plain English (without any typographical errors) | A lengthy description of the incident is included, and of events leading up to the homicide. The fullness and clarity of the account however could be improved. For example:<br>• References are made to specific wards and facilities, but their function is unclear (e.g., Hellingly Centre; that this is a medium secure forensic facility is material, but not described in the report).<br>• References are made throughout to specific medications, without stating what these were prescribed for.<br>• References are made to criminal 'charges' without elaborating on what these are (e.g., p4).<br>• It is not clear what the roles are of some key staff (e.g., LPD).<br>• There is also some local jargon, e.g., "Buddy monitored" (p5). It would appear that this is an electronic tagging device, but it would have been helpful to clarify this.<br>• On occasion, events provided in the summary section are non-sequential, which makes the sequence of events difficult to follow (e.g., penultimate paragraph of p5).<br>We are of the opinion that a more rigorous peer review and editing stage would have been helpful, particularly to | |

| Standard | | Niche commentary | |
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| | | lay readers, including the victim's and perpetrator's families. | |
| 1.6 | Staff have been supported following the incident | The Trust has a formal offer (documented in policy) for critical incident stress management, which includes a 'diffusing' meeting, follow up discussion in team meetings and supervision, and support from trained debriefers.<br>Counselling and support from Occupational Health was also made available. The extent of post-incident support is good practice compared to other NHS mental health trusts. | |
| **Theme 2: Thoroughness** | | | |
| 2.1 | A summary of the incident is included, that details the outcome and severity of the incident | The report contains a summary of the incident, detail of the outcome, and severity of the incident. | |
| 2.2 | The terms of reference for the investigation should be included | The ToR for the investigation are included in the report, but feature on page 8, after a detailed background to the incident. It would be helpful to the reader if they featured earlier in the report to understand the purpose and scope of the investigation. | |
| 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 | The report details the investigation type, process and methods used:<br>• Tabular timeline<br>• Panel review (which included membership from a peer NHS organisation, to provide independence of perspective, and input from the CRC. This is reflective of good practice)<br>• Review of the clinical information system care notes<br>• A review of referrals to the Forensic service, and contact dates from other Trust's involved in the patient's care<br>• Discussion with six members of staff<br>The Incidents and Serious Incidents Policy and Procedure does not state specifics about what activities should be undertaken as part of a 'comprehensive' RCA investigation.<br>It is atypical that practice has not been compared to relevant policies in the report (e.g., policies relating to clinical risk assessment, Care Programme Approach (CPA), offender management and disclosure of domestic violence). These issues are, in our opinion, key findings from our reading of the report. | |

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| | | All interviewees are listed, although it would be helpful to include their roles in all cases, to understand the relevance of their evidence to the incident. This has not been done for all staff interviewed.<br><br>As a learning point for the Trust, there are also examples of individuals' full names in the report (both R and a doctor) which is contrary to relevant guidance. | |
| 2.4 | Bereaved/ affected patients, families and carers are informed about the incident and of the investigation process | The Trust sought to engage R and family members in the investigation process.<br><br>The SI Lead did seek to engage R in the process of the investigation, although he remained too unwell for this to take place. These efforts are reflective of good practice.<br><br>R agreed that the Trust could contact his sister, although contact attempts were unsuccessful.<br><br>The police requested that no other members of the victim's family were contacted as the investigation remained ongoing.<br><br>The victim's family were informed about the investigation process through the PFLO. They asked for no direct contact from the Trust about the investigation. | |
| 2.5 | Bereaved/ affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care | There is no specific testimony from the affected families. The victim's family was, however, invited to ask questions to be considered as part of the investigation. One question was provided by the family and has been detailed in the report, with the answer provided directly underneath so that it is easy to see how their question has been responded to.<br><br>In this case (why R no longer received depot medication) this is relevant to care/service delivery problem (1) identified on p34 of the report. As a learning point, it would have been helpful for the report to link to actions taken as a result of these delivery problems, to clearly describe to the family how the Trust has learnt from this. | |
| 2.6 | A summary of the patient's relevant history and the process of care should be included | A background and context section is included at the start of the report. This totals nine pages, six of which pre-date the investigation timeframe (per the chronology). Understanding R's history of violence, at times the level of detail provided is excessive, and in our view could have been condensed to manage the length of the report.<br><br>It would have been helpful to include a summary table of all healthcare referrals and discharges from each service, as well as all periods of incarceration. The lengthy narrative approach taken makes it difficult to understand which services R was under at various periods. As | |

| Standard | | Niche commentary | |
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| | | referenced above, some events are also described out of sequence. | |
| 2.7 | A chronology or tabular timeline of the event is included | A detailed tabular chronology from April 2016 is provided, detailing the patient's care from the time he was assessed by a Consultant Psychiatrist at HMP Lewes, to July 2018, when he was remanded to custody.<br>The use of the first person in some of the narrative chronology suggests that this information might have been copied and pasted from source records on occasion.<br>The fullness of the chronology could also be improved. For example:<br>• The entry of 28/6/17, "Reported that R had held a knife to his partner's daughters throat." It is unclear where this information came from.<br>• Following discharge from Hellingly, it is unclear whether he was discharged from all services, or still on CPA.<br>• There is a reference to R having assaulted Dr L previously under entry 7/718, which is not described under the summary and context, or elsewhere in the chronology. | |
| 2.8 | The report describes how RCA tools have been used to arrive at the findings | The report details the investigation type, process and methods used, which include a review clinical notes and referrals, interviews with staff and incident mapping (tabular timeline).<br>It does not, however, provide details of specific RCA tools used (e.g., Fishbone diagram or the Five Whys). The latter in particular would have been helpful throughout the report to deepen the level of enquiry. For example:<br>• Engagement with CFOS was not included in R's signed licence agreement with CRC. It is unclear why this was the case.<br>• The report states that there was no face-to-face engagement with R's partner but does not state why this was the case.<br>• It states that an HCR20 was not available on the clinical information system, but does not state why this was the case.<br>• It states that a 117 meeting is "not documented as having occurred" but does not state why this is the case. | |
| 2.9 | Care and Service Delivery problems are identified (including whether what | CDP and SDPs are identified in two sections of the report: adjunct to the tabular timeline, and in a standalone section of the report. These two sections do not align, and some | |

| Standard | | Niche commentary | |
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| | were identified were actually CDPs or SDPs) | of those identified under the chronology section are not, in fact, CDPs or SDPs, for example:<br>• "No legal grounds on which to enforce treatment"<br>• "Put in Crisis plan"<br>• "No cold calls at home"<br>In the latter section, seven care/service delivery problems are identified, although the report does not state whether each relates to care or service delivery, so it is difficult to identify the most relevant recommendations arising from these.<br>In addition, we are of the opinion that some CDPs and SDPs have not been identified, including:<br>• A lack of formal consideration as to whether R's partner was acting as his carer, given her active role in managing his condition.<br>• The fact that R's risk status was repeatedly recorded as amber in CFOS team meetings, despite his known disengagement. The team had no assurance that he was taking his medication, and the risk associated with this was well-documented.<br>• On 22/5/18 (two months before the homicide), the chronology has an entry from Dr C stating that "*R appears to be working and holding down a job and communicating with CRC albeit to cancel appointments… I can only assume that his mental state is probably still stable. I also have not been able to confirm whether R has been taking olanzapine*." There appears to have been a bias towards concluding that disengagement meant that R was stable, rather than interpreting this as a risk factor and raising the risk rating in CFOS team meetings. This is in spite of the team not being able to take assurance of this from speaking to R or his partner in person. This is not identified as a CDP in the report.<br>• There are indications throughout the chronology that both CRC and CFOS considered discharging R if he continued to disengage; this is an inappropriate response, particularly in light of R's extensive forensic history.<br>• No HCR20 appears to have been available, which may have identified relevant risk factors to R relapsing. | |
| 2.10 | Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, | The report identifies 80 contributory factors, although some of these are repeated. They are classified accordingly:<br>• Patient factors (21) | |

| Standard | | Niche commentary | |
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| | examination of human factors) | • Task factors (19)<br>• Communication factors (16)<br>• Team and social factors (12)<br>• Individual staff factors (11)<br>• Organisational factors (1)<br>• Education and training factors (0) (*although training on Claire's Law has since been undertaken*)<br>• Equipment and resources factors (0)<br>• Work environment factors (0)<br>Again, some of these are not in fact CFs and it is unclear what their materiality is, for example:<br>• "Team were keen to ensure that R had access to antipsychotic medication."<br>• "Staff provided encouragement for R to register with a GP"<br>Using causal statements ("X happened, which led to Y, the impact of which was Z") would have been a helpful way of articulating CFs, and in helping the reader to understand their cause and effect.<br>In addition, some CFs appear for the first time in this section of the report e.g., "sharing of information was not discussed in CFOS team meetings", "there are no checks in place to identify when a section 117 meeting has not been held" with no further information given as to how these findings were identified, and what their impact was. | |
| 2.11 | Root cause or root causes are described | One root cause was identified: "Significant information which was known to other statutory bodies was not shared with the CFOS, which resulted in missed opportunities to take a robust approach in managing R's risk and mental health." (We assume that this refers to instances of domestic violence with the victim.) Applying the "5 Whys" question to this statement shows that it is not a root cause and could have been investigated further.<br>Information relating to this issue in the chronology is also incongruous; it is stated at different points that the information was *not shared*, not shared *appropriately,* or not shared *formally.* However, CFOS staff were present at a Recovery meeting (15/11/17) in which a domestic incident was discussed. In addition, information from MARAC was shared with the Trust through minutes of the meeting. That this information was not extracted by the service was a separate issue, which would have merited further investigation. | |

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| | | The service was aware of R's "significant history of domestic violence" (Patient Factors, p39) and this could and should have been picked up in risk assessment. The report acknowledges that "Questions regarding domestic violence are not routinely asked at assessment" (Team and social factors, p40). Clinicians at Broadmoor Hospital also stated in 2009 that R "continued to present as a risk to his ex-partner and children, particularly if the psychotic symptoms returned".<br><br>Therefore, missed opportunities to undertake a more robust risk assessment, including through a s119 meeting and completion of HCR20 processes, is in our view the root cause. |
| 2.12 | Lessons learned are described | There is a section defined 'lessons learned' but only one sentence is provided: "Interagency communication is crucial in gaining a comprehensive view of the risks a person may present." While it is difficult to dispute this point, this is very high-level learning and as such, in our view, unlikely to change practice if it is the key message to be disseminated from the investigation.<br><br>Expanding upon this with more specific learning to be implemented is more likely to change practice.<br><br>Other key lessons from our reading of the report include:<br><br>• The importance of robust risk assessment<br><br>• Contingency plans, specifically relating to disengagement. This has since been implemented in FOLS (formerly CFOS). |
| 2.13 | There should be no obvious areas of incongruence | We identified some areas of incongruence. These include:<br><br>The report states that R's partner did not seem worried; this is incongruent with notes recorded in the chronology by LPD.<br><br>• It is stated that "Information regarding domestic violence was not shared with CFOS, prison or the inpatient team"; this is not fully accurate, given that minutes from the meeting "Minutes from the meeting were provided to Sussex partnership staff, as there were no actions to be carried out by Sussex Partnership, this information was not documented within the clinical record of a patient closed to service." There was also discussion of a domestic violence incident at a meeting at which CFOS staff were present in November 2017. This was not identified as a CDP. CFOS were aware of R's earlier history of domestic violence with his previous partner.<br><br>• It is stated that R was charged with murdering his partner on 5 July 2017. This date is incorrect. |

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| | | • It states that DoC was completed by the service, although this was not the case. | |
| 2.14 | The way the terms of reference have been met is described, including any areas that have not been explored | Eight items are listed under the ToR; all of these have been covered in the report. See however 3.1 below. | |
| **Theme 3: Lead to a change in practice – impact** | | | |
| 3.1 | The terms of reference covered the right issues | The ToR set by the Panel do not match the ToR described in the report, those set by the Panel being much more detailed (see Appendix A).<br>The ToR used in the investigation and report appear to be generic to a level 2 investigation and, in our view, are missing some key points. Particularly in light of the extent of R's forensic and violent history, more explicit consideration should have been given to:<br>• The extent and quality of risk assessments undertaken<br>• Compliance with relevant policies and procedures<br>• The effectiveness of inter-agency working<br>• The extent to which family was involved in care planning arrangements<br>• The service's response to historic charges of domestic violence<br>• Compliance with relevant safeguarding processes and procedures<br>Had the former ToR been used and the report structured around these ToR more explicitly, in our opinion findings would have been richer and may have extracted further learning.<br>There was no explanation for the use of the generic ToR, and quality reviews by SPFT and the CCG did not identify this as an issue. | |
| 3.2 | The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence | The report contains a long and detailed summary, followed by a detailed chronology. It provides extensive information of what happened and when, but (crucially for a RCA investigation), often does not address the 'why', Examples include:<br>• "Potential information regarding domestic incident not sought…" The report does not explore this further.<br>• "Good liaison took place between the CRC service and CFOS, initially with the hope of having attendance at health appointments as part of his licence conditions. This did not happen." Acknowledging the extensive | |

| Standard | | Niche commentary | |
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| | | efforts made to engage R by the service, this detail is critical, and should have been investigated.<br>• As regards MAPPA: "R would not meet the criteria to be automatically eligible and it was not believed that he would be seen as a Category 3 Offender." It is unclear why this is the case, given R's history of convictions for violent offences, including those under Schedule 15 of the Criminal Justice Act. This would have warranted further investigation.<br>• "There was no face-to-face contact with R's partner": The report does not explore why this was the case, or the extent to which CFOS staff attempted communication with R's partner, in light of his disengagement.<br>• "Information [regarding HCR20] was not available on the clinical information system". The report does not explore why this was the case and if, for example, there are training, technology or environmental issues which may have inhibited this. Or rather, if there is a wider training need about HCR20 and its relevance in CPA compliance.<br>• "117 is not documented as having occurred": the report does not explore if this is, for example, due to poor recording or a failure to follow policy.<br>In all cases, supplementing the report with feedback from interviews and / or staff statement of events may have provided further clarity. It is unclear how feedback from staff has been used throughout.<br>As referenced elsewhere, the report does not assess adherence with relevant policies and procedures, therefore it remains unclear if appropriate policies and procedures were in place and how the service complied with these throughout R's care. This is particularly the case in relation to clinical risk management given R's violent and extensive forensic history. | |
| 3.3 | Recommendations relate to the findings and are designed to lead to a change in practice | Recommendations are listed in a table, under the heading 'lessons learnt and recommendations. These [lessons learnt] do not correspond to the one identified in the separate 'lessons learnt' section of the report.<br>As outlined above, CDPs/SDPs and CFs have not been fully identified, therefore we cannot take assurance that recommendations made will lead to a change in practice. | |
| 3.4 | Recommendations are written in full, so they can be read alone | Recommendations are mostly written in full, as standalone actions. Recommendation 1 is an exception; it is multifaceted and difficult to interpret. In our view this is two | |

| Standard | | Niche commentary | |
|---|---|---|---|
| | | separate matters and is actually a finding rather than a recommendation.<br><br>There is some use of technical jargon in the recommendations (e.g., HCR20, s117). Explanations would help lay readers understand their meaning, including the families of the victim and perpetrator (e.g., “risk assessment tool” or “meeting to arrange aftercare”). | |
| 3.5 | Recommendations are measurable and outcome focussed | It is unclear how progress against actions will be monitored in most cases, although evidence submitted shows that some audit activity has been undertaken, such as compliance with HCR20.<br><br>Desired outcomes are unclear in most cases e.g., “Triangle of Care to be implemented with all patients.” This is the first reference to Triangle of Care in the report, such that it is unclear which finding it seeks to address. A lay person (including the victim’s family) is also unlikely to understand this term. | |

**Summary of findings and recommendations**

2.7 A detailed report has been provided by a trained and experienced investigator, which provides significant contextual history about R's background and care. Staff involved were engaged in the investigation process and, in our opinion, good levels of support were offered to staff in the service following this incident.

2.8 The ToR agreed by the Trust SI Panel were not adhered to in the investigation and the report itself. This means that there are some areas of learning which may not have been identified and acted upon following the investigation, including adherence to relevant policies, and partnership arrangements in place with criminal justice agencies.

2.9 There is a tendency in the report to describing events that occurred, as opposed to the underlying reasons for these (the 'why') to enable the correct identification of contributory factors, care and service delivery problems (CDPs and SDPs) and root causes. This in turn may have reduced the impact of the associated action plan.

2.10 Throughout the report, some key facts remain unclear, including the extent of knowledge the service had about R's recent history of domestic violence, and which risk assessment tools had been used and when. In addition, the use of technical language reduces the clarity of the report to the lay reader.

2.11 We have set out three key improvement areas below and provided residual recommendations:

**Clarity and consistency of terms of reference**

2.12 The ToR agreed by the Panel (set out at Appendix A) are detailed and contain the elements which we would expect to feature in an investigation of this nature. These did not translate into the final report, nor can we see where some key factors were investigated, including compliance with relevant policy and partnerships with criminal justice agencies.

2.13 It would be helpful to provide an appendix in the report which maps out where all elements of the ToR can be found in the report to provide assurance that all factors have been fully investigated, with findings reported.

2.14 **RR1**: Amend the Trust SI template to include an appendix in which the investigation ToR are provided, and the author identifies where findings on each part of these can be found in the report.

**Identification of contributory factors, CDPs and SDPs, and root causes**

2.15 The report has a tendency to describe what events occurred and when, without full exploration of why certain things happened. There should be clearer consideration of the 'why' throughout, in order to accurately identify all CFs, CDPs and SDPs and root causes. Using RCA tools more explicitly (such as the five whys) would support this.

2.16 **RR2**: Ensure that RCA tools are used effectively to consistently explore why certain events occurred when investigating an SI.

2.17 **RR3**: The Trust and the CCG should ensure that their reviews of SI reports have a consistent focus on ensuring that the 'why' is fully explored in SI reports, as opposed to simply describing the timeline of events.

**Report editing**

2.18 We are of the opinion that a more rigorous peer review and editing stage would have identified some of the improvement themes outlined in this report, such as consistent anonymisation of staff and the perpetrator, areas of incongruence or inconsistency, and compliance with the agreed ToR.

2.19 **RR4**: SI report authors should ensure that reports are subject to a peer review stage before submission to the relevant Service Director in order to identify, at an early stage, any quality improvement opportunities.

# 3 Action plan implementation

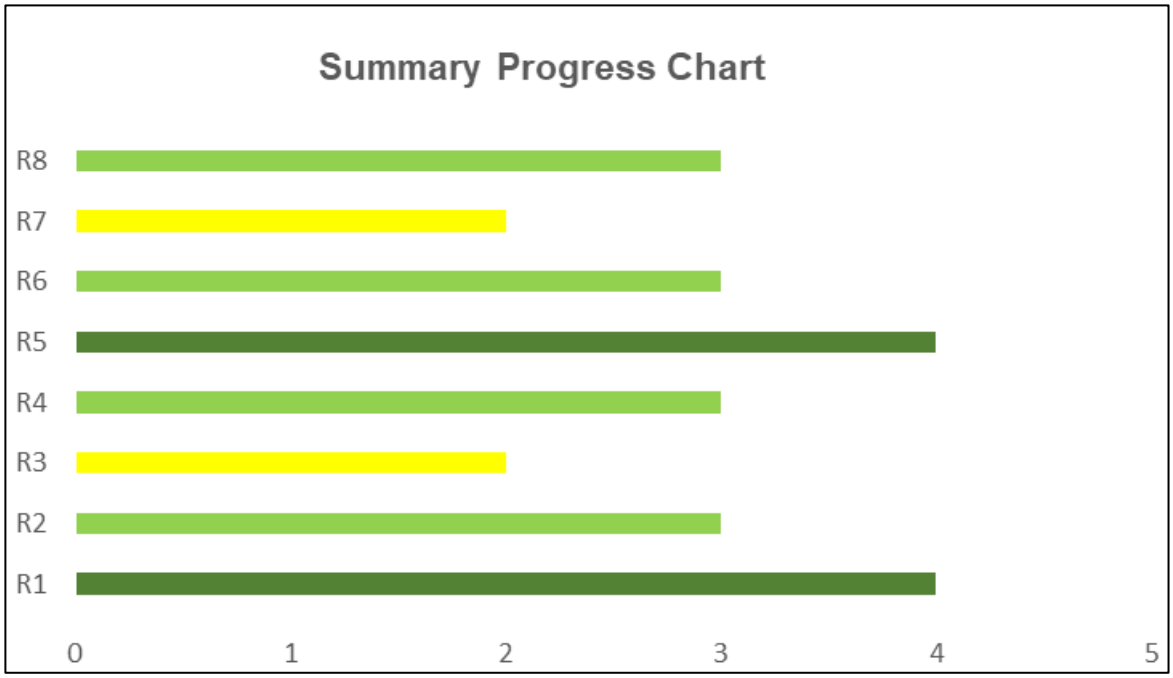
## Overview

3.1 We have assessed evidence submitted to us by SPFT to demonstrate that actions identified through the internal report have been closed. We use a numerical grading system to support the representation of 'progress data', which is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. Our scoring criteria are as follows:

| Score | Assessment category |
|---|---|
| 0 | Insufficient evidence to support action progress / action incomplete / not yet commenced |
| 1 | Action commenced |
| 2 | Action significantly progressed |
| 3 | Action completed but not yet tested |
| 4 | Action complete, tested, but not yet embedded |
| 5 | Can demonstrate a sustained improvement |

## Summary of findings

3.2 Considerable progress has been made in relation to all actions apart from recommendations 3 and 7, where further assurance is required to demonstrate that actions have been fully completed and are having the required impact. Audits are showing positive progress in some areas, and regular testing should continue in order to demonstrate ongoing impact and improvement. We also note that many of these actions will have been implemented or sustained during the pandemic period, when services faced significant additional pressure. That said, the extent to which these actions are likely to address all potential root causes is impeded by the lack of accurate CFs, CDPs and SDPs identified within the report. See recommendations 2 and 3.



**Rationale for progress data scores**

3.3 Some headline commentary to support these ratings has been provided in the following pages. We have provided examples of further assurance required to demonstrate that actions have been completed, embedded and sustained. Appendix B (evidence review) provides a more detailed assessment against each piece of evidence submitted to Niche.

3.4 Our findings are summarised below:

| SI report recommendation | Niche progress score | Rationale |
|---|---|---|
| 1. All patients deemed at risk of disengagement from services will have a risk management plan. To Rag rate Red this will ensure discussion at weekly team meeting [sic]. | 4 | The Trust's action plan states that this has been completed and is in place, and we agree with this assessment. A zoning procedure has been developed, and there is good evidence to show that this is actively used and referred to in weekly FOLS team meetings. Fortnightly audits now take place to ensure that these are completed and we have seen evidence of high levels of compliance through audit results.<br><br>The service now needs to assure itself that the new procedure is having the desired impact, for example, through a reduction in incidents reported over time which can be linked to disengagement.<br><br>It will also be helpful to periodically audit risk statuses against the examples defined in the procedure, to ensure that service users are being rated consistently and appropriately. |
| 2. Alerts [regarding engagement] to be discussed at MDT prior to putting on Carenotes. | 3 | Engagement is a standing item on the FOLS weekly MDT meeting agenda. This is documented in the evidence submitted under action 1. A FOLS specific policy regarding non-engagement has been developed, which clearly sets out expected protocol for disengaged service users.<br><br>The revised CPA process and Care and Safety Plan template also seek to strengthen engagement at the care planning stage to reduce the risk of disengagement, and we have been informed that all patients now have a disengagement contingency plan.<br><br>The service now needs to assure itself that these processes are having the desired impact, through a reduction in incidents reported over time which can be linked to disengagement. |
| 3. Lead practitioners to be aware of the importance of patients being registered with a GP. | 2 | A process is now in place to ensure GP registration, with regular KPI reporting to show compliance.<br><br>We have seen no evidence to support the third part of this recommendation: Lead practitioner to discuss preference with patient to aid collection. |

| | | |
|---|---|---|
| List of community pharmacy contact details to be available so that FP10 can be sent directly to community pharmacy.<br><br>Lead practitioner to discuss preference with patient to aid collection. | | |
| 4. Mental Health Act Assessment to be considered and documented if a patient misses more than 3 appointments with lead practitioner (MDT). | 3 | No specific information submitted, although the commentary above relating to R1 and R2 applies. |
| 5. Inpatient wards to complete HCR20 prior to discharge.<br><br>Community Forensic Outreach Service staff to highlight to ward staff if this has not been completed. | 4 | Risk assessments are undertaken at biannual CPA reviews. These are also undertaken within four weeks of discharge from inpatient services, and should include HCR20. FOLS managers told us that they rely on the ward undertaking these assessments (which is compliant with the Clinical Risk Policy expectation), and now follow this up if this has not been completed.<br><br>HCR20 has also been added to the s117 checklist.<br><br>Compliance with the above is audited monthly, although raw audit data from July-December 2021 illustrated mixed results from the Hellingly Centre. |
| 6. Protocol to be put in place to ensure that all eligible patients receive a s117 discharge meeting. Follow CPA policy and ensure representative from community and Local Authority are in attendance. | 3 | Some evidence has been provided that compliance with s117 meetings is being monitored to positive effect. However, the audit sample provided was small, such that it remains unclear if change has been embedded for all required patients.<br><br>We have received no evidence that representation from community services and the relevant local authority has become standard practice. |
| 7. Identify carer champions within the CFOS. Attendance at Trust Triangle of Care[2] (ToC) meeting. | 2 | Forensic services have identified an improvement plan for their work with carers. There is a local ToC meeting, which reports to the Trust-wide ToC forum.<br><br>Recording of carer details is now being monitored in performance meetings, however compliance remains low. |

[2] The Triangle of Care describes a therapeutic relationship between the patient, staff member and carer that promotes safety, supports communication and sustains wellbeing. Source: Carers Trust, 2020. The Triangle of Care membership scheme is a three-stage recognition process for services who commit to self-assessing their existing services and action planning to ensure the Triangle of Care standards are achieved

| | | |
|---|---|---|
| Carer details to be completed on Carenotes for each patient | | |
| 8. Community Forensic Outreach Service representative to attend MARAC meetings<br><br>Trust IG to advise if an alert can be put on the Carenotes system for any discussion about Trust patients open or closed to services. | 3 | These actions have been completed, but not yet tested. CFOS staff attend MARAC meetings, guidance has been provided to staff on how to update MARAC information in Carenotes, and the role of MARAC is included in the FOLS Operational Policy.<br><br>The impact of these actions now needs to be understood, e.g., if these processes are driving more proactive risk assessment in relation to domestic abuse, and if a better understanding of risk factors is increasing patient, families' and carers' safety. |

# 4 Sharing learning

4.1 Following the incident, a learning event was undertaken in the service, via the Continuing Professional Development session. This was attended by 54 staff. Reflective learning sessions were also offered in individual supervision, and in group debriefs.

4.2 Training on Clare's Law[3] has taken place since, and we have been told that there is an intention to make this training available on an ongoing basis. This is positive, although we note that no specific SDP was identified in the report regarding the application of Clare's Law.

4.3 An independent Thematic Review of Mental Health Homicides was undertaken in the Trust in 2016, which looked at relevant SIs between 2011 and January 2016; this homicide fell outside of this timeframe. A follow-up quality assurance review of recommendations made was also undertaken in Autumn 2018 (after this homicide). This found that seven out of the eight recommendations made had been implemented across the whole organisation, including in regard to investigations management, CPA reviews and implementation of the Triangle of Care. Our findings did not support this view, although we note that the Trust has since received Stage Two accreditation by ToC (awarded to mental health trusts who self-assess all their inpatient, crisis and community services in order to promote continuous improvement).

4.4 A virtual learning event was held on 2 December 2021 which focussed on learning from homicides and suicides. Over 130 staff attended this event, which also had a specific focus on the importance of engaging carers and families. Hundred Families4 provided specialist input to this event. These actions are all positive, although we note that there was no specific CDP/SDP identified in the report about inadequate identification of carers or family engagement.

4.5 Clinical risk assessment training is mandatory for all clinical staff. The Trust is aware that a key theme from its SIs relates to risk, including risks not being reviewed, a lack of clinical curiosity, a need for more collaborative risk assessment, a need for more sharing of risk with other agencies, and a need to link risk assessments with care planning. This training stresses the importance of involving families and carers. It is unclear how any learning has been shared more widely across the Trust and with the wider system, or fed back to improve the quality of SI investigations.

[3] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/
[4] Hundred Families: an organisation which provides support to families affected by mental health homicides in Britain.

# 5 Duty of candour

**Overview of the Regulation**

5.1 DoC applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred. We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour. In interpreting the regulation on the DoC, the Care Quality Commission 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."

5.2 To meet the requirements of Regulation 20, a provider must:

- "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."

5.3 The SIF underlines the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the investigation process and must be involved and supported throughout. The developing Patient Safety Incident Response Framework (PSIRF) echoes this principle.

**Summary of findings**

5.4 Clear efforts were made to engage the victim's family in the investigation. While the family chose not to be involved, the Trust answered in the report their question submitted through the PFLO about the perpetrator's medication.

5.5 There was scope to comply more fully with the Regulation, including documentation of all verbal and written apologies made, and more explicit consideration of whether R himself was owed a DoC.

5.6 The report states that DoC was completed by the service, although staff in the service told us that this was undertaken by the SI Lead. No further detail is given in the report, including in relation to whether R had been considered a 'relevant person'.

5.7 During interviews, the SI Lead confirmed that the following steps were taken in relation to DoC and / Being Open:

- The family of the victim were contacted via the PFLO, who clarified that they did not want direct contact from the Trust. The family submitted questions to be considered in the investigation via the PFLO. These were included in the final report.
- Face to face contact was made with R, although he remained too unwell throughout the course of the investigation to participate fully.
- The Trust attempted to contact R's sister but received no response on the telephone number provided.

5.8 We have been told that the Trust were unable to contact R's children following police instruction. It would have been helpful to provide detail of this in the report given that, (while family members do not fulfil the criteria of the definition of a "relevant person" within the DoC regulations) the SIF states that families of both the deceased and the perpetrator should be at the centre of the investigation, fully involved and have appropriate input into the process.

5.9 The Trust made clear efforts to fulfil some of these requirements, and we commend the efforts made to engage R in the investigation process. There are areas, however, where the Trust could have demonstrated compliance more fully:

- Noting that the victim's family did not wish to be involved in the investigation, we can see no evidence that the Trust provided an apology (verbal or written) to the families involved.
- The report does not state what contact was made with R's family, namely his adult children. This is material given the likely impact of this case on them.
- There does not appear to have been explicit consideration of whether R was owed a DoC.

5.10 **RR5**: Verbal and written apologies should be given to those owed a DoC, even if they have expressed a wish not to be involved in the investigation itself.

5.11 **RR6**: SI reports should outline how DoC was enacted with all relevant persons. In cases such as these, explicit consideration should be also given to whether the perpetrator is owed a DoC.

# 6 Clinical Commissioning Group oversight of the internal report

**Context**

6.1 The incident occurred in July 2018; since this time, commissioning in Sussex has seen significant changes to key personnel, governance and operational structures. In particular, the seven predecessor CCGs across the county have merged as part of the new Integrated Care Board, and there have been various changes to senior staff who oversee SI processes (including the retirement of the Head of Quality who was in place at the time of this homicide).

6.2 Accordingly, our work in this area has focussed on the arrangements which are now in place and future intentions regarding the oversight of SIs. We note the following changes made since 2018:

- The Clinical Quality and Performance Group (CQPG) which was in place to oversee quality and performance issues has since been replaced by the Quality Review Meeting (QRM). This is a formal quality assurance meeting with providers, as well as new Reconciliation Meetings. We have been told that the former will be overseeing themes and trends in SIs.
- Work is also in progress to develop a Quality Strategy, and the intention is for the content of this to reflect the PSIRF, particularly as regards thematic analysis of incidents.
- Having recognised that the previously SISG received a high volume of reports which impacted on time available for a thorough review, this forum now meets weekly, reviewing a smaller number of reports in greater detail.

**Quality assurance of 2018/16725**

6.3 The incident occurred on 5 July 2018, initial learning was identified by the service on 7 July, with the initial management review agreed on the 9 July. Extensions were formally agreed with the CCG to ensure appropriate stakeholder engagement (including from the victim's family) and a comprehensive review by the Trust Panel. The report was signed off internally by the SPFT Service Director on 27 December 2018, secondary sign off from the Deputy Chief Nurse was completed on 2 January 2019 and it was sent to the CCG on 3 January 2019.

6.4 The CCG Quality Lead completed the first line triage on 5 February 2019, later than intended, due to a backlog of SIs to review. We support this process of quality assurance at an early stage, which is designed to ensure that any gaps, inconsistencies or quality issues are addressed before Panel review. This process identified numerous factors which, in our view, were not fully addressed in the final report, including:

- Use of technical language (e.g., in reference to the MHA) which the lay reader would be unlikely to understand
- Inclusion of staff and patient names, which had not been anonymised consistently throughout
- That substance use and MAPPA referrals were not appropriately addressed by the service

6.5 We note that the CCG also shared the report with its Safeguarding team for comment, and that the CCG Designated Nurse (Safeguarding Adults) was also a member of the DHR Panel. Their review of the draft SI report returned 21 questions and / observations. These do not appear to have been answered fully in the final report, and we can see no evidence that the CCG challenged this.

6.6 **RR 7:** The CCG should update its quality assurance processes for SI reports, to ensure that all first line triage and comments from other sources of review (e.g., specialist teams) are tracked, responded to fully, and incorporated into the report before receipt at the Serious Incident Surveillance Group (SISG), or equivalent forum in the new ICB.

6.7 Safeguarding does not feature in the report and, in our view, this should have formed part of the investigation ToR. During interview, the CCG agreed that there is scope for the CCG to become more actively involved in SI management with the Trust at an early stage, including in shaping the investigation process for the most serious incidents, such as mental health homicides, including by contributing to the investigation ToR.

6.8 **RR8:** The Trust should ensure that specialist teams in the ICB have an opportunity to shape the ToR for SI investigations, where this is proportionate and appropriate. The same teams should then review the draft report to ensure that the ToR have been properly addressed.

**Incident closure**

6.9 The report was reviewed at the Sussex SISG on 25 April 2019 and was closed on first submission, with positive feedback provided: "This was felt to be a very well written and detailed report with a robust investigation." This is surprising given that the CCG's feedback from the first line triage process had not been fully addressed (including a number of questions about safeguarding). The CCG should also have, in our opinion, been more challenging about extent to which why events occurred were explained in the report.

6.10 The Group recommended that the CQRM follow up the primary care referral policy for violent patients (Special Allocation Scheme, SAS). The exact action required from the Trust and CQRM in relation to this policy is unclear, as well as the desired outcome. The CCG told us that scheme had been in place since 2004 "with the aim of providing a secure environment in which patients who have been violent or aggressive in their GP practice can continue to receive general medical services." It is unclear why R was not referred to this service, and there is no reference to this in the final SI report as a potential CDP or SDP.

6.11 The CCG Guidelines for SI Reporting and Investigation contain a set of criteria which needs to be met for SIs to be closed. The report in question did not meet a number of these, namely:

- DoC clearly demonstrated
- RCA methods followed
- SDPs and CDPs accurately identified and root cause identification, and recommendations linked to these
- A SMART action plan
- Accessible to families, e.g., medical terminology and abbreviations fully explained

2 The ICB has since strengthened its processes in relation to SI closure. An audit of 85 SI case files which reported in May 2022 found that 100% of the cases had the SI panel documentation fully completed. We also note the improvements in timeliness of review by the SI Panel.

**Implementation and embeddedness of learning**

6.12 Following sign-off of this incident, the CCG Designated Safeguarding Nurse delivered training across the system on domestic abuse and its impact on health, in collaboration with primary care and Sussex Police. The CCG (now ICB) continues to offer this training on a monthly basis. This is positive, both in ensuring that new staff have the opportunity to receive training and that more established staff can seek refresher sessions.

6.13 There are, in our view, other lessons to be learned from this incident, including in relation to inter-agency working, risk management and carer involvement. An opportunity may have been missed for the CCG to share this wider learning from this SI across its footprint.

6.14 It is important to note that since the 2018 Mental Health Homicides Thematic Review, both the Trust and CCG (now ICB) have made a number of changes to processes for overseeing actions arising

from SI investigations. These were not in place at the time of the incident in question, and we note the time elapsed since this SI. At the time of the homicide and the subsequent SI process, the 2018 SISG ToR stated that its responsibilities included:

- To ensure organisational learning and ongoing quality improvement is evidenced by providers
- To identify and action any emerging themes from SI investigations

6.15 We found that recommendations made in relation to this SI were also made in another incident, which Niche had access to, having been commissioned to undertake an assurance review (StEIS 2015/24621) the report for which was completed one month prior to this SI. These included:

- Implementation of the engagement and DNA policy
- MHA assessment to be considered and document in cases of disengagement
- Recording and use of MARAC information
- Findings were also identified in relation to carer engagement and how Triangle of Care had been implemented.

6.16 Noting the close timeframe of these two incidents, there is a need to ensure effective thematic analysis is regularly taking place to ensure that these themes have been addressed by SPFT and that later incidents do not have the same causal factors.

6.17 **RR9**: Ensure clarity in the new ICB quality governance structure about how and where themes and actions arising from serious incidents will be monitored. There should be a particular focus on outcomes of action plans and learning.

# Appendix A - Terms of reference for the internal investigation

1. The review will establish the facts of the incident, including any participating factors and root cause where available by review care in the immediate eight weeks prior to the incident including:
    - Assessments, including risk assessments and management plans resulting from these assessments
    - Interactions with service users and others
    - The robustness and application of policies relating to
        - The management of service users in the community
        - The supervision of service users
        - Protection plans including any MoJ restrictions
    - Any concerns raised and the responses to those concerns
    - The arrangements for consultant responsibilities and its impact on individual care plans
    - The action taken subsequent to the assault by the service user
    - Review of historical decisions relating to discharge including:
    - Type of care upon discharge
    - Decisions about outpatient care
    - Decisions about suitable housing for the service user
2. Review the partnership arrangements at the time of the incident in place between the local health services, other providers involved in the service users care and the criminal justice system for sharing of information, specifically with regard to the management of risk.
3. Investigate other matters arising during the course of this investigation which, in the opinion of the panel, are relevant to the occurrence of the incident or may prevent recurrence.

# Appendix B – Evidence review of the Trust's action plan

| **Recommendation 1 -**<br>**All patients deemed at risk of disengagement from services will have a risk management plan. To RAG rate Red this will ensure discussion at weekly team meeting.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| Forensic Outreach and Liaison Service (FOLS) –<br>Zoning Process for Weekly Team meeting | The purpose of this document was to introduce a zoning process into the FOLS weekly MDT meeting. Examples to support the definition of each RAG rating have been provided in the appendix. |
| FOLS team meeting zoning tracker | This document is a 'community tracker' which appears to have all redacted patients' zoning RAG status.<br>The document shows a standard team meeting agenda for the FOLS MDT. Risk reduction, including this community tracker, is to be discussed at every (weekly) meeting. |
| FOLS weekly team meeting agenda | A standard agenda template has been shared, which shows that 45 minutes should be dedicated at each meeting to the community tracker. In the example shared, there were 100 patients on the tracker, therefore time to do this fully may be constrained. |
| Community RAG tracker Sep-Nov 2021 | This is an example of an output of discussion of the community tracker. There is evidence of patients' risk status changing following discussion, and of actions taken as a result, e.g., accommodation changes. It is not always clear from reading this, why certain RAG changes have been made (e.g., 1078919 who was up rated to red on 29/7/21) although this will likely be covered in Carenotes. |
| SI Team meeting | This document describes the structure of the FOLS team meeting. Patients rated red or amber on the community tracker are discussed weekly.<br>The document also describes the "DNA action plan": if a patient misses three consecutive appointments an MDT review of needs will be held to agree appropriate action, documentation to be updated and other agencies informed. There is evidence the team has been reminded of this at various team meetings, although no evidence has been shared that this has been enacted or specific DNA action plans discussed in the FOLS weekly meeting. |

| **Recommendation 2 - Alerts [regarding engagement] to be discussed at MDT prior to putting on Carenotes.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| Active Engagement incorporating Did Not Attend (DNA)<br>Management Policy & Procedure (year) | This policy was introduced in July 2019 across the Trust, and incorporates learning from SIs as an indicator of increased risk. The Trust launched this policy with 15 interactive learning events across the Trust.<br>The policy does not state how it will be implemented or measured as to its impact. We have seen no evidence demonstrating levels of compliance with the policy. |
| Forensic Outreach and Liaison Service (FOLS) - Disengagement of Case- | This document is specific to FOLS, and provides a greater level of guidance and detail around non-engagement; there are 24 separate steps to consider |

| | |
|---|---|
| managed Service Users Policy (year) | if patient DNA/cancels three consecutive appointments. This includes consideration of the need for an MHA assessment.<br>The expectation is clear that non-engagement should be discussed at MDT meetings: "*service users who have disengaged should be identified at the weekly Forensic Outreach and Liaison Service Team meeting, and RAG rated accordingly. There must be a documented clinical review including discussion of appropriate actions and identification of who will take responsibility for those action points recorded within the service user's care record."* |
| My Care and Safety Plan | This is a blank template, which has suggested examples of engagement which might be expected of service users. |
| New CPA Process within FHS Community (January 2020) | This is a presentation, undertaken in January 2020 (attended by 33 members of staff) which focuses on reviewing the CPA process and its role in the My Care and Safety Plan. It focuses on collaboration between care professionals and services users, and demonstrates the new guidance.<br>Engagement is a new heading which features in the new care plan template.<br>It is not clear how compliance with the new process has been measured, e.g., through audit. |
| Patient Safety Matters | This is a learning bulletin which includes guidance on DNA for staff, including prompts about s117 considerations, the person's risk rating, safeguarding and liaison with other agencies. |
| Supplementary information received | CPA Process within FCOS (dated July 2017 – this pre-dates the SI). |

| **Recommendation 3 - Lead practitioners to be aware of the importance of patients being registered with a GP.**<br>**List of community pharmacy contact details to be available so that FP10 can be sent directly to community pharmacy.**<br>**Lead practitioner to discuss preference with patient to aid collection** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| Unnamed spreadsheet | This is raw data, which lists the GP surgery details for patients on the FOLS caseload. It is not clear if the data is complete, or how many patients (if any) or not registered with a GP. |
| Local pharmacy contact details | The evidence submission states that these are held on the local shared drive. |

| **Recommendation 4 - Mental Health Act Assessment to be considered and documented if a patient misses more than 3 appointments with lead practitioner (MDT).** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| No specific information submitted, although evidence submitted under R1 and R2 applies. | |

| **Recommendation 5 - Inpatient wards to complete HCR20 prior to discharge.**<br>**Community Forensic Outreach Service staff to highlight to ward staff if this has not been completed.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| 20220105 6 months HCR data - Hellingly Centre | Raw data which appears to show audit results for HCR20 completion at the Hellingly Centre over the last six months for four wards. We note positively that this has been consistently 100% on Oak Ward, and compliance has ranged between 92%-100% on Ash Ward.<br>Blossom Ward's compliance has ranged between 56%-100%.<br>It is unclear what the sample size was, what actions have been taken forward as a result of mixed compliance, and if there are intentions to reaudit. |
| Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure | The Clinical Risk Policy was ratified in May 2020. This provides guidance on risk assessment tools and frequency.<br>This states that on the Forensic caseload, an HCR20 must be completed within three months of admission. It is unclear, from this document, if there is an expectation that HCR20 is completed for community forensic patients. |
| Minimum Standards for the Recording of Risk Assessment and Safety/ Management Plans in Adult, Learning Disability, CHYPS & Forensic Healthcare | Ratified in May 2020, this document underlines the importance of using the Triangle of Care, and the 5 P's model for risk formulation.<br>It also sets out expectations for when the risk assessment must be reviewed. |

| **Recommendation 6 - Protocol to be put in place to ensure that all eligible patients receive a s117 discharge meeting. Follow CPA policy and ensure representative from community and Local Authority are in attendance.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| 20220105 117 Compliance Hellingly Centre Jul 21 to Dec 21 | Spreadsheet containing what raw data from an audit of discharges from the Hellingly (forensic inpatient) Centre between July and December 2021.<br>The data suggests that, of the ten patients discharged who were eligible for a s117 meeting, there was 100% compliance.<br>It is unclear from the evidence shared:<br>• How eligibility is determined<br>• If Community and Local Authority representation was present in all cases<br>• What compliance is like at the Chichester Centre (low secure)<br>• If there are intentions to reaudit s117 completion to ensure that actions have been embedded |

| **Recommendation 7 - Identify carer champions within the CFOS.**<br>**Attendance at Trust ToC meeting.**<br>**Carer details to be completed on Carenotes for each patient.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| Minutes from Triangle of Care meeting, 18/9/2019 | Two members of staff attended the first ToC meeting in September 2019. It is unclear if attendance has been maintained since 2019, and what the impact of this has been. |
| Interview questions (various) | Triangle of Care has been incorporated into recruitment questions. |
| Letter template | This is a letter template which suggests that CFOS has sought to contact all patients' families to ensure that family and carer details are up to date. It is unclear how successful this exercise was. |
| Sussex Partnership NHS Foundation Trust Forensic Healthcare Service Carers' Strategy 2021 | This document sets out the importance of working well with carers, and the Trust's 15 priorities in this area. We note that not all of these priorities have named leads or updates on progress noted. |

| **Recommendation 8 -**<br>**Community Forensic Outreach Service representative to attend MARAC meetings.**<br>**Trust IG to advise if an alert can be put on the Carenotes system for any discussion about Trust patients open or closed to services.** | |
|---|---|
| **Evidence submitted** | **Niche commentary** |
| MARAC Carenotes data entry | This is a form of SOP for staff to support them in entering MARAC information on the Carenotes system. It suggests that an alert can now be set up on the system, for both the victim and the perpetrator:<br>"*For open cases, the MARAC Representative should inform Lead Practitioner of the MARAC Meeting date and advise the case was discussed. They should request the LP then complete a care plan to this effect, and add a Risk Event to the notes*." |
| Forensic Outreach and Liaison Service Operational Policy | (No date of ratification).<br>The policy has guidance on the role of MARAC, but does not specify the team's responsibilities in relation to MARAC. |
| Agenda for CCPDD (1/5/19) | MARAC featured on this team meeting agenda; it is unclear what the outcome of this discussion was. |
| Clinical risk assessment tool on Carenotes | The Trust implemented a new clinical risk assessment tool on Carenotes in December 2018. All staff in all services must use this. The associated guidance underlines the need for families and carers to be as involved as possible in risk assessment and care planning.<br>The new form includes sections on, among others: disengagement, violence and aggression, and risk to others. |
| Supplementary information received | Clare's Law training materials (the report concluded that there were no training or educational contributory factors) |

## Appendix C – Glossary

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|---|---|
| **CDP** | Care Delivery Problem |
| **CF** | Contributory Factor |
| **CFOS** | Community Forensic Outreach Service |
| **CPA** | Care Programme Approach |
| **CQPG** | Clinical Quality and Performance Group |
| **CRC** | Community Rehabilitation Clinic |
| **DHR** | Domestic Homicide Review |
| **DNA** | Did Not Attend |
| **DoC** | Duty of Candour |
| **FOLS** | Forensic Outreach Liaison Service |
| **GP** | General Practice / General Practitioner |
| **HCR20** | Historical, Clinical and Risk Management -20 |
| **ICB** | Integrated Care Board |
| **MAPPA** | Multi-Agency Public Protection Arrangements |
| **MARAC** | Multi-Agency Risk Assessment Conferences |
| **MHA** | Mental Health Act |
| **PFLO** | Police Family Liaison Officer |
| **PSIRF** | Patient Safety Incident Response Framework |
| **QRM** | Quality Review Meeting |
| **RCA** | Root Cause Analysis |
| **RR** | Residual Recommendation |
| **SI** | Serious Incident |
| **SIF** | Serious Incident Framework |
| **SISG** | Serious Incident Surveillance Group |
| **SPDP** | Service Delivery Problem |
| **SPFT** | Sussex Partnership NHS Foundation Trust |
| **ToC** | Triangle of Care |
| **ToR** | Terms of Reference |

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