Sussex Partnership NHS
NHS Foundation Trust

NHS England

An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust. Prepared by Caring Solutions (UK) Ltd.

Volume 2 Supporting evidence

An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust: Volume 2 Supporting evidence

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Dr Martin Lawlor (Consultant Psychiatrist)
Dr Ashok Roy (Consultant in the Psychiatry of Learning Disability)
Mr Alan Worthington (Lay member)

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Appendix A: Members of the review team

The proposed team for this thematic review consists of a clinical panel supported by two senior associates with expertise in thematic analysis, benchmarking and quality assurance, and a lay carer to provide a further independent perspective on the work. All members of the team have experience in independent investigations.

Clinical Panel:
Dr Colin Dale: Dr Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the RCN, NIMHE, NPSA and the Department of Health and has a track record of research publications and international conference presentations. He has successfully worked on a large number of projects in recent years including: national projects with the Royal College of nursing, the Offender Health Services, the Youth Justice Board together with and a number of local and regional projects for individual Trusts and organisations. Colin has led: the review of 38 Homicides by Mental Health Service users in the North West of England; the thematic review of 40 Homicides by Mental Health Service users in London; the review of 81 unexpected deaths in the North East of England; and works as an independent investigator in SUI's in the health and prison services. He is a member of the Mental Health Review Tribunal and was the mental health adviser with the National Patient Safety Agency.

Dr Martin Lawlor: Consultant Psychiatrist, Carraigmor Centre, Cork, Ireland. His current role involves the management of complex patients with both Axis I and Axis II pathology in a 20 bed PICU setting along with providing a special interest in Forensic Psychiatry with a particular emphasis on effective risk assessment and management. He contributes to teaching, clinical audit, research, management and is registered with the Royal College of Psychiatrists for CPD. He was appointed regional CPD representative for the Irish College of Psychiatry in November 2009. In 2008, Dr Lawlor led a team to establish the Centre for Recovery and Social Inclusion (www.crsi-cork.com), Ireland, which is a charitable foundation aimed at promoting social inclusion in Mental Health Services.

Dr Lawlor has successfully worked with both in–patient and community multidisciplinary General Adult, Rehabilitation and Forensic psychiatry teams using a bio-social treatment model to manage the needs of complex clients. He is an experienced Consultant in Rehabilitation Psychiatry with a special interest in Forensic Rehabilitation who is committed to delivering excellent care to service users. He has worked in a number of sub-specialities including Learning Disability, Substance Misuse, and Academic Psychiatry. Dr Lawlor has Section 12 approval and Approved Clinician Status. In addition to his psychiatric experience, Dr Lawlor has extensive experience in management, with a MSc in Human Resource Development and he is currently undertaking a Doctorate in Business Administration.

Dr Ashok Roy: Consultant in the Psychiatry of Learning Disability in Solihull Community Services and Coventry and Warwickshire Partnership Trust. He is Medical Lead for the Learning Disability Assessment and Treatment Service for the Trust. He is the Chair of the Faculty of Intellectual Disability at the Royal College of Psychiatrists. He represents the Faculty at the Department of Health and at the Learning Disability Professional Senate. He is a Senior Clinical Lecturer in the Psychiatry Department at Birmingham University. His interests include clinical

outcome measures, service development, access to primary care services, and ethical issues in Learning Disability. He was previously Medical Director of an NHS Mental Health and Learning Disability Trust. Dr Roy has worked with Caring Solutions (UK) Ltd on a previous independent investigation.

Ms Maggie Clifton, MA, MCMI: (Review Manager). Maggie has managed and contributed to a number of Independent Investigation Panels, for former SHAs and for NHS England, and to the review and audit of internal and independent SUI investigation reports. She trained and worked as social scientist, specialising in qualitative research including interviewing, documentary and transcript analysis and report-writing, in health and social policy related areas. She is also a qualified general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. As an independent management consultant she has worked on projects for the Department of Health, Royal College of Nursing, Primary Care Trusts, Universities of Liverpool and Lancaster. She is currently a Senior Associate and Investigations Manager for Caring Solutions (UK) Ltd and Director of Quality Assurance for The Development Partnership and British School of Coaching. She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

Dr Tony Fowles – Dr Fowles is a senior associate at Caring Solutions(UK) Ltd and is a specialist in criminal justice with a background in research and university teaching; including being Dean of the Law School at Thames Valley University. He was the lead reviewer for the NHS London project, 'Learning from Experience - report of consultancy to support the compilation and analysis of learning from the 2002-2006 London mental health homicide reviews and analyses'. He was chair / lead investigator of two independent inquiries into the care and treatment of mental health service users. The inquiries were commissioned by NHS London SHA and NHS Yorkshire and the Humber SHA. He has also provided specialist criminal justice input into other independent inquiries carried out by Caring Solutions (UK) Ltd. In 2013 he produced Lessons Learnt from Independent Inquiries, a report prepared for Mersey Care NHS Trust. In 2015 he was chief technical editor of the revised Reference Guide to the Mental Health Act 1983.

For eight years Tony was a criminologist member of the Parole Board of England and Wales which is responsible for the early release of prisoners. This work involved assessments of risk, for example, further violent offences as well as reputational risk. He was Chair of the Lancashire Probation Board between 2002 and 2007. Tony has published several books on criminal justice, and was from 1997 to 2008 one of the Editors of the Howard Journal of Criminal Justice which is Britain's main criminal justice policy journal. He is currently a member of the editorial advisory board of the Journal of Intellectual Disabilities and Offending Behaviour.

Mr Alan Worthington – lay member, carer. Formerly in science education, he 'retired' early to become a carer of twin foster sons who developed psychosis in 1988. Soon afterwards he was appointed in Exeter to develop support and education services for mental health carers becoming one of the first Carers' Support Workers in the country. This work involved identifying Best Practice and finding ways for its introduction into carer involvement. For several years he worked for both MIND and

the National Schizophrenia Fellowship and organised training days and conferences for staff and carers. He has contributed to the Care Quality Commission's inspection standards; participated in the Royal College of Psychiatrists' Accreditation - Peer Assessment Schemes; both in the Inpatient (AIMS) programme and the Crisis-Home Treatment (HTAS) Scheme. In the latter he took part in the process of selecting Standards for Home Treatment and is currently involved in the HTAS Awarding process. He is a member of the DH National Mental Health Safety Advisory Committee which is currently looking at ways of applying the Safety Thermometer concept to the reporting of mental health risk. Previous experience of investigations in care and treatment include a Review of 5 SUI service users in Cornwall and a SUI Conference run by DH in Leeds in 2009. Mr Worthington will bring an independent voice and challenge to the review process.

Although different members of the team will be leading on different elements of the review, the team will work collaboratively to ensure that each member receives and feeds back on each element of the project. The team will collectively identify possible recommendations for discussion with sponsors and stakeholders.

Appendix B - Terms of reference

Terms of reference

1) The purpose of this thematic review is to establish whether there are service related themes / wider issues or links recurring across the range of mental health homicides.

2) This process should focus on emerging themes and not the reinvestigation of individual incidents or an examination of Trust policies and procedures unless these are directly pertinent to the review.

3) The review should identify whether all learning from these incidents has been identified and that all required changes to practice have been embedded in the organisation.

4) The review should identify whether the organisation's Quality Assurance Framework provides effective reporting and monitoring of serious incidents in line with the NHS England Serious Incident Framework Supporting learning to prevent recurrence) and subsequent policy and organisational development.

5) The outcome may include recommendations for the Trust and Clinical Commissioning Groups (CCGs), over and above those identified in the individual serious incident investigation reports, with the expectation that the Trust's response to any recommendation is fed back to the group.

6) There should be external clinical and carer involvement in the thematic review.

7) The review should provide advice to the relevant CCGs about mental health commissioning, data management and analysis.

There will be 4 elements to the work

Thematic review

1) Review of every independent investigation following a mental health homicide from 20011- January 2016. The aim of this element is to ensure that processes are in place to review the action plans and ensure lessons have been learnt from them.

2) Benchmarking data

To provide a contextual view, key benchmarking data items will be used to compare mental health homicides rates of people in receipt of services from Sussex Partnership NHS Foundation Trust with similar mental health trusts (in terms of size and number of patients treated). Following this it will be possible to identify whether Sussex Partnership NHS Foundation Trust incident reporting is in keeping with best practice within other mental health trusts.

3) Adverse events indicators

This information will be used to identify common themes and trends and any common contributory factors. Information about patterns in these incidents may help to identify key indicators of risk for predictable and preventable homicides. Such information will be summarised to inform the Trust of any key policy, organisational and/or training development requirements.

4) Further Learning

To make recommendations about what further actions are required going forward to address any identified gaps from board to ward.

Outputs

1) A report identifying any service related themes/ wider issues or links that are apparent from the thematic review.

2) A report that establishes whether learning from independent investigations has been implemented and identifies any gaps in that learning, and steps that are being taken to address those gaps.

3) A report that identifies any good practice or areas for development in relation to the organisations quality assurance framework.

4) A set of recommendations for the Trust, NHS England and/or CCG, (over and above those identified in the individual serious incident investigation reports), and guidance regarding the actions necessary to complete those recommendations.

Appendix C. Methodology

1. The Terms of Reference included four key elements of the review:
   - Thematic review.
   - Benchmarking data.
   - Adverse event indicators.
   - Further learning.

Review of investigation reports

2. Eleven reports were reviewed. These included:
   - eight independent investigation reports into the care and treatment provided by the Trust following a homicide committed by seven service users (seven of these have been published by NHS England, one is pending publication)
   - two internal investigation reports into the care and treatment provided by the Trust following a homicide committed by a service user
   - one internal investigation report into the care and treatment provided by the Trust to a service user who became a victim of homicide.

3. We anticipated that generic themes would include:
   - quality and documentation of risk assessment and management
   - communications policy & practice
   - training and supervision
   - organisational learning
   - quality assurance
   - how well services are supporting families, as part of care and treatment, and after an incident.

4. Once identified, the themes were, as far as possible, grouped according to the following types of contributory factors, taken from the Patient Safety literature:
   - patient factors
   - task and technology factors
   - individual (staff) factors
   - team factors
   - work environment factors
   - organisational and management factors
   - institutional context factors
   - communication.

5. In particular, in order to identify potential indicators of serious incidents, the team looked for organisational issues such as service change, staffing or workforce issues, resource issues or service gaps – where the Trust with their Commissioners can proactively mitigate risks associated with the indicators. The factor types listed above will also be utilised in this analysis.

6. We reviewed the action plans arising from the investigations and reviews. We identified whether there were any limitations in the plans (e.g. actions are not SMART, actions do not have an identified person/role responsible for implementation) – the expectation is that inadequate plans are less likely to

have been implemented and lessons learnt effectively. We also identified any repetition of required actions– if actions (e.g. to provide training in CPA) were repeated after a reasonable time period - it may be evidence that actions were not been embedded in practice in the organisation. We compared the action plans were to recommendations to identify any potential misinterpretation in translating recommendations to actions – again, if there are weaknesses in this element of the process, lessons are less likely to have been learnt effectively.

7. The Trust was asked to provide documentary evidence of implementation of action plans. We reviewed this evidence and evaluated implementation of the plans using an adaptation of the NHS Litigation Authority (NHSLA) model. This uses three levels of assessment of risk and the principles applied to each level were applied to the implementation of action plans. These are:
   - Level 1 - Policy: evidence has been described and documented
   - Level 2 - Practice: evidence has been described and documented and is in use
   - Level 3 - Performance: evidence has been described, documented and is working across the whole organisation.

8. This analysis provided evidence to conclude whether or not lessons had been learnt and embedded in the organisation. However, the conclusions were limited in that this methodology does not allow the team to evaluate actual changes in behaviour or practice 'on the ground'. The methodology allows the team to identify with some degree of confidence where action plans have not been fully implemented, but are more limited in providing evidence that action actions have been fully embedded in the organisation and have made a difference to care and service delivery, and to the service user and carer experience.

9. We reviewed and evaluated the Trust's Quality Assurance Framework, systems and processes against the NHS England Serious Incident Framework (March 2015) to identify whether there has been effective reporting and monitoring of serious incidents. This version of the Framework was published after most of these action plans were created though a previous version was published in 2013.

10. The Trust provided a number of policies, procedures and guidance documents for us to review in order to identify their systems for reporting and learning from adverse events. 'Adverse events' include incidents and serious incidents, complaints, claims, Patient Advice and Liaison Service (PALS) information, coroner's inquests, and any significant issues relating to the application of the Mental Health Act. For the purposes of this report, we have only reviewed information which is relevant to incidents which are analysed in this report. The following policies and guidance (full details in Appendix C, References) were reviewed.
    - Trends and Lessons Guidelines (2010 – review date of 2013)
    - Lessons learned (2014 incomplete draft)
    - 'Being Open' including Duty of Candour (2015)
    - Incident and Serious Incident Reporting Policy and Procedure (October 2015)

- Risk Management Strategy (not yet ratified).

11. We supplemented our review and analysis of these policies and procedures by conversations with the Director of Nursing Standards and Safety and the Head of Governance for the Trust. The Trust then provided:
    - the Board reporting structure (as relevant to quality assurance)
    - terms of reference for the Quality Committee (a sub-committee of the Board); and for the Suicide and Homicide Review Group and the Serious Incidents Review Group (both sub groups of the Quality Committee)
    - the template for the serious incident reporting web-based system
    - a Trust-wide Quality and Patient Safety report as an example of the reporting and accountability system.

12. Finally, we downloaded from the Trust website the following public Board papers:
    - Minutes of the Board of Directors meeting, 27 January 2016 and Action Points
    - Board Assurance Framework – Extreme Risks, 30 March 2016
    - Quality Committee Summary Report, 24 February 2016
    - CQC Must Do Actions Status Report, 8 February 2016 (submitted to the 24 February 2016 Board of Directors meeting)
    - Fundamental Standards paper, 24 February 2016
    - Board Assurance Framework Version V4, 24 February 2016
    - Trust Quality and Performance Report, 24 February 2016.

13. Drawing on these documents and information we have been able to describe the systems the Trust employs to assure itself that incidents are recorded and reported, that appropriate levels of investigations are carried out and that recommendations lead to action plans which are disseminated across and embedded in the care and services provided by the Trust.

Benchmarking data

14. We analysed numerical data from the investigation reports using a template which was tailor-made for this purpose. We benchmarked these data in the three ways set out below. Because the number of these incidents are, fortunately, small, the utility of this benchmarking exercise is limited.

National Confidential Inquiry into Suicides and Homicides (NCISH)

15. The most authoritative benchmarking information in the UK is that provided by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) based in the University of Manchester who publish an annual report; the most recent being July 2015 (NCISH, 2015). We compared Trust data with data for England on the following topics:
    - homicides by mentally ill people in the general population
    - persons in contact with mental health services in the 12 months prior to the offence
    - age group of service user
    - gender of service user
    - number of patients who refused drug treatment

- number of patients who missed their last appointment with services
- number in contact with Crisis Resolution/Home Treatment Services
- alcohol and drug misuse
- number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse).

16. Each of the annual NCISH reports provides commentary on trends for that reporting period and trends over time. It was possible therefore to evaluate whether the national trends are reflected locally or there are important differences.

National criminal statistics

17. The Criminal Statistics for England and Wales provide information on homicides among the general population of England and Wales. Again it is possible to compare local and national trends. The Criminal Statistics publishes information annually on the number of convictions for the different types of homicide during each financial, the most recent data refer to 2014/15.

18. Other information provided annually includes:
    - age and gender of the perpetrator
    - method used in the homicide
    - relationship between perpetrator and victim.

Comparisons with other published thematic inquiries

19. Over the past five years a number of thematic inquiries have been carried on homicides in individual Trusts and in the former NHS Strategic Health Authority regions. Many of these are in the public domain. For example, Caring Solutions (UK) Ltd conducted two previous regional reviews of homicides (the North West of England and London). The North West review analysed 38 cases of homicides occurring between 2002 and 2006 and the London review considered 40 homicides occurring between 2002 and 2006. We have used the data from the London study to inform the benchmarking process. Additionally, there are several academic studies of homicide inquiries (References in Appendix C).

20. We are aware that overall conclusions of this element of the work may be that it may be that the numbers are so small that the value of benchmarking is limited.

Adverse events indicators

21. A qualitative analysis of investigation reports was undertaken to identify any common themes, trends and contributory factors and any patterns in the findings and recommendations in the investigation reports. We have tried to assess whether there was any relationship or causal connection between the themes identified and the ‘predictability or preventability’ of the homicides, as concluded by the investigation report authors.

Further learning

22. Caring Solutions (UK) Ltd anticipated that there would be further learning arising from this review. We met as a clinical forum when we reviewed initial findings to generate draft recommendations. We have added to these after further consultation with stakeholders. This included consideration of how recommendations might be lead to real change ‘on the ground’ in addition to an understanding of how service and care delivery might be improved.

23. We sought feedback from the sponsors and stakeholders to enhance the draft recommendations and enable all stakeholders to ‘own’ the outcome.

Appendix D. Benchmarking data

1. Quantitative data from the internal and independent investigation reports from the Trust have been analysed using a template which we have tailor-made specifically for this particular purpose. These data may be benchmarked in three ways, some have been described in the main report and others are set out below. We would also include a caveat, that the numbers of these incidents are, fortunately, small, and this may limit the utility of this benchmarking exercise.

National criminal statistics

2. The Office for National Statistics (ONS) publishes annually an analysis entitled 'Focus on Violent Crime and Sexual Offences'. The figures included in the Focus provide information on homicides among the general population of England and Wales. The authors compare local and national trends as well as a number of trends over time. The Focus includes information on the number of homicides recorded by each police force in England and Wales which it then aggregates to produce national figures for each financial year, the most recent data refer to 2014/15 (ONS 2015a).

3. The following remarks about the incidence of homicide should not be understood, in any way, as down-playing the traumatic effects of homicide on the victims and the victims' families, nor the perpetrators and their families. The statistics on homicide do not convey the human costs of homicide.

4. 'Homicide' in this context covers the offences of murder, manslaughter and infanticide. Murder and manslaughter are common law offences that have never been defined by statute, although they have been modified by statute law over the years. The manslaughter category includes the offence of corporate manslaughter which was created by the Corporate Manslaughter and Corporate Murder Act 2007 which became effective on 6 April 2008. The offence of infanticide was created by the Infanticide Act 1922 and was later refined by the Infanticide Act 1938.

5. The Index from which these figures are produced is based on the year when the offence was recorded, not when the offence took place or when the case was heard in court. While in the vast majority of cases the offence will be recorded in the same year as it took place, this is not always the case. Caution is needed when looking at longer-term homicide trend figures because of the way these figures are recorded as they become known to the police. For example, the 172 homicides attributed to Dr Harold Shipman as a result of Dame Janet Smith's inquiry took place over a long period of time but are all recorded by the police as if they had occurred during the year ending March 2003.

6. Similarly, a single incident may have a disproportionate impact on the figures so that the year 2003/04 includes the 20 cockle pickers drowned in Morecambe Bay (the victims of manslaughter by their gang masters); the year 2005/06 includes 52 victims of the 7 July London bombing; and the year 2010/11 includes the 12 victims of Derrick Bird (a Cumbria taxi driver).

7. When the police initially record an offence as a homicide it remains classified as such unless the police or courts decide that a lesser offence, or no offence, took place. In all, 530 deaths were initially recorded as homicides by the police in the year ending March 2015. By 13 November 2015, 12 were no longer recorded as homicides, giving the total 518 offences currently recorded as homicides reported earlier.

8. This figure of 518 recorded homicides in the year ending March 2015 was 5 fewer than in the previous year, a decrease of 1 per cent. This was the lowest total since 1983 when 482 were recorded. Homicides generally increased from the late 1960s up to the early 2000s (peaking in the year ending March 2003 including the 172 homicides committed by Dr Shipman).

9. There were 331 male victims of homicide in the year ending March 2015, down 3 per cent from 340 in the previous year and continuing a generally downward trend. On the other hand, the number of female homicide victims increased slightly, from 183 to 186 victims (a 3 per cent increase), although the longer-term trend is slightly downwards.

10. As far as the circumstances of homicides are known to the police, the ONS report that about half (48 per cent or 247 offences) of all homicides in the year ending March 2015 resulted from a quarrel, a revenge attack or loss of temper (ONS 2015a). This proportion was higher where the principal suspect was known to the victim (59 per cent), compared with when the suspect was unknown to the victim (33 per cent). These figures for irrational acts do not account for all homicide committed by mentally disturbed people, as offences with an apparent motive (for example, during a robbery or a quarrel) are instead included under the respective circumstances. The ONS then refer the reader to the NCISH for more complete information on homicides committed by mentally disturbed people. A further 7 per cent (35 offences) were attributed to irrational acts and 4 per cent of homicides (19 offences) occurred during furtherance of theft or gain. The circumstances of 17 per cent of homicides (87offences) were either unknown or not recorded at the time of publication of the report.

Table 1. Patient homicide: age of perpetrator at the time of the incident

Age of perpetrator at the time of the homicide	Trust	NCISH cohort	London sample
Under 25	2	165 (27%)	7 (18%)
25 to 44	2	360 (59%)	18 (45%)
45 or more	4	89 (14%)	10 (25%)
Don’t know	1	1	5 12%)
Total	9	615	40

Sources: NCISH Annual Report 2013 Figure 26; Fowles et al (2008)
Note: * Although these numbers are below 50, a percentage has been provided to allow easier comparison.

11. Of the nine Trust service users under investigation here two were under 25 years of age at the time of the homicide, two were between 25 and 44, and

four were aged 45 or more. The oldest perpetrator was 66. The Sussex group of perpetrators is somewhat older than any of the other samples available to us for comparison.

Table 2. Patient homicide: ethnicity of perpetrator

2001 Census ethnicity groupings	Trust	London sample	Maden sample	rates of access per 100,000 population by ethnic group, 2014/15
White				
British	9	15	-	3634.0
Irish	-	1	-	3125.8
Any other white background	-	3	-	5037.3
All White groups	9	19	16	3612.3
Mixed				
White and Black Caribbean	-	1	-	3581.2
White and Black African	-	1	-	3794.6
White and Asian	-	-		2373.1
Any other Mixed background	-	1	-	6021.8
All Mixed groups	-	3	-	3868.6
Asian or Asian British				
All Asian groups	-	3	1	3295.1
Black or Black British				
Caribbean	-	8	4	4975.8
African	-	2	1	3177.6
All Black groups	-	10	5	4798.8
All ethnic groups (including White)	9	35	25	3616.6
Ethnicity not stated	-	5	-	-

Note: the groupings used here follow those used by the Office of National Statistics
Sources: Fowles et al (2008); Maden (2006).
HSCIC Mental Health Bulletin Annual Report 2014-15. Table 1.4 Number of people in contact with NHS funded adult secondary mental health and learning disability services and rates of access per 100,000 population by ethnic group, 2014/15

12. No information at all about the ethnicity of the patient homicide group was available from the independent investigation reports. The information was obtained later from Trust staff. All of this group were ‘White British’. It is to be

hoped that if any of these service users had been of any other ethnic background that investigators would have commented on the cultural appropriateness and sensitivity of their treatment. There is nothing in the current Serious Incident forms used by the Trust to indicate the ethnicity of the service user involved.

13. The ethnic composition of the Trust area does not show a widespread presence of minority ethnic groups but rather there are a number of small and perhaps isolated groups which may raise problems for service providers. The 2011 Census gives the data in the next table.

Table 3. Ethnic composition of the Sussex population by local authority area

Local authority	White British	Mixed	Asian or Asian British	Black or Black British	Chinese
Brighton & Hove UA	81.19	2.34	4.84	2.30	0.94
East Sussex CC	89.49	1.45	2.30	1.62	0.43
West Sussex CC	87.60	1.54	3.64	1.48	0.45
Adur	89.89	1.63	2.45	1.14	0.33
Arun	90.33	1.20	2.40	1.07	0.37
Chichester	89.52	1.33	2.31	1.18	0.44
Crawley	78.92	1.99	9.78	2.37	0.38
Horsham	88.98	1.39	2.37	1.46	0.39
Mid Sussex	87.08	1.67	3.04	1.60	0.68
Worthing	87.99	1.76	3.52	1.37	0.39

Source: ONS 2011 Census

Table 4. Patient homicides: relationship of perpetrator to victim

Relationship of perpetrator to victim	Number		
	Trust	NCISH cohort	London sample
Family member	2	111	7
Spouse / partner†	-	113	4
Acquaintance	5	232	11
Stranger	2	91	15
Relationship not known	-	-	3
Total	9	547	40

Sources: NCISH Annual Report 2014, para 1.2.3
Note: † includes current, former and ex-spouses and partners

14. At a national level, the data on the relationship to the principal suspect for the year ending March 2014 show similar findings to previous years. There were differences between male and females in the pattern of relationships between victims and suspect. Acquaintances were the most likely victims comprising 42 per cent of all victims. Female suspects (31 per cent) were proportionately less likely than male suspects (44 per cent) to have been acquainted with the principal suspect. Women were proportionately more likely than men to kill a family member – 33 per cent as opposed to 18 per cent. Women patients were

proportionately more likely to kill a spouse/partner (either current or ex) than men - 27 per cent versus 19 per cent.

15. In particular, women were far more likely than men to be killed by partners/ex-partners (44 per cent of female victims compared with 6 per cent of male victims). Men are far more likely to be killed by friends/acquaintances (32 per cent of male victim and 8 per cent of female victims) or strangers (31 per cent of male victims compared with 12 per cent of female victims).

Table 5: Patient homicides: apparent method of homicide

Apparent method of killing	Number – percentage where appropriate		
	Trust	England and Wales	NCISH cohort
Sharp instrument	5	186(36%)	487 (53%)
Blunt instrument	-	42(8%)	not stated
Hitting, kicking (without a weapon)	4	95(18%)	not stated
Strangulation/asphyxiation	-	53(10%)	163 (18%)
Shooting	-	21(4%)	not stated
Burning	-	11(2%)	not stated
Poison or drugs	-	27(5%)	not stated
Other methods	-	54(10%)	not stated
Don't know	-	29(6%)	not stated
Total	9	518	915

Sources: NCISH Annual Report 2014 para 1.2.3
ONS (2015) Appendix table 2.04a

16. Male perpetrators tend to be more violent than females in their methods of killing and that is reflected in the Trust figures. From the information available it seems that weapons were used in five of the nine homicides and in the remaining four fists and/or feet were the means used to kill the victim. The means of killing reflect the impulsive nature of the majority of the killings.

Table 6. Patient homicides: Reasons for initial contact with mental health services

Reasons for initial contact with mental health services	Number	
	Trust	London sample
Drug misuse	1	7
Depression / severe depression	-	6
Aggression / violence / anger management	-	5
Psychosis / psychotic ideation		4
Alcohol abuse	-	3
Drug induced psychosis	1	3
Schizo-affective disorder	-	3
Paranoia/paranoid schizophrenia	1	2
GP referral to CMHT (reasons not stated)	-	2
Transfer under s 48/9 Mental Health Act	-	2
Personality/conduct disorder	2	2
Anxiety	-	1
Obsessive-compulsive disorder	-	1
Adjustment disorder	-	1
Manic-depression	-	1
s. 177 aftercare	-	1
Suicidal/likely to self-harm	2	1
Trauma	1	-
ADHD	1	-
Total reasons mentioned	9	45

Notes: The London figures in this table are based on 39 cases.

17. Service users who went on to commit a homicide came into contact with mental health services initially for a variety of reasons. The largest single category for the Trust service user was a suicide attempt or suicidal ideas but that accounts for only two cases. The majority (seven people) came into contact for very different reasons and each was distinctive. The service user who was thought to be suffering from ADHD was also experiencing challenging behaviour while the individual diagnosed with trauma had been severely physically abused at an early age. Unlike the other samples for which information is available only one was initially referred because of psychosis or drug-induced psychosis.

Table 7. Patient homicides: Number of patients who refused drug treatment in the month before the homicide

Year	Number	
	Trust	NCISH cohort
2001	-	8
2002	-	2
2003	-	6
2004	-	6
2005	-	11
2006	-	12
2007	0	11
2008	-	11
2009	-	8
2010	0	4
2011	0	7
2012	0	4
2013	0	6
2014	0	n/a
2015	0	n/a
Total	0	96

Source: NCISH Annual Report 2015 Figure 26

18. Refusal to take medication is often regarded as in the NCISH reports, for example, as an indicator of likely breakdown. The information provided here is based on case records as reported by investigators. They may be no evidence in case records that the service user had refused to comply with their medication as it may not have been seen as important in the way the homicide happened. In some cases, these was no information about the service user's adherence to their medication. It is, of course, not possible to tell whether service users were taking medication when in fact they were not. In several of these cases diagnosis was incomplete and medication was being varied as clinicians tried to arrive at a firm conclusion. The delay in getting service users to specialist services for a definitive judgement accounted, in part at least, for this uncertainty.

19. Refusal to take medication is not reported an issue in any of these cases. There is no evidence here that any of the service users were self-medicating with cannabis as an alternative to prescribed medication with side effects which the service user disliked.

20. At the national level the NCISH reports that 96 out of about 900[1] cases had refused medication. There is no information about those who varied the dosage of the medication they were taking or who found other ways of not complying.

21. It is impossible to say from this review how many service users in general do not comply with their medication but do not go on to commit homicide. None of this sample of mental health service users appeared to have had long term

[1] The NCISH do not always provide the base figure for their analyses and the total varies as information may be missing.

histories of poor or non-compliance unlike some of the other samples that have been investigated. Although medication is seen as an important part of the care and treatment no attempts to monitor compliance seem to be recorded apart from asking for the service user for re-assurance. On the other hand, at least one of this group seems to have been on long-term medication with little or no apparent sign of improvement in the service user's quality of life.

Table 8. Patient homicides: number of patients who had missed their last appointment with services

Year	Number of patients who had missed their last appointment with services	
	Trust	NCISH cohort
2001	-	21
2002	-	12
2003	-	24
2004	-	27
2005	-	28
2006	-	31
2007	0	19
2008	-	27
2009	-	15
2010	0	16
2011	0	14
2012	1	6
2013	-	n/a
2014	1	n/a
2015	1	n/a
Total	3	240

Source: NCISH Annual Report 2014 Figure 26

22. Three Trust service users seem to have missed their last appointment with services. There are at least two cases in this sample who raise the question of how assertive outreach ought to be, especially when cases such as these do not reach the criteria for acceptance on to an Assertive Outreach Team's caseload.

Table 9. Time interval between first known contact with mental health services and incident which triggered report

Time interval between first known contact with mental health services and incident which triggered report	Number	
	Trust sample	London sample
Less than one month	1	2
1 month but less than 3 months	-	2
3 months but less than 6 months		1
6 months but less than 12 months	-	2
12 months but less than 2 years	2	9
2 years but less than 4 years	-	3
4 years but less than 10 years	2	7
10 years or more	4	10
Not known	-	4
Total	9	40

Table 10. Timing of last contact with mental health service

Timing of last contact	Number	
	Trust sample	NCISH cohort
Less than 7 days	1	160 (26%)
1 to 4 weeks	3	135 (23%)
5 to 13 weeks	3	123 (20%)
Over 13 weeks	1	197 (31%)
Not known	1	-
Total	9	615

NCISH Slide 15 England 2002-12

National Confidential Inquiry into Suicides and Homicides (NCISH)

23. The most authoritative benchmarking information in the UK is that provided by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) who publish an annual report; the most recent being July 2015.

24. The NCISH collect information initially on general population homicides as defined as convictions for murder, manslaughter (culpable homicide in Scotland), infanticide, and verdicts of not guilty by reason of insanity and unfit to plead as presented by year of conviction. Patient homicides are those committed by people who have had mental health service contact within 12 months before the offence. Identification of mental illness in non-patients relies on information from psychiatric reports prepared by psychiatrists for the court.

25. The NCISH researchers state that for the period 2003-2012 they have presented patient homicide numbers notified to the Inquiry plus additional cases for 2007-13 which account for questionnaires sent to Trusts/Health Boards but had not been returned at the time of initial analysis. For example, for 2013, they have received notification concerning 36 patient homicides, 27 questionnaires have been returned and a further 9 are currently outstanding.

26. The NCISH figures are based on Trust records only. They obtain and use these reports for their figures on symptoms of psychosis at the time of the offence, diagnosis history of schizophrenia, and history of drug and alcohol misuse, whether the offender was a patient or not. They note that the number of psychiatric reports undertaken and disclosed in court has fallen over the period which they report. They assume that those with serious mental illness, particularly psychosis, are more likely to have been assessed but there is no direct way of confirming this. However, the people they know to have serious mental illness (i.e. patients with schizophrenia nearly all had a psychiatric report – 94 per cent). They think it is probable that non-patients with serious mental illness will also have psychiatric reports. They acknowledge however that their figures may be underestimated.

27. When the whole cohort of patient homicides in England for 2003-13 are analysed in terms of their mental health care 17 (3 per cent) were inpatients at the time of the offence. There were 42 homicides within 3 months of discharge from inpatient care, 7 per cent of all patient homicides. 25 (6 per cent) patients in 2005-13 were under crisis resolution/home treatment (CR/HT) teams at the time.

28. One homicide was committed by a patient subject to a Community Treatment Order (CTO) at the time of the offence. Three patients had previously been on a CTO at the time of their discharge from inpatient care but this was subsequently rescinded.

29. Three hundred and fourteen patients (51 per cent) had been convicted of a previous violent offence. 266 (48 per cent) had previously been in prison. 34(6 per cent) had a history of admission to a high, medium or regional secure unit. 151 (26 per cent) patients had previously been involuntarily detained under metal health legislation. The number of previously detained patients has decreased over the report period.

30. Homicide followed by suicide is defined in the NCISH as when the offender dies by suicide within three days of committing homicide.

31. Each of the annual NCISH reports provides commentary on trends for that reporting period and trends over time. It will be possible therefore to evaluate whether the national trends are reflected locally or there are important differences.

Comparisons with other published thematic inquiries

32. Over the years there have been a number of studies which have looked at the reports produced by independent investigators of patient homicides.

Independent investigations are carried out under the terms of Department of Health circular HSG (94) 27 which

> "sets out good practice which should be followed for all patients who are discharged following referral to the specialist mental health services. It is based on application of the Care Programme Approach, with particular emphasis on the need for risk assessment prior to discharge".

This circular was updated in June 2005. These studies tend to concentrate on the recommendations to Trusts and commissioners arising from the care and treatment of service user made in independent investigations rather than the characteristics of the service users.

33. According to Crichton HSG (94) 27 inquiries typically describe men in their twenties or thirties fatally stabbing with a kitchen knife a family member (often in a caring role) in their shared home. Homicides arising from fights between young men unknown to each other are under-represented. This difference in victims does much to explain differences between the demographic characteristics between the HSG (94) 27 cohort and generic homicide statistics (Crichton, 2011). The NCISH demographic data is more complete because HSG (94) 27 inquiries have not been carried out in all required circumstances and only a proportion is published.

34. Clifton and Duffy published their review of inquiry recommendations in 2000. The study analysed some 500 recommendations in 42 inquiry reports published between 1990 and July 1997. The primary aim of the project was to make it easier for those involved in mental health care to benefit from these intensive and expensive inquiries, and to reduce the risk of repeating the mistakes of the past. All the recommendations were analysed with the exception of those judged not generalizable to a wider audience. Recommendations addressed solely to named bodies such as a trust, health commissioning body, local authority or local organisation; and those targeted on national or central bodies such as Royal Colleges, the Department of Health or the Mental Health Act Commission were not included.

35. The authors presented in tabular form, using the headings that they said minimised their interpretation of the sense of recommendations wherever possible. They placed headings in alphabetical order of headings as opposed to the usual social science practice of listing categories in descending order of magnitude in order to avoid inferring relative importance of particular issues.

    Anti-discriminatory practice (nine statements in 11 reports) – recommendations related to equal opportunities, privacy, services for people from ethnic minorities, services for women, the rights of service users and their carers, and the Patient's Charter. The availability of therapeutic services for patients from ethnic minority backgrounds were not always mentioned under this heading.

    Care of disturbed behaviour (38 statements in 14 reports) – 'disturbed' in this context meant violent or potentially violent behaviour had been specified or implied, and where specific management techniques were the focus of the recommendations. Recommendations covered the need for liaison and

communication between agencies and staff; and made reference to physical restraint, seclusion, observation, searches, shields, locked wards and the deployment of staff in response to incidents. These recommendations referred primarily to care for disturbed patients in inpatient settings.

Care Programme Approach (90 statements in 37 reports) – although some inquiries were published before the introduction of the policy in 1991, some recommendations were included here as they were 'in the spirit of' the guidance. The recommendations under this heading highlighted aspects of multi-disciplinary and multi-agency approaches to needs assessment, care planning and coordination, coordination of transfer, and planning for discharge or extended leave.

Communication and confidentiality (13 statements in 35 reports) - recommendations were made about communications both between and within agencies, including communications with users and carers. Policies and procedures for arriving at common agreement and shared understandings were stressed. The requirements of confidentiality with those of risk assessment were highlighted.

Complaints (13 statements in 4 reports) – recommendations covered circumstances in which complaints might be referred to the police, the need for prompt investigation, and the use of independent investigators.

Empowerment (33 statements in 24 reports) – these recommendations related to advocacy, and carer and user involvement. Recommendations also included the need for ethnically sensitive advocacy. The importance of knowledge provided by relatives, friends and other informal carers to healthcare professionals was stressed as were the rights of carers to information about services and treatment plans.

Incidents and inquiries (32 statements in 21 reports) – support for staff, patients and their relatives in the aftermath of a serious untoward incident was recommended. Authors of reports suggested procedures for reporting and responding to incidents as well as issues such as drawing up terms of reference and the composition of inquiry teams.

Inter-agency working (64 statements in 36 reports) - recommendations here covered general issues around inter-agency collaboration as well as making points about specific agencies and the relationships between them. Surprisingly few references are made under this heading to child protection services.

Mental Health Act, 1983 (41 statements in 20 reports) – recommendations were made of general relevance to the Act and its application in practice. References were made to proper implementation of various sections of the Act and the role and functioning of Approved Social Workers (now Approved Mental Health Practitioners) and Mental Health Review Tribunals.

Mentally disordered offenders (9 statements in 6 reports) – reports recommended improvements in working relationships between agencies,

sharing information, and in the provision of services required to meet identified needs.

Monitoring and audit (21 statements in 31 reports) – these included general maters such as monitoring caseloads ad quality standards. Clinical audit should cover issues relating to patient care and treatment, including uni-disciplinary and multi-disciplinary approaches.

Multi-disciplinary working (20 statements in 29 reports) – recommendations central to this heading included the proper creation and functioning of multi-disciplinary teams and their individual members. Issues around record-keeping and information exchange between professionals were raised.

Policies and procedures (4 statements in 7 reports) – recommendations covered the processes of development, implementation and monitoring of policies, procedures and guidelines in general. Policies should be accessible to staff and indexed for quick reference.

Professional responsibilities (44 statements in 29 reports) – many recommendations stressed that the role and responsibilities of healthcare professionals should be clearly identified.

Records and record-keeping (19 statements in 29 reports) - recommendations referred to the recording of information about service users. They referred to technological systems for the storage, security, retrieval and disposal of information, and patients' access to their own records.

Risk assessment and management (36 statement in 31 reports) - inquiry recommendations see effective assessment and management of risk as key issues. Both strategic and operational aspects of reducing risk are reported. This group of recommendations also includes reference to safety in the design of buildings and levels of physical security.

Service provision (53 statements in 30 reports) – many reports made reference to the provision of adequate resources of various types including access to general and forensic mental health services. Inquiry reports considered only those issues leading up to the incident, so there is no reference to balancing conflicting demands or to working within resource restraints.

Staff development (59 statements in 33 reports) – a common theme was the importance of staff training and development. Recommendations dealt with arrangements for providing, and quality assurance of, development activities.

Staff management (52 statements in 26 reports) – there were recommendations about a wide range of issues in the management of different professionals working in a variety of agencies.

Therapeutic approaches (26 statements in 21 reports) – recommendations were made about the provision of a range of treatments and therapies, delivered in a variety of settings by different healthcare professionals. The

importance of a balanced, needs-led approach to the provision of therapies by adequately skilled personnel was stressed.

36. There is considerable repetition in the broader themes. Given the nature of the inquiry process as single case studies, the repetition of broad themes might indicate either systematic bias on the part of inquiry panels, or a genuine reflection of deep-seated and endemic difficulties and failings in service provision and professional practice. The authors argued that the degree of differentiation within broader themes suggests that inquiry panels were highlighting real and complex issues that should be seen as arising from wider phenomena rather than isolated events.

37. The interrelated nature of the themes indicates that whole service systems need to be considered for improvement, not just individual topics such as risk assessment or staff training.

38. In 2010, the NCISH published a study of independent investigations after homicide by people receiving mental health care (NCISH 2010). This study is based on independent investigation reports published between 2006 and 2009. The project had three aims of which the third is of importance here – to collate key themes emerging from the recommendations of report published between 2006 and 2009.

39. The NCISH obtained 39 independent investigation reports relating to the 40 homicides within the study period and analysed the recommendations made. There were over 500 recommendations across all 39 reports. The recommendations were collated and organised into the following six broad themes:
    - clinical practice
    - clinical procedures
    - service management & support
    - staff training
    - working with external agencies
    - serious untoward incident management.

40. The categories into which these themes were grouped were developed and refined through a series of consensus meetings with senior NCISH clinical staff. The expanded themes were:
    - “Clinical practice: Emerging sub-themes within this category included the Care Programme Approach (CPA), assertive outreach and crisis services, risk assessment and management, treatment issues, dual diagnosis and personality disorder.
    - “Clinical procedure: Within this category the following sub-themes were identified; communication, information sharing and record keeping, staff work practice and policy, failure to attend appointments, assessments and reviews, referrals and discharges.
    - “Service management & support: This theme included recommendations in the areas of professional support and supervision, service provision, management and leadership, staffing levels/ workloads and equality/diversity
    - “Staff training: Key issues within this theme included training in relation to the CPA, risk assessment and management, communication, dual

diagnosis and substance misuse, carers and safeguarding children. Recommendations referring to training with external agencies such as police and probation were included in the next category.

- "External agencies: This theme included recommendations about working with external agencies mostly in relation to the criminal justice system. Key issues included domestic violence and safeguarding children, Multi-agency Public Protection Arrangement (MAPPA), information sharing, liaison and transfer of care and multiagency training.
- "Serious untoward incident management: Included within this theme were recommendations on the process of investigations, progress made with report recommendations, supporting families and media interest." (pp. 20-1)

41. The authors of the report state that there was wide variation in the style and level of detail in recommendations made. In many cases, the recommendations were considered to be somewhat bland and unfocused. Several themes within the recommendations were identified as recurring not only across the reports analysed here but also in earlier reports. The main areas which appeared repeatedly were:
    - the CPA – comments include the failure to implement a national policy some years after its introduction. In some cases, this failure happened several times in the same Trust and had been commented on unfavourably, in more than one investigation report.
    - Risk assessment and management – examples include the failure to carry out risk assessment on a multi-disciplinary basis; failures to exchange information about risk; failures to use a single evidence-based risk assessment tool; and, failures to update risk assessments and the absence of carer involvement.
    - Communication, information sharing & record keeping – NCISH found a great similarity in these recommendations across time. They provide examples from 1997 through to 2008 where investigators ask for information to be conveyed to GPs on discharge in a timely way, or that liaison between services should be reviewed and information sharing protocols established, or that guidelines be introduced to inform the quality of information being shared with GPs, or even that GPs should be kept informed of developments in the care and treatment of their patients.
    - Working with families/carers & assessing their needs - there are regular references to families and carers in the recommendations. The need for families/carers to receive their own needs assessments is raised frequently. Another related area is that of involving families and carers in the CPA and risk assessment processed. Families should be an important source about the patient's behaviour and their likelihood of complying with treatment in the future. Families and carers should also be given information about patients if they are to support them in the community.

42. NCISH found other themes running throughout the investigation reports.
    - Issues regarding the variable positon of forensic community service were raised in several reports and problems were identified in the coordination of care between general and forensic services. In some investigations referrals to forensic services just never happened.

- The inflexibility of assertive outreach services (AOT) in accepting patients, for example, the risk highlighted in one case where the AOT responded that as the patient had not been disengaged for the requisite six months or more, and was not adhering to medication, and was using illicit drugs he did not meet their eligibility criteria. It is clearly important to have robust eligibility criteria to maintain case load size (smaller in the case of AOTs) and to ensure that staff with appropriate skills treat patient subgroups. Eligibility criteria should be liable to modification to meet the needs of the population being served.
- A number of reports raised concerns about the need for risk assessment at transition points e.g. transition from prison to the community or discharge from inpatient care. Transition problems may be made worse if the discharge assessment is carried out by a trainee with limited psychiatric experience. On occasions assessments by specialist registrars which did not address the issue of risk adequately are later found to have been signed off by a consultant. Some trainee psychiatrists have been found to have had limited amounts of supervision time.
- Investigation reports made a number of points regarding risk to victims e.g. failure to recognise previous patterns of violence (in three case the service user/perpetrator had been previously been convicted of homicide), there may be reasons for caution when service users with previous histories of domestic abuse begin new relationships. On occasions where there was known domestic abuse in a relationship the couples are treated as individuals. Several cases were identified where the service user/perpetrator had expressed delusional thoughts about the eventual victim. Knowledge of threats may be important when decisions about discharge from inpatient care are being considered. Delusions of this type may be about children as well as partners or neighbours.
- Three reports concerned homicides on inpatient wards. In one case the service user had a significant history of violence towards women particularly those with whom he formed intimate relationships, and he was transferred to a mixed sex unit despite having been turned down previously by the unit on the grounds of the risk he posed to women. He went on to form a relationship with a female service user and later killed her. Issues have also been raised about observation and seclusion. In one case the failure to follow local policy on seclusion led to the death of a healthcare assistant. Reports note the inappropriateness of inpatients being ‘in association’ whilst out of sight of staff members. Bullying and abuse are also reported, where abuse has been reported but not acted on or not taken seriously enough by staff.

43. In 2011, John Crichton published a review of independent inquiries into patient homicides published between 1995 and 2000. Crichton identified the inquiry reports through a Freedom of Information request to the Department of Health and an internet search of the Strategic Health Authority websites and the website of Dave Sheppard Associates Ltd which also has a large database of reports. 236 reports from 1994 to the end of 2010 were identified: 201 full reports, 33 summaries and two redacted reports. Most inquiries report on a single case but 10 reported on groups of unrelated but similar homicides, ranging from two to seven.

44. Crichton found that, on average, each inquiry made 17 recommendations most of which comment on local practices, but on average two recommendations were made regarding national policies or practices. Crichton carried out what he described as ‘a crude content analysis’ (p. 773) of the published inquiries which revealed the 10 most frequently made recommendations in rank order. He divided the recommendations into two time periods 1991-2001 and 2001-2010. The frequency of recommendations decreased between the two time periods with one exception – the recommendation to improve clinical audit and governance and the recommendation to improve internal incident procedures.

Table 11. Frequency Rank Order of HSG (94) 27 Inquiry Recommendations split by date of homicide

Rank order	Recommendation	1993-2001 (%)	2001-2010 (%)	χ^2 p value	Total percentage
1	Improved use of CPA	64	53	P < .01	59
2	Better risk assessment/ management	58	46	P < .01	53
3	Better note keeping	50	34	P < .01	47
4	Better interagency working/ communication	54	28	P < .01	43
5=	Improved training	47	22	P < .01	36
5=	Improved multi-disciplinary working	39	21	P < .01	36
5=	Improved internal incident reviews	32	35		36
8	Improvement to clinical audit or governance arrangements	21	45	P < .01	31
9	Better liaison with family/carers	28	24	P < .01	27
10	Better liaison with GPs	33	10	P < .01	24

Source: Crichton 2011 p.773

45. Over the past five years a number of thematic inquiries have been carried on homicides in individual Trusts and in the former NHS SHA regions. Many of these are in the public domain. For example, Caring Solutions (UK) Ltd conducted two previous regional reviews of homicides (the North West of England and London). The North West review analysed 38 cases of homicides occurring between 2002 and 2006 and the London review considered 40 homicides occurring between 2002 and 2006. Some individual mental health Trusts have published thematic reviews of homicide inquiries in their areas. In addition, one published (London) and two unpublished thematic reviews have been carried out by Caring Solutions (UK) Ltd (a group of Trusts in the North West).

46. The team are aware that overall conclusions of this element of the work may be that it may not be feasible to collect the required data; and/or that the numbers are too small for benchmarking to be effective. If this is the case, it will be clearly evidenced.

47. In 2015 Niche Patient Safety published a Briefing Paper ‘What Safety Lessons Can We Learn?’ which brings together the results of nine homicide investigations their company had carried out in 2014 and 2015. Eight of the service users were cared for by community mental health services and one was an in-patient. Eight of these individuals killed an acquaintance while one killed a parent.

48. A total of 78 recommendations were made in the nine reports and these were grouped into 8 common areas.

Table 12: Frequency of recommendations made

	Frequency of mentions	
Recommendation	Niche	Trust
Communication	19	3
Policy Management	13	4
Practice/risk	13	22
Training	9	4
Organizational (sic) learning	7	8
Contact with families	7	5
Miscellaneous	6	1
Pathway development	4	1
Total recommendations made	78	48

Source: Niche 2016

49. Under the heading of 'Communication' the most frequent recommendation was for the sharing of information between professionals. People suffering from mental illness often have professionals caring for their physical health, their substance misuse or housing problems. They may also be involved with the criminal justice system. In all of these cases there were examples of breakdown in communication that may have impacted negatively on the mental health of the subject. In some cases, there were breakdowns in communication between inpatient and nursing teams, within GP practices were one GP was responsible for managing the service user's methadone programme while a colleague managed the service user's general health. There was also the problem of the absence of comprehensive history taking which hindered robust risk assessment.

50. Policy management recommendations fell into two distinct areas; first, the need for local policy development; and second, the development of Trust wide assurances. The former included the need for a drug detection policy to be backed by the use of drug detection dogs, or that the serious incident policy should state that interviews should be transcribed and stored securely, or that the policy for the management of risk should include items allowed on the unit. At the Trust level, there were recommendations that systems should be developed to provide assurance that the risk policy was being implemented, o that policies should be implemented consistently, or that the risk management policy should show clear links between risk assessment, care planning and CPA.

51. Most of the recommendations relating to practice and risk concerned documentation. For example, violent behaviour must be documented and reported to the police. Full and comprehensive multi-disciplinary mental health assessments must be undertaken to inform a detailed care plan including gathering information from family and carers. A record must be made in notes when a decision has been made to refer the service user to MAPPA for all service users with a forensic history. Mental health discharge summaries must contain a narrative description and the context of risk, protective factors and triggers.

52. The authors of the Briefing Paper note that

> "A combination of Practice / Risk and Communication made up 32 out of 78 recommendations, 41 per cent of the recommendations concerned the sharing of service user information between professionals." (p. 3)

53. Under the heading of training they say that recommendations fell into two distinct areas. First, additional training was needed on topics such as domestic violence, the role of the care coordinator, therapeutic relationships between inpatient and community teams and service users, serious incident training, and safeguarding training. Second, recommendations were made specifically to address concerns about how serious incidents were reported and investigated, so that primary care and GP notes should be accessed in cases of homicide, or that NICE guidelines should be referenced as part of investigation reports, or that GPs should be interviewed as part of the process, or that executive summaries must include the whole process of investigation including the lessons learnt.

54. Learning for organisations considered the development of qualitative and quantitative evidence to support quality. For example, systems should be developed to provide assurance that key policies were being implemented, or that systems should be developed so that action plans could be signed off and an assurance process was in place to evidence that changes were embedded in practice, or that feedback mechanisms should be in place so that staff were informed of the outcomes when involved in serious incident investigations.

55. Under the heading of 'contact with families' recommendations were made for Trusts for make contact with the families of the victims and perpetrator after a serious incident, or that Trust should develop a resource pack for families involved in independent investigations. The carer's needs must be given consideration when violence towards a family member or carer has been reported.

56. The 'Miscellaneous' category included recommendations referring to the review of provisions of care where gaps had been identified. These included, for example, a review of services available for assessment and treatment for service users with "personality difficulties" (sic) alongside other mental health issues, or the development of robust and routine performance management system and Board reports for secondary commissioning of placements, or the need to evaluate the impact of changes introduced as a direct result of the serious incident recommendations.

57. The 'Pathway development' category included recommendations to integrate specific risk assessments with generic risk assessments and he discharge plan, or the development of care pathways for young people in custody at risk and coordination across primary and secondary mental health services and the Youth Justice teams, or the application of Personalised Budget to be standard in the support of service users with mental health concerns.

58. The Niche Paper also looks at the issues of predictability and preventability of homicide. They define predictability as "the quality of being regarded as likely

to happen, as behaviour or an event". Prevention means to "stop or hinder something from happening, especially by advance planning or action" and they go on to say that it implies "anticipatory counteraction". This means that for a homicide to have been preventable there should have to be the knowledge, legal means and opportunity to stop the incident from occurring.

59. Their review of the evidence in seven applicable cases used to decide on predictability showed that four of the perpetrators were known to have risks of violence against property or persons but none had previously identified their victim. One perpetrator had identified another person during treatment sessions but this was not the actual victim.

60. Three of the individuals were reluctant to engage with services and in one case the independent investigation team identified more information that would have enhanced risk assessments than the Trust internal investigation was able to find. In two of the cases the investigation found that professionals had omitted to listen to the concerns of the family. Parents and carers had identified changes in mental state, increased alcohol intake or changes in behaviour that gave hem cause for concern and were known trigger for increases in risk.

61. Niche argue that there was no evidence to suggest that any of the victims were subject of a pre-planned attack. They draw this conclusion even though the investigations identified lack of assessment, care planning, engagement of the family and that perpetrators were known to be violent or at risk of offending.

62. Niche conclude that there are consistent recommendations relating to often limited and incomplete serious incident process, management and assurance of recommendations. The recommendations for training around the serious incident process are evidence of these findings. The quality and timeliness of training are often more important than the specific subject being recommended. The absence of families from serious incident investigations seems to be a common denominator as was the fact that all the subjects were male. Their final point is that many service users are low risk when inpatients but their level of risk increases when they are in the community without any protective factors.

63. Niche recognise that their review covers only seven cases but each of the subjects was receiving a complex package of care involving a number of multi-disciplinary professionals and the complexity increases the risk of potential breakdown in communications between and within teams, service user and family/carer(s). The background family structure from which the service user comes is frequently characterised by domestic violence and mental ill-health. Building an informed picture of the service user requires inputs from all of these people.

64. They also suggest that the recommendations point to the need for training about the serious incident process and report writing which would greatly enhance the validity and robustness of internal investigations so that services could properly learn from incidents and put changes in place that are more likely to reduce the recurrence of some of these incidents.

65. Niche recommend a number of actions to enhance the safety of mental health provision in line with the findings from the most serious safety breaches in mental health. Actions are addressed to provider Trusts, to CCGs and to NHS England. Provider Trusts
    - should develop a 'Patient Safety Strategy' that sets out the focus of effort, incorporates the process for ensuring learning lessons and the steps needed to embed a safety culture
    - need to focus on improving the quality of investigations and action plans
    - develop, regularly review and refresh risk management systems and structures that identify and mitigate risks
    - develop and deliver a set of metrics that provide quality information to inform the Board of progress on safety in line with its strategy.

66. From the information Niche have published it is possible to categorise the recommendations made to the Trust in the eight independent investigation reports under review here using the same broad headings. (This excludes the two internal Serious Incident reports as these are not necessarily comparable to the independent reports analysed by Niche.)

67. It can be seen in Table 16 that the largest single category of recommendations relates to 'Practice/Risk', 22 mentions out of 48. Indeed, this is the largest single category of recommendations. In this category are recommendations such implementing 'at a glance' summaries of integrated care and risk management plans, or checks on the legal status of informal patients.

68. Many of these recommendations can be seen as investigation panels asking the Trust to make sure that its existing policies and procedures are being carried in a systematic basis, every day, with every service user.

69. The next largest category is that of 'Organizational Learning' which includes recommendations that the Trust should audit all new processes for effectiveness or carry out an audit to check on the timeliness of referral processes.

70. Contact with families is the third most frequent category of recommendations and includes the Trust signing up to the 'Triangle of Care' - a systematic and comprehensive approach to involvement of families, significant others and carers.

71. In this context 'Policy management' includes the recommendations that the Trust will examine all extant clinical policies and procedures to ensure that NICE guidance is incorporated, or that the Trust must revise all policy documentation in keeping with the findings of the investigation report.

72. The 'Training' category includes the Trust ensuring that all medical trainees and consultants receive sufficient support from colleagues and peers who are available to them.

73. 'Communication' recommendations include comments such as that the Trust should ensure that professional communication and liaison processes are built into all care pathways and all clinical policy and procedure documents. Or, that

the final outcome of contact with secondary mental health services should always be communicated to the service users' GP.

74. The 'Miscellaneous' category includes the recommendation that the Trust would agree how and when a new integrated IT system will be introduced.

75. The historical surveys of recommendations made over a period of twenty or so years demonstrates a remarkably high degree of continuity. Improvements in record keeping may have moved on from complaints about illegible handwriting and the need for all records to be shared across professional boundaries but problems persist in getting staff to record the reasoning behind their decisions. The failure to complete risk assessments or update them when circumstances change persists regardless of the actual format of the risk assessment system being used. The lack of a comprehensive working knowledge of the Mental Health Act and the respective powers of nurses, psychiatrists, police officers and AMHPs crop up with each new generation.

76. Many of the recommendations made here and elsewhere require Trusts to audit practice to ensure that everyone is complying with Trust policies and procedures, but few spell out precisely what is being asked for and many do not set timescales against which Trust performance could be assessed though this is changing with the new NHS England approach to independent investigations.

77. The usual prescription to assess service users' needs or to assess the level of risk they pose and then to formulate a risk management strategy (including indicators of breakdown and means of spotting and avoiding breakdown) is frequently followed by recommendations for more training. But many of the aspects of practice that are being described as of poor or variable quality are already part of initial training and in-service professional development. The implication seems to be that training in its current shape does not always achieve what is expected of it.

Historical problem

78. One of the issues that struck the project team early in the review process was that the incidents being reviewed were spread over a lengthy period, the earliest being 2007 with the latest in July 2015. The authors of individual reports often note how much has changed between the incident they are reporting on and the time they completed their report. Some of the changes reported are organisational – the Trust carried out a major re-structuring of its services over the last five years.

79. This historical problem occurs whenever information, such as that of Clifton and Duffy or Crichton is used. Over the time scale they are describing there have been changes in the way mental health services have been provided, inspected and their performance assessed e.g. the increasing number of specialist forensic staff, or data that had been reported to the Department of Health was later also monitored and managed by the local Strategic Health Authority or now NHS England, or the CHI metamorphosed into the Healthcare Commission and later the Care Quality Commission.

80. It is clear from the research reports that policy and practice diverge in many cases and consequently tragedies have occurred. A number of inquiry reports state for example, that if the CPA had been in effect at that point in time then the outcome might well have been different. But it is clear from contemporary comments that even though the CPA has been in effect since 1990, its implementation has been patchy and rarely as policy makers intended.

81. Reference is made in some of the reports in our sample to service users persistently failing to attend appointments and being discharged from caseloads as a result. Some of these examples predate the establishment of Assertive Outreach Teams and this approach would now be seen as the most appropriate means of managing this type of service user. What is not clear is whether the subjects of the inquiries would have responded to the kinds of approach employed by Assertive Outreach Teams. It is not clear how effective Assertive Outreach Teams are with difficult non-responsive service users. Some of subjects of other thematic inquiries were described as actively resisting treatment interventions through non-compliance with medication, or through using drugs or alcohol when they knew that staff would not give medication to someone who was not abstinent.

82. In a significant number of cases there were comments about the records and systems of record keeping. The comments included the illegibility of hand written notes, the absence of signatures, failure to record decisions or the reasons for decisions, on occasions records were not available to all the staff involved in caring for an individual, or private records were kept in separate formats from the wider Trust record system. We are not clear how far the new electronic integrated record system introduced in the Trust will solve any or all of these problems.

Appendix E. Recurring themes

1. The task of identifying 'recurring themes' is to some degree open to interpretation as this is not a quantitative exercise. As a rough rule of thumb we have included themes if they occur in at least two of the investigation reports. One of the problems with drawing themes from the material available to us is that the report refers to a long period of time. The first homicide took place in 2007 and the organisation of services changed considerably in 2012/13. Some of the themes may have occurred before the reorganisation but we believe that some of the themes represent attitudes and ways of thinking which are separate from the details of how services are organised at any one point in time. The structural changes did not involve wholesale changes in staffing, the existing staff moved to new roles possibly taking former ways of working with them.

Escalating service users to a proper level of expertise

2. Several of the cases considered here illustrate the problem of arranging access to service quickly, while the service user is motivated to address their mental illness. In some cases, there is a delay in the initial contact; for example, when a GP referred, it took 14 days for the letter to be dealt with. In others instances there were delays once contact had been made with mental health services when assessments by specialist services are required. Access to some specialist services such as the local Neurobehavioural clinic have taken as much as eight months.

3. The service user may receive little therapeutic input while awaiting specialist assessment although there are cases where junior staff have taken guidance from their more senior colleagues and made interim decisions about what needs to be done

4. The more recent changes in referral procedures mean that referrals for initial assessment can now be graded in terms of urgency and really serious cases can be seen in as little as four hours if required.

Problems of assessment of risk and risk management

5. There are two general questions which underpin the whole area of risk assessment and the connection between risk assessment and risk management:
   a) A comprehensive risk assessment would, it is believed, lead to some cases being given high priority. In some cases, if greater attention was paid to risk assessment then Trust staff might have identified people who posed a higher risk than their general assessment demonstrated.
   b) There is an assumption that staff would have been more cautious in their management of the case if the people involved had available to them a clear assessment of the violence risks involved in the case.

6. The Department of Health's 2007 guidance 'Best Practice Managing in Risk' sets out a framework of principles covering self-harm and suicide, violence to others and self-neglect to underpin best practice across all adult health settings. The philosophy underpinning this framework is one that balances care needs against risk needs and that emphasises:

- positive risk management
- collaboration with the service user and others involved in care
- the importance of recognising and building on service user strengths
- the organisation's role in risk management alongside the individual practitioner's.

7. 'Refocusing the Care Programme Approach' (Department of Health 2008) includes the comment that

   "Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes".

8. In seven out of the eight independent investigation reports under review here there was criticism of either the risk assessment process and/or the design of a risk management plan. The amount of criticism varies but in several cases the process was seen as inadequate and the risk posed by the service user was unrecognised or severely underestimated. Criticisms of risk assessment and risk management fall into the following areas: initial assessments, collecting and integrating information, using specialist knowledge when it is available, following trust policies on domestic violence and vulnerable adults, and risk management plans - including relapse strategies.

Initial assessments

9. One of the problems stemming from the organisation and staffing of area access teams in Brighton & Hove was that the service was under very great pressure of numbers. One report suggested there could be as many as 600 to 800 referrals per month. Not all of these referrals from primary care were appropriate and staff had the task of dealing with the great range of issues being presented to them. The time allotted to the initial sessions was 20 minutes.

10. Examples where the initial assessment was criticised in the independent investigation report include the following:

    - The initial risk screening was often not completed, information about risk behaviours was missing or the screening was not completed to the point where a risk assessment could be made.
    - Risk assessments at the first medical appointment did not include information from the service user's family.

11. Other earlier examples had been resolved, including not assessing older people for risk of violence on admission (no longer the case); or hand-written records being illegible.

Failing to complete risk assessments

12. A recurring theme seen in a number of the reports is that risk assessments were incomplete. For example:

- Risk assessments were not updated when circumstances changed (as required by Trust policy) – such as a new criminal conviction.
- Assessments were started but not completed.
- Risk assessments and care plans were not routinely reviewed as required by Trust policy.
- Over-reliance on self-reporting by the service user, without giving appropriate consideration of information from third parties.

Using specialist knowledge

13. In a number of cases specialist assessments had been made of service users' needs. Local services were not always aware of previous specialist assessments (e.g. in prison) or did not seek further information about these findings of these assessments or preferred to wait for a local assessment.

14. Consequently, access to specialist care and treatment could also be slowed down or not arranged.

Underestimating the seriousness of criminal behaviour

15. The information about service users' criminal records seems not always to have been properly understood by healthcare staff. For example, robbery or aggravated burglary were seen as property, rather than violent offences.

16. On other occasions, there were reported to be references to criminal offences in the records, but staff tended not seek out the full details. Sometimes service users made threats to kill others but no further action, for example informing the police or warning the person threatened, was taken.

Following Trust policy on vulnerable adults and domestic abuse

17. Several of the investigations found that service users were physically abusive or were exploiting their nearest relatives and/or partners. The Trust has policies on both safeguarding vulnerable adults and domestic abuse but these were not used in these cases.

18. Some service users were vulnerable and could have benefited from access to additional resources and services if they had been dealt with in accordance with policy but they were not always recognised as being subject to these policies.

19. We also noted that the Trust was slow to introduce their own policies regarding domestic violence in line with national requirements

No relapse strategies in risk management, no risk management planning

20. The investigation reports state that risk and needs assessments did not always lead to risk management planning or to the formulation of relapse strategies. The underlying idea is that after coming to a diagnosis (or a working diagnosis pending assessments) and a clear and explicit formulation of the risk(s) posed by the service user to himself or to others, then a plan should be drawn up as to how to manage the individual either in the community or as an inpatient. Decisions will be made about any medication

and dosage to be given, the type and frequency of any contacts with Trust staff, such as support workers, psychologists, psychiatrists, social workers and/or staff in specialist services such as substance misuse.

21. Relapse strategies are often devised to make sure that if the service user's mental state deteriorates then this should be brought to the attention of healthcare professionals as quickly as possible. In some cases, a carer may be given information about the signs of relapse together with (out of hours) telephone numbers for use if the service user starts to deteriorate. Similar information is usually given to the GP in case the service user returns to primary care. Information is also often given stressing the need for a prompt response as some service users can deteriorate very quickly – a matter of hours in some instances.

22. The Trust's 2014 Clinical risk assessment and safety planning/risk management policy states that

> "People using Trust services who have identified risks will, in partnership with the staff working with them, agree a safety plan. The principles behind the safety plan will be to value the person's human rights, independence, choice and social inclusion. The safety plan will set out how risks are to be managed. For people where there is a risk of being exposed to restrictive interventions (such as restraint or seclusion) the safety plan must incorporate a Positive Behavioural Support Plan" – so that restrictive interventions are only used as a last resort.

23. The policy goes on to note that new information or a change in the service user's presentation or circumstances could potentially impact on risk. In the cases, the risk assessment and management plan should be reviewed. These changes might include movements into or out of inpatient care including leave of absence, transition between services, changes in key staff such as care coordinators or significant life changes or events.

24. Risk and safety management plans, according to the policy, must be proactively shared with the service user. They should also be shared with other people and agencies involved, with the consent of the service user. The policy is clear that they can also be shared without consent to prevent harm to other people. 'Other people' may include carers and the police.

25. Under the question 'What is Risk?' the policy document states

> "Where here is little or no information about the service user, the information should be sought from the GP, other Trusts, Police etc. to help inform the assessment".

26. Carers and families are not mentioned which seems contrary to current good practice. The wording of the 'Risk Screening Tool' - 'Family member/carer in receipt of our services? If yes, give details below' seems designed to screen 'out' any other type of carer from assessment of their needs. It would be helpful to know how staff routinely interpret this question.

27. Later the document includes a section on 'Relational security' which is defined as the

"the knowledge and understanding staff have of a service user and of the physical and social environment and the translation of that information into appropriate responses and care".

28. Does this policy mean that staff have a responsibility for the health and welfare of the service user's family and/or carers? The risk assessment and management policy document states that in all assessment staff think about the whole family and the potential risk to children posed by other family members. It also states that

    "In the event of an adult service user being identified at risk or the victim of abuse (physical, financial, sexual), local procedures for safeguarding vulnerable adults must be followed".

29. This way of phrasing the policy should be more explicit – that service users can be perpetrators of abuse as well as victims. Is the phrasing of the risk screening tools euphemistic in the sense that the 'Think Family' section asks

    "Always consider the potential risk posed by family members/carers to other people (children and adults) in the family network".

    Does this mean 'posed' to family members/carers by the service user? Otherwise the wording is not sufficiently direct. What do staff routinely think this phrasing means?

Knowledge of and use of the Mental Health Act

30. Several of these cases raise the question of Trust staffs' knowledge of the Mental Health Acts and related legislation. On several occasions, Trust staff did not know the extent of their legal options when working with service users. Where appropriate, compulsory detention rather than voluntary admission would allow staff to control the environment in which service users lived, for example, to control their illicit drug use which was interfering with their prescribed treatment.

Systemic or Professional Problems Identified

31. Several of the investigations reported that one or more aspects of practice that did not conform to local policies and/or to national guidelines, for example:
    - Carers in these cases had not been identified in a legal sense as carers (Carers Act, 2014) and their rights and needs had not been assessed.
    - Non-compliance with NICE guidance for treatment of people with psychosis (NICE (2014) - referral for psychological services or occupational therapy).

32. Investigators considered that greater emphasis on recovery was needed. There appeared to be a lack of evidence that service users in long-term contact were subject to longitudinal assessments - they could remain on caseloads for several years without a critical review and a fundamental re-examination of their presentation.

Conclusions

33. This appendix has looked at the way in which themes and issues occur over time and keep recurring in the same cases. The sorts of issues thrown up by investigation reports happen more than once in cases. Risks assessments were not completed or were completed incorrectly, risk management plans were not completed, parents and other carers had not been contacted and used to supply background information. Some diagnoses are incorrect and remained unchanged in the face of the service user's behaviour.

34. There is a considerable degree of continuity in staff behaviour over time when working with different service users. Independent investigations take place and recommendations are made but practice seems to be very firmly embedded.

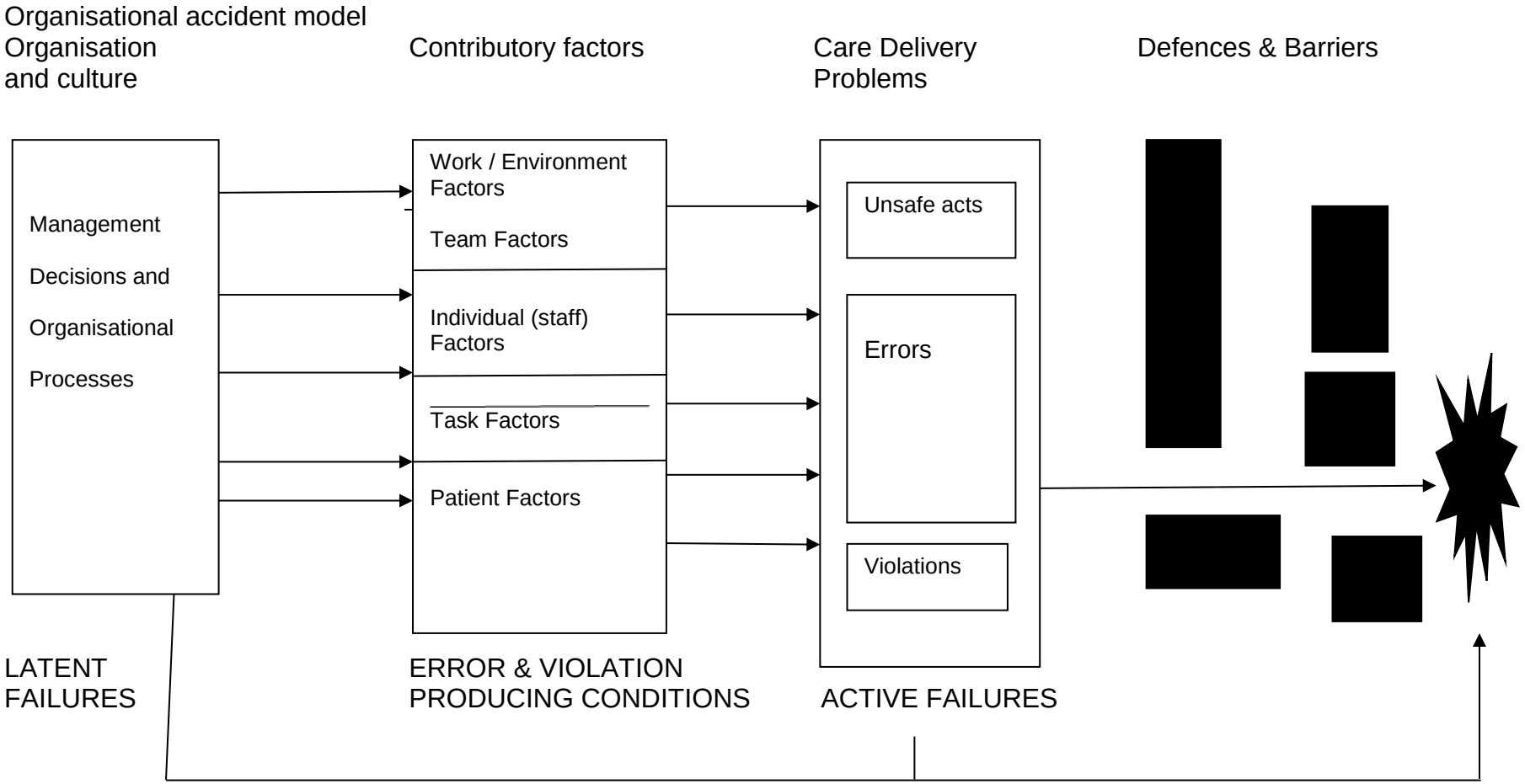
Appendix F. Emerging themes

1. We have analysed the investigation reports, looking for common themes using a ‘Safety Framework’ (following Vincent, 2010). The Safety Framework has been developed in investigations of homicide and classifies conditions which may produce errors and organisational factors into a single broad framework affecting clinical practice.

2. Vincent and colleagues (1998) begin from the point that many ‘accidents’ in healthcare and elsewhere need to be viewed from a broad systems perspective if they are to be understood fully. Although the behaviour of individual people, in terms of their actions and their failures, may play a central role, the immediate working environment and wider organisational processes are both strongly influential and constraining. Some errors are limited to local contexts and can be explained largely by individual factors and the nature of the tasks at hand. But Vincent and colleagues argue that major incidents almost always evolve over time, involve a large number of people and a large number of contributory factors. In these circumstances, the following organisational model proves very illuminating.

3. The accident sequence begins in the diagram below from the left with the negative consequences of organisational processes, such as planning, scheduling, forecasting, design, maintenance, strategy and policy. The latent conditions which are created then in turn affect the workplace (the ward, the office) where they create local conditions that promote the commission of errors and violations (e.g. high workloads). Vincent and colleagues make the point that many unsafe acts are committed but few will penetrate the defences and barriers leading to damaging outcomes. The fact that designed intentional safety features, such as standard procedures, can be deficient due to latent failures as well as active failures, are shown in the diagram by the arrow connecting organisational processes directly to defences.

4. The model therefore presents the people at the sharp end as the inheritors rather than as the instigators of an accident sequence. James Reason (2008) makes the point that this may simply appear to shift the ‘blame’ from the sharp end to the system managers. But managers are also operating in a complex environment and the effects of their actions are not always apparent; they are no more, and no less to blame than those at the sharp end of the clinical environment. Furthermore, any high level decision, whether within a healthcare organisation or made outside it by government or regulatory bodies, is itself a balance of risks and benefits. Sometimes, such decisions may be obviously flawed, but even decisions that appear reasonable may later be found to have unfortunate consequences.


Organisational accident model
Organisation and culture
Contributory factors
Care Delivery Problems
Defences & Barriers
Management Decisions and Organisational Processes
Work / Environment Factors
Team Factors
Individual (staff) Factors
Task Factors
Patient Factors
Unsafe acts
Errors
Violations
LATENT FAILURES
ERROR & VIOLATION PRODUCING CONDITIONS
ACTIVE FAILURES

5. The factors which are seen as contributing, in varying degrees, to the homicide or other event fall under the following headings:
    - Patient factors
    - Individual (staff) factors
    - Task factors
    - Communication factors
    - Team factors
    - Education and training factors
    - Equipment and resources
    - Working conditions factors
    - Organisational and strategic factors

6. At the top of the framework are patient factors. This is because the service user's condition will have the most direct influence on practice and outcome. Other service user factors such as personality, language and psychological problems may also be important as they can influence communication with staff. The design of the task, the availability and utility of protocols and test results may influence the care process and affect the quality of care. Individual factors include the knowledge, skills and experience of each member of staff, which will obviously affect their clinical practice. Each member of staff is part of a team within the inpatient or community unit, and part of the wider organisation of the hospital, primary care, or mental health service. The way in which an individual practises and their impact on the patient is constrained and influenced by other members of the team and the way they communicate, support, and supervise each other. The team in turn is influenced by management actions and by decisions made at a higher level in the organisation. These include policies for the use of locum or agency staff, continuing education, training and supervisions and the availability of equipment and supplies. The organisation itself is affected by the institutional context, including financial constraints, external regulatory bodies and the broader economic and political climate.

7. The themes described below come from the eight independent investigation reports (homicides), two internal Serious Incident reports (homicides) and one internal Serious Incident report (homicide victim).

Patient factors

8. Factors relating to the personality, characteristics or life style of the service user were referred to in 10 of the cases. Examples of these factors are:
    - complex mental health needs without specialist input
    - alcohol and drug misuse and non-engagement with substance misuse service
    - homelessness, unsettled lifestyle, need for supported accommodation
    - history of violence
    - unwillingness or accept medication or engage with services

Individual (Staff) Factors

9. This factor is concerned with the performance of individual staff carrying out their tasks and duties was found in seven of the reports. None of the inquiries and reviews identified any individual who had acted in such a way as to be culpable. Examples of staff factors include the following:
   - failure to collect and record accurate information about the service user
   - inadequate supervision of medical trainees
   - care needs assessments inadequate and risk assessment forms not correctly or fully completed
   - missing information in clinical records – index offence not recorded or reason for decisions not recorded
   - lack of communication between different teams
   - threats to others not acted upon,
   - carer's concerns not recorded
   - clinical guidance not followed
   - staff not following policies
   - poor understanding of rules about confidentiality and risk to third parties

Task and technology factors

10. This factor includes adherence to Trust policies and procedures as they relate to the care and treatment of the service user and include the following which cannot be attributed to the poor performance of individual staff members to perform their roles. These issues show how the teams work collectively. Team factors includes issues such as staff supervision and on the job learning (opportunities for reflective practice). They occur in 10 of the investigations, for example:
    - assessments were made without the use of diagnostic tools
    - level of medical expertise made available to service users
    - inconsistencies in collection and communication of risk information
    - family relationships not fully understood
    - possible physical causes of mental health issues not investigated
    - range of possible diagnoses not fully explored
    - confusion within team about the meaning of 'urgent', 'priority', and 'emergency' referrals, how these should be handled and within what timescales
    - Trust policies not followed
    - risk assessments not consistently translated into risk management and care plans

Communication factors

11. The category of 'communications' is not used in the Vincent model but it is used in the fishbone analytical device that is part of the NPSA model to highlight contributory factors. Comments about communications occur in seven of the investigations. It is clear from the examples which follow that communications within and between organisations create problems.

- full risk, treatment or care needs information not shared within teams or between services
- no communication with family to gain fuller picture of needs and risks
- slow response to letters
- referral sent to incorrect members of staff

Team factors

12. Team factors are concerned with written and verbal communications, the arrangements for staff supervisions and for staff seeking help and advice and team leadership. Examples included:
    - unauthorised absence from ward not communicated
    - focus on risk posed to self rather than others despite clear evidence to the contrary
    - missed opportunity to use the Mental Health Act
    - service users not allocated to the appropriate team
    - high turn-over of team and senior managers
    - lack of access to specialist services
    - no team culture of working with the police in relation to possible offending behaviour
    - no shared team culture – i.e. medical, nursing and therapy staff not working together either in relation to service users or to the leadership of the service
    - not involving appropriate health care professionals in assessments.

Work environment factors

13. The work environment presented problems in four of the cases. These included:
    - resource problems in area of high deprivation and multiple complex needs of service users.
    - high level of referrals, not all of which were appropriate
    - up to 12 months' wait for appointment with specialist services for assessment e.g. Neurobehavioural clinic
    - electronic record system not fully meeting the needs of the service
    - insufficient ward staffing, reliance on bank and agency staff
    - lack of clarity on responsibilities of staff

Organisational and management factors

14. Vincent et al give 'Financial resources and constraints', 'Organisational structure', 'Policy, standards and goals' and 'Safety culture and priorities' as examples of 'Organisational and Management Factors'. Issues included:
    - Clinical records were not available to staff in all parts of the organisation at the time.
    - The way teams and specialist services were organised.
    - Teams found themselves working with service users whose needs they were not designed for.
    - Access to recovery teams for long-term care and treatment was difficult.

- Service users referred to service on grounds of age, although the service did not meet their needs.

Institutional context factors

15. These would include factors such as the economic and regulatory context of the organisation (in this case the CQC), the structure of the NHS as well as links with other organisations (such as the police or the prison service). Examples included:
    - There was no system for involving other agencies
    - Systems that did exist for involving other agencies were used.

Appendix G. The ‘mind-set’ of policies

1. Trust policies seem to be written from the perspective of the service user as potential victim rather than potential perpetrator. This tendency occurs in several places. The policy on Domestic and Sexual Abuse which begins with the statement that:

   “The aim of this policy is to ensure that both service users and staff who have experienced domestic and sexual abuse in the past or present are supported safely and appropriate”.

2. Admittedly it does then mention service users as possible perpetrators in one of the more specific objectives

   - Give staff a framework within which to assess and appropriately respond to disclosures of domestic and sexual abuse by service users and carers
   - Incorporate an assessment for domestic and sexual abuse into the routine assessment of all service users, alongside the trust risk assessment process.

3. In their discussion of clinical staff’s ‘duty of care’ when there is domestic or sexual abuse, the main import of the duty is in respect of the service user while third party victims are not mentioned.

4. The Trust’s policy on Incident Reporting sees the safety of service users, staff and the environment as of paramount importance. Staff knew about a variety of criminal acts one service user had committed over a period of years but did not complete an incident form.

5. These comments are not saying that service users may not be vulnerable people and indeed many are and their needs should be recognised and ways found to alleviate their suffering. But some service users may be perpetrators of violence, exploitation and abuse and Trust policies should reflect that reality and in the process alert staff to a more questioning approach. A more questioning approach may lead to better and more accurate risk assessments and more effective risk management plans, some of which will involve multiple agencies.

Appendix H. Adverse events indicators

1. Many, but not all, independent investigations of patient homicides are asked, or set themselves, the problem of deciding whether the homicide was either predictable or preventable, or both. The Niche overview of the seven cases they had investigated included consideration of these questions. Comparisons with this group of Trust cases will be made.

2. Niche use this definition of predictability – "the quality of being regarded as likely to happen, as behaviour or an event". Prevention is taken to mean to "stop or hinder something from happening, especially by advance planning or action" and say that it implies "anticipatory counteraction". They say that for a homicide to be preventable there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.[2] On this basis they say that four of their seven cases were known to have risks of violence against property or persons but none had previously identified their victim. One perpetrator had identified another person during the treatment sessions but this was not the victim.

3. They go on to say that three of the individuals were reluctant to engage with services and in one case the independent investigation identified further information that would have enhanced risks assessments. This was information that the Trust's internal investigation team was able to find. This is slightly odd remark as it was the Trust staff working with the service user who should have found the information rather than the internal investigation panel.

4. The Niche investigations identified that in two cases professionals had omitted to listen to the concerns of the family. Parents and carers had identified changes in mental state, increased alcohol intake or changes in behaviour that gave them cause for concern and they knew these to be triggers for increased risk.

5. In all the cases that Niche investigated they conclude that none of the homicides were considered to be preventable. They say that while

   > "the investigations identified lack of assessment, care planning, engagement of family and that perpetrators were known to be violent or at risk of reoffending, there was no evidence to suggest that any of the victim were subject of a pre-planned attack". (p.5)

6. In seven out of the eight Trust patient homicides considered here the investigating panels explicitly address these questions. Different investigators tend to have their own definitions of predictability and preventability (some more explicitly spelt out than others). Verita seems to have formalised its definitions more than have other companies.

   > "The following is our criteria for assessing preventability: We consider the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from

[2] This definition is derived from Munro and Rumgay (2000)

occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy."

7. The underlying factors are the same as those used by Niche.

8. Importantly, where the panel conclude that the homicide was preventable, they restrict their comments to the knowledge that professionals have rather than the knowledge available to family members and carers. Perhaps, a definition that combined both would be more useful and more effective.

9. In one further case, an investigation panel concluded that the homicide was preventable because the service user was not effectively managed by the healthcare team; they were thought not have assessed the level of risk posed properly and if the service user had been assessed as high risk then a management plan would have been triggered. In the panel's view there was known evidence of risk factors. In the remaining six cases of patient homicide the panels did not believe the homicide was preventable.

10. When the Verita panel considered predictability their criteria were:

    "We consider the homicide would have been predictable if there had been evidence from the service user's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred".

11. They then go on to say that this homicide was not considered predictable because there was nothing in the service user's words, actions or behaviour which suggested that he was likely to become violent towards the victim. They saw

    "no evidence of behaviour, statements or signs that could have alerted professionals that the service user might imminently become violent".

12. In one other case the investigation panel believed that the homicide might have preventable if an effective risk management plan had been in place in which case admission to hospital would have been an option or if a more assertive approach had been taken and if a more detailed risk assessment had been carried out.

13. In all the other cases the panels decided that the homicide was not preventable though in one case the panel report the perpetrator's family as saying that if the service had seen a consultant psychiatrist the incident might well have been prevented. This might have been true if the consultant was able to say that the service user was detainable lawfully under the Mental Health Act 1983. The criteria for sectioning someone are strict and bizarre or challenging behaviour alone would not suffice. Carrying out a Mental Health Act assessment that is lawful depends on getting together an Approved Doctor and an Approved Mental Health Practitioner and the service user in circumstances where the

service user provides sufficient evidence of their illness for a decision to be made. The assessors also have to know what their powers are if the service user decides to walk out during their assessment or is generally uncooperative. Decisions have to comply with the statutory guidance set out in the 'Mental Health Act 1983: Code of Practice' in effect at the time.

14. There is one of these cases where the Niche/Verita criterion of predictability was met. Here the perpetrator was quite explicit about his threats to his wife and when questioned was able to persuade healthcare professionals that this was his fantasy and that he was a greater threat to himself than to others. The service user's adult children provided information about his previous violent behaviour. This case probably also represents an instance of healthcare professionals concentrating on the service user rather than seeing him or her as part of a wider set of relationships as would be suggested in a domestic abuse policy.

15. The Terms of Reference for this thematic review included identification of any 'adverse event indicators' in relation to predictable and preventable homicides. As there were only two investigations which concluded that the homicide was preventable or predictable, we felt it would not be meaningful to draw any conclusions in this regard.

Appendix I. Board assurance, governance and embedding learning

Introduction

1. The documentation and all sources of information reviewed for this section of the report are listed in detail in the Methodology section, Appendix C above. This section first describes the Trust's assurance processes as they are now. Systems have changed over the period of this review: superseded systems which are obsolete are not discussed.

2. The first point to note, however, is that one of the policies provided was out-of-date, in terms of both the local and national structures and the local systems they describe; one was incomplete; and one has not been approved by the Trust. The Trust makes the point that the constant internal and external change means in practice that, by the time a policy has been reviewed and revised, it can be out-of-date before it is validated and the Trust has to go back to the beginning of the process.

Trends and Lesson Guidance 2010

1. This guidance was scheduled for review in 2013, and is now being updated. The purpose of the guidance is to ensure a systematic approach to bringing together and identify trends from a variety of 'adverse events', including incidents, serious incidents and homicides. Significant risks are transferred to the relevant high-risk registers and managed through the Trust's Risk Management Strategy. The intention is to learn from all adverse events and disseminate that learning in order to improve safety for service users and staff.

2. Reports about Serious Untoward Incidents (including homicides) are provided quarterly to the Quality Committee. This Committee is chaired by a non-executive director and takes place bi-monthly. Integrated Governance Teams take place at 'care group' level at least monthly and are chaired by either the Service Director or Clinical lead for the care group. Both are attended by professional leads, whose role is to ensure that recommendations and learning are fed back into the appropriate professional group.

3. Final reports following Serious Untoward Incidents are reviewed by the relevant Service Director and Clinical Director (or individuals with delegated authority) prior to approval by the Executive Director of Nursing and Quality and Chief Operating Officer (or delegated individuals). The Suicide and Homicide Groups scrutinise in detail two completed final reports.

4. A Report and Learn Bulletin is published quarterly Trust managers are encouraged to share and discuss the content of the bulletin with staff at team meetings, in order to share learning, encourage change in practice and to implement risk reduction measures within the organisation.

5. Clinical staff are also able to take part in the review of case presentations, to debate root causes and the learning to take away so that they can reflect on their own practice.

6. There is an integrated action plan which brings together trends and themes from all serious events. This plan is communicated to Care Groups on a quarterly basis. Evidence of improvements against action plans is scrutinised and the plan is amended accordingly.

7. The Quality Committee monitors local and organisational learning from adverse events through a six-monthly review of the integrated action plan which includes details of actions being implemented with the Care Groups.

8. The Quality Committee and Integrated Governance Teams keep under review the effectiveness of the Trust's reporting and learning arrangements.

Risk Management Strategy and Policy (not yet ratified)

11. The current Risk Management and Strategy Policy describes the core of the reporting and monitoring arrangements. The policy is intended to define the Trust's strategy and policy for risk management (all types of risk). This is a high level policy, which covers all aspects of risk within the Trust, including financial risk, health and safety risk and information risk as well as clinical risk. Serious incidents such as homicides bring risks of harm to the perpetrator/service user; to the victim; to the families of perpetrator and victim; to staff providing care and services to the perpetrator; to the reputation of the Trust; to public confidence in the Trust.

12. The overall objective of the policy is to achieve compliance with the standards required by regulators such as the Care Quality Commission (CQC):

> "to integrate risk management with the Trust's strategic aims and objectives; and to bring together controls assurance, financial risk management, and health and social care governance systems through integrated governance" (Section 2, p. 4).

13. In the remainder of this section, we will look at this policy only as it relates specifically to serious incidents.

14. All leaders in the Trust will monitor clinical performance including risk assessments and counter-measures and ensure that these are reviewed and updated regularly. They will ensure that clinical risk assessment processes and procedures are adhered to, monitored and evaluated. The 'Safeguard' risk management system produces monthly risk registers which are sent out automatically to directorates, managers and teams.

15. Care Delivery Services (CDSs) are to ensure that all identified senior staff have received risk management awareness training; senior clinical staff and professional leads are to undertake approved Root Cause Analysis (RCA) training; incident investigation training for all Band 7 clinical managers; from April 2016, CDSs are to ensure that the Governance Performance Audit is

reviewed annually and that significant risks are place on the risk register; and the web-based risk assessment system is to be implemented by April 2017.

16. The Assurance Framework (AF) is a 'dynamic document' which is reviewed and revised every quarter. The AF is reviewed in full by the Board of Directors three times during each financial year and by the Audit Committee at least annually. Risk assessments identified in the AF are entered on the Safeguard database.

17. Compliance with the NHSLA risk management standards and with the CQC fundamental standards of care is monitored by the Governance Support Team. All staff should attend risk assessment awareness training as part of their induction, followed by an annual update; incident reporting training (with more detailed and in-depth training completed by staff who have to complete incident report forms as part of their role). The in-depth training in incident reporting is to be undertaken by 'team managers, ward managers, team leaders, charge nurses, senior staff nurses and managers' (Para 8.2.2). This group of staff, with the addition of service managers, and matrons, also undertake one-off training in:
    - Investigation of incidents
    - Root Cause Analysis.

18. Clinical risk assessment training consists of:
    - fundamentals of risk management
    - positive risk management
    - working with service users and carers
    - individual practice and team working
    - tools for supporting best practice.

19. This training is to be undertaken by 'all registered and non-registered nursing staff, all medical staff, all psychologists and psychotherapists, all occupational therapists, all clinical registered and non-registered bank staff' (Para 8.2.2). It is to be undertaken within 6 months of commencing employment with the Trust or commencing a role where this training is applicable and updated at 2 yearly intervals.

20. Compliance with these training requirements is monitored through the 'Essential Training Policy'. The Risk Management Strategy and Policy is to be read in conjunction with a number of other policies and guidance. Of particular relevance is the following.

Incident and Serious Incident Reporting Policy and Procedure, V2 Ratified October 2015

21. This policy and procedure for reporting incidents, serious incidents and near misses applies to all Trust services in all setting and sets out what is expected of all Trust staff and managers, including agency and bank staff, volunteers and people seconded to work in the Trust. It is based on the NHS England

‘Serious Incident Framework – supporting learning to prevent re-occurrence.’ (2015).

22. A web-based incident reporting form is used, with paper incident forms in a book as a back-up in case the web-based system is down. The policy defines a number of types of incident – which include the incidents addressed in this report. All managers at all levels will actively lead on incident reporting as a fundamental part of service delivery, risk management and sound governance.

23. The policy is based on the principles of learning and reduction of risk to future patients, as well as concern for those who may suffer as a consequence of an incident. The use of root cause analysis and examination of contributory factors establish the underlying causes of incidents. Staff reporting or involved in incidents will be treated fairly, without prejudice and with the aim of reducing risk of further harm. Disciplinary action will not be pursued except in cases of negligence or wilfully failing to comply with policy, professional standards and codes of practice.

24. The Board is committed to ensuring that incident reporting forms an integral part of risk management; and that the provision of training is central to this aim. All serious incident will be subject to thorough review, using Root Cause Analysis to determine any underlying causes, contributory factors and root causes, and to identify any improvement action to reduce the risk of similar incidents happening in the future.

25. It is made clear that all staff have a responsibility to report incidents; and to ensure that ‘visitors, carers, contractors, agency and bank staff’ are aware of their responsibilities to report all incidents. Specific duties for a range of staff and groups are set out, ranging from the Board of Directors through senior and middle management to patients, carers and relatives.

26. The key points arising from these duties are the detailed requirements of staff to act in accordance with the principles of the policy, the focus on learning and risk reduction and the need to provide appropriate support to all those affected by the incident, including other service users and carers/relatives (‘Being Open’ policy), and staff. Early actions are to make the area (on Trust premises) safe and to protect the area if the police and criminal prosecution may become involved.

27. There are very detailed definitions and procedures for the various roles, groups and committees within the Trust. This includes the requirement to inform external bodies where relevant, including homicides and other serious incidents. The web-based incident reporting system is described in some detail, which illustrates how incidents are automatically escalated to more senior managers and clinical directors where appropriate.

28. Some aspects of the policy highlight the importance of ensuring that risk assessment are accurate, complete and up-to-date – for example where a service user goes missing from a Unit, the police should only be called if the person presents a risk of harm to him/herself or others.

29. The decision as to the Level of investigation relevant to an incident, including if the incident should be reported to NHS England, is made by the Director of Nursing Standards and Quality.

30. Other than at Level 3 (independent investigations commissioned by NHS England), investigations are allocated by those responsible for the service in which the incident happened; and the draft report is scrutinised by the same person.

31. The policy describes in detail the Root Cause Analysis methodology and stresses the importance of identifying lessons learnt from the causal factors and root cause(s); and the significance of carrying out causal analysis correctly if appropriate improvements are to be made. Recommendations should be explicitly derived from the lessons learnt identified in the report and the connection between the lessons learnt and recommendations should be clear so that care and service improvements can be made.

32. An action plan derived from the recommendations will be written by the General Manager responsible for the area the Serious Incident occurred in. It will be written following SMART principles (Specific, Measurable, Accurate, Relevant and Time bound). Delivery of the action plan will be the responsibility of those named; overall responsibility remains with the relevant Service or Executive Director.

33. Actions are entered onto the risk management system by the Governance Team who will provide a monthly performance report to update Executive and Service Directors on the actions which are still open and to report progress for their services.

34. Actions are implemented by the team where the incident occurred. Action plans are also entered into the Safeguard system (web-based reporting system) and an 'actions register' is sent out to all Service and Clinical Directors, general managers and Managing Directors. The Director of Nursing Standards and Quality looks at action plans arising from all serious incidents and updates the quarterly Quality report – this report goes to the Board of Directors to share themes of learning and actions from serious incidents. Once approved by the Board, the quality report is shared with all staff on the intranet and with external stakeholders. The monthly 'Report and Learn Bulletin' includes information about key safety issues. Progress against actions are is updated on the Safeguard system. Action Plans are removed from the register once all actions are complete.

35. A weekly performance report on outstanding serious incident is sent to Service Directors and their deputies, business managers, legal team and the Executive Director of Nursing and Quality. After final scrutiny and sign-off is forwarded to the Director of Nursing Standards and Safety: once approved, she sends it to the relevant lead CCG. The CCG provides final external scrutiny.

36. The lead CCG meets on a monthly basis to scrutinise all Serious Incident reports. On a quarterly basis the CCG will review two reports to follow up on action plan progress.

37. The Quality Committee receives and scrutinises final reports and action plans in relation to homicides and other very serious incidents, including review of monitoring of independent investigation reports and action plans; to review quarterly reports to consider trends and actions.

38. The Trust aims for quality improvement in specific areas, including serious incidents. The Trust aims for demonstration and quality assurance in the same specific areas. Key sub-groups of the Quality Committee examine specific areas of learning: the chairs of these groups are usually members of the Quality Committee. Quality and Safety reports are available to all staff through the intranet.

39. Service Managers and Matrons receive monthly reports through the Safeguard system and review the monthly incident reports to identify themes and trends in their area of responsibility.

40. Managers and supervisors ensure that members of staff attend the appropriate incident reporting and investigation training in line with policy. Training is monitored and reviewed at the relevant Forum. Training in the incident reporting system is mandatory for all staff; staff at ward manager, or equivalent level undertake mandatory one-day investigation training; those at Service Manager/General Manager/Matron and professional/clinical leads undertake two-day mandatory Root Cause Analysis training.

'Being Open' Policy including Duty of Candour (ratified April 2015).

41. The 'Being Open' policy is a key document in relation to learning from 'adverse events'. The policy identifies the responsibility of all staff to implement 'Being Open' in order to learn from adverse events as part of the Trust's 'commitment to maintaining high quality services, supporting staff and maintaining public confidence.

42. The Statutory Duty of Candour is a new CQC registration regulation which places a requirement on providers of health and adult social care to be open with patients when things go wrong. It also applies to organisations providing services under the standard NHS contract.

43. The policy relates to harm which happens to service users: it also applies to incidents where service users cause harm to others such as homicides – the impact on the service user is likely that s/he will be detained in secure accommodation (prison, secure health facility) for a period of time.

44. 'Being Open' means:
    - Acknowledging, apologising and explaining.
    - Apologising is the right thing to do and is not an admission of liability.
    - Conducting a thorough investigation into the incident.
    - Assuring patient and/or carers that lessons learnt will reduce the likelihood of the same thing happening again.
    - Supporting those affect to help them cope with psychological and physical effects.
    - Sharing the findings of the investigation.

- Communicating learning and monitoring the implementation of the action plan.

45. The Duty of Candour means that, where moderate or severe harm or death has occurred, the Trust needs to:
    - notify the service user or person acting on their behalf that an incident has occurred, including an apology
    - advise and agree with the service user what further inquiries are appropriate
    - provide all information directly relevant to the incident
    - provide reasonable support to the service user
    - inform the service user in writing of the original notification and the results of any further enquiries.

46. The 10 principles of 'Being Open' are:
    1. acknowledgement
    2. truthful, timely and clear communication
    3. apology
    4. recognition of patient and carer expectation of the investigation, including confidentiality
    5. professional support (to staff affected by incidents)
    6. improve risk management and systems through investigation and learning
    7. a multi-disciplinary responsibility and approach to 'Being Open'
    8. Clinical Governance frameworks are applied to ensure dissemination, learning, audit of implementation, and to ensure accountability for implementing changes through the Chief Executive to the Board
    9. confidentiality
    10. continuity of care and treatment is maintained, unless the service user/carers wish for a different team.

47. The policy applies to all staff in all roles and goes on to describe in detail the specific responsibilities of specific levels of staff and staff who are involved either prior to, during or after the incident. The procedures go on to describe how and by whom the initial and follow-up 'Being Open' discussions are to be held, and how the process is to be completed once the investigation is completed, including feedback to the service user and/or carers. All communications must be recorded.

48. Compliance with the policy will be monitored by:
    - completion of the final Serious Incident report sections on communication with the service user and/or carers
    - an annual 10 per cent audit of incident reports for compliance with Duty of Candour requirements: the outcome of this to be reported to the Quality Committee.

The Quality Committee

49. In summary, the governance and assurance arrangements for the Trust are as follows.

50. The Quality Committee has four sub-groups reporting to it:
    - Homicides and Suicides review group
    - Serious incidents review group
    - Mental Health Act review group
    - Information governance review group.

51. This structure and monitoring/reporting process is intended to assure the Board that:
    - proper investigations are carried out
    - that learning takes place
    - that learning is embedded in the organisation.

52. The Board receives a 'Quality and Performance' report every month; this includes serious incidents, incidents and issues related to these.

53. The Quality Committee includes two Non-executive Directors, one of whom chairs the meetings. The Quality Committee reports to the Board, which receives a copy of all Quality Committee papers and high level summaries. There is an opportunity for the Board to question and discuss the reports. These papers published on the website. The Quality Committee meets bi-monthly and are timed to fit with Monitor reporting requirements. Particularly relevant duties of the Committee are:
    a) To alert the Board to any areas of concern in relation to quality.
    b) To oversee the Trust's compliance with the Care Quality Commission's standards of registration, advising the Board of any issues of concern.
    c) To seek evidence that the Trust has in place systems that ensure it acts across the five Francis Inquiry themes:
        i. Preventing Problems
        ii. Detecting Problems
        iii. Taking action Promptly
        iv. Robust accountability
        v. Well trained and motivated staff
    d) Monitor the development of and recommend agreement of the Trust's Annual Quality Account.
    e) To seek assurance and evidence that all Quality Governance systems and structures are operating effectively and are subject to continual improvement.
    f) To formally receive and scrutinise final reports and action plans in cases of homicide or other extremely Serious Incidents (SIs). This will include the review and monitoring of independent inquiry reports and action plans.
    g) To review and scrutinise quarterly SI reports to consider trends and required action, including scrutiny of particular samples of topically grouped SIs.
    h) To receive a six monthly Safeguarding Children and Adults report that identifies issues, areas of poor or best practice and those of strategic interest and importance requiring Board level discussion.

i) To review and scrutinise progress against the clinical audit programme. To include ad-hoc consideration of reviewing internal and external non-financial audits not reviewed by the Audit Committee.
j) To discuss and consider matters of concern or potential concern in relation to quality in its widest sense.
k) To receive and scrutinise reports from the Patient Experience work streams, including the annual patient survey, Fifteen Step Challenge, 4 Friends and Family Test.
l) Formally receive and approve the Monitor quarterly self-assessment submissions prior to presentation to the Board.
m) To ensure that the Trust has effective and transparent system for ensuring quality is not compromised as a result of cost improvement.

The Quality Committee Summary Report

54. As an example of this, we reviewed the report submitted to the February meeting of the Board. The report describes the following issues.
    - Initial feedback from the CQC following an unannounced inspection of 6 wards for older people – this included good practice and significant work in three areas. These were statutory and mandatory training and supervision of staff; gender segregation; and care planning.
    - Compliance with statutory and mandatory training requirements more widely – clinical directors assured the meeting that they 'understood all the issues and were ensuring appropriate action in their services'.
    - Development of CDSs and the governance structures they are establishing – good practice in relation to learning from serious incidents was noted and the meeting agreed that there needs to be an emphasis on shared learning across CDSs. It was noted that each CDS has its own service improvement plan and that these would be considered at the next meeting of the Quality Committee in respect of risks and mitigation to quality.
    - Serious Incidents, reporting, learning from and recent national and media coverage – the work of the two Review Groups and the review of the SI policy and process were noted. A 'Report and Learn' conference was being planned for April 2016 to 'disseminate learning from Serious Incidents as widely as possible within the Trust'.
    - Proposed changes to 'sharpen the focus and function' of the Committee were discussed and would be introduced in March 2016.
    - Feedback for the Council of Governors and related actions – this had included a suggestion for a 'buddy' system for patients leaving hospital which was being piloted in some areas of the Trust. Concerns were expressed about the national media reporting of a significant increase in the number of Serious Incidents reported. A seminar was to be arranged.

55. Four Review Groups report to the Quality Committee. Relevant to this thematic review are the Suicide and Homicide Review Group and Serious Incident Review Group which provide summary reports and reports by exception.

The Suicide and Homicide Review Group

56. The former meets quarterly and its duties (agreed in January 2015) are to:

- act as the overarching review point for all suicide, suspected suicide and homicide related incidents across the Trust
- ensure that robust action plans are in place following incidents and that any learning has been widely shared
- commission as necessary, reviews of clusters of suicides or suspected suicides, homicides and 'near miss' homicides involving people known to the Trust. Such review will be overseen by an executive sponsor and their findings presented to the Group
- identify any trends identified and take action
- review the Trust's policies and practices in the management of safety, ensuring that they reflect national guidance and best practice
- ensure that Report and Learn publications, and Report and Learn Live events reflect the key learning identified through the work of the Group
- formally receive Independent Homicide Investigation reports, and ensure any learning is efficiently shared.

57. The Group presents an update on progress to the Quality Committee on a quarterly basis. The Group agrees key messages for communication to the wider Trust at the end of each meeting.

58. The Suicide and Homicide Review Group is evolving to cover mortality more generally now. This is a response to ongoing changes in the Executive Team and the Mazar's report.

The Serious Incident Review Group

59. The Serious Incident Review Group meets quarterly and undertakes 'any activity in relation to the review, learning from and improvement as a result of Serious Incidents' (Terms of Reference, item 4). The Group's duties are to:
    - ensure that there are robust systems in place at every level of the Trust, to identify share and change practice as a result of learning from Serious Incidents and near misses
    - identify emerging themes, trends and hot spots, taking remedial action to address them
    - consider actions required and to test the sharing of learning across the trust through the commissioning of audit and review processes
    - ensure that the SI policy, process and sign off points work as effectively and efficiently as possible, meeting all required standards and timescales
    - ensure Directorates have in place robust systems to ensure delivery of action plans and audit of compliance on a continuing basis.

60. Minutes of meetings will be provided to the Quality Committee; and Trust-wide communication will be via the Report & Learn Bulletin.

61. These two Review Groups are relatively recent additions to the reporting and monitoring structure of the Trust's quality and learning from homicides (and other Serious Incidents).

62. Membership of both groups consists primarily of Executive Directors and Directors. The Serious Incident Review Group allows for Clinical Directors to

be invited for specific purposes; and the Suicide and Homicide Review Group membership includes at least one Professional Lead for all the Care Groups.

63. Consequently, the structure and systems described so far relates primarily to the higher levels of the Trust, which are at an organisational distance from the 'front line'. It appears from the Summary Report of the Quality Committee described above that Clinical Directors do take an active part in the meeting. The Summary Report also illustrates the potential for the Quality Committee to provide a 'bridge' between the Board and CDSs. However, given the relative newness of the current Board reporting structure, of the CDS organisational structure and of the recent appointment of Clinical Directors it may be too early to assess the effectiveness of this link.

Care Delivery Services

64. The model of Care Delivery Services was created in 2015. These Services are responsible for and accountable for investigations, action plans and monitoring implementation within their services. This responsibility lies with the clinical lead for the CDS. They are given a set of 'key principles' (e.g. the Duty of Candour) for carrying out internal investigations and have to demonstrate how they have embedded learning.

65. These activities are logged and tracked via the Serious Incident system, Ulysses. There is also a 'fundamental standards' tracker. CDSs self-assess themselves against the standards on a quarterly basis and put the evidence on to the 'Quality and Performance' system. This also includes monitoring. The tracker takes information from the ward level upwards; which goes into the each CDS's dashboard; which in turn goes on to the Trust dashboard. The CQC has defined these 'fundamental standards of care' which replace the essential standards of care.

66. This responsibility is quite new and the process is still evolving. The electronic system will highlight gaps in the process, but the CDSs will need local systems to monitor embedding learning. There is no separate guidance for 'front line' staff. As part of their approach to improving communication, the Trust is developing a 'Policy on a Page', model which disseminates policies to front line staff in an easy to digest format.

67. The Report and Learn Bulletin is emailed to all staff and displayed put on ward/office notice boards. The CDSs are encouraged to use the Report and Learn Bulletin as a basis for discussion, case reviews, on how to change practice. This approach is used in business meetings with staff.

68. The risk system is now all web-based. The CDSs upload their own risks onto the 'Safeguard' system and the system checks when reports are complete and audits are done.

69. The CDSs now have to demonstrate how they are embedding learning.

70. The Executive Team and their responsibilities are being re-structured. The Executive Director of Nursing and Patient Experience role will include

responsibility for safeguarding. The distinction between adult and specialist services is going so that there will be one Managing Director across all services.

71. There will be a centralised team for monitoring Serious Investigations.

Board Assurance Framework

72. The Board Assurance Framework (BAF) is also published on the Trust website. The high layer of the Risk Register is aligned to the core Trust objectives; and aligned to the Trust's 20:20 vision (5-year plan); and to the quality and safety priorities for the year.

73. The Board receives a routine report from the Risk Register quarterly; and of 'extreme risks' at every meeting.

74. The Board reviews the BAF in full at least three times and years and the Executive Assurance Committee reviews 'extreme risks' monthly.

75. We have reviewed the Board Assurance Framework Version 4 (January 2016). This identifies eight 'extreme' risks of which two are financial and six are related directly or indirectly to quality of care. These six are:
    - successful implementation of Carenotes (the electronic clinical record system)
    - deliver evidence-based clinical pathways
    - meet statutory training requirements
    - improve staff engagement
    - develop skills and behaviours in line with Trust values
    - recruit and retain high calibre staff.

76. Using this framework, the Board receives information which:
    - describes known risk(s) in relation to each Board objective
    - assesses the likelihood and impact of that risk, giving a risk rating prior to any interventions
    - describes the key controls and sources of assurance for limiting that risk
    - identifies gaps in the controls
    - identifies gaps in the information which provides assurance
    - reassess the likelihood and impact of that risk, giving a risk rating following the interventions.

77. Specifically in relation to incidents, the report notes 'variable reporting of incidents in CDSs' as a 'gap in assurance' in respect of delivering five 'sign up to safety' pledges. The minutes of discussion of this agenda item are however brief, but one action was agreed, namely to develop a strategy of evidence-based pathways to go to the May meeting of the Board.

78. A BAF tracker for 2015-16 is presented to the Board, which describes changes made to Version 3 in order to create Version 4. At the March meeting, a paper was presented to the Board which described Extreme Risks in some detail,

again setting risk ratings before and after interventions, provides the current score, describes the controlling and influencing factors and the gaps in those factors.

Fundamental standards (including Duty of Candour)

79. A paper is presented to the Board quarterly on progress in demonstrating compliance with the twelve fundamental standards introduced by the CQC and Duty of Candour regulations. This paper reports completion of a self-assessment assurance dashboard tool which relates to the Fundamental Standards and which each CDS completes quarterly. The evidence is tested by unannounced visits by the Director of Nursing Standards and Safety and Head of Compliance and Quality, and is compared with other sources of relevant information – which includes Serious Incident reviews. Compliance with the Duty of Candour requirements forms part of the incident reporting and management procedure.

80. The paper for the February Board meeting notes that compliance with the self-assessment requirement has not been comprehensive. 66 per cent of teams across the Trust submitted self-assessment ratings (59 out of 90).

Trust Quality and Patient Safety Report

81. We reviewed the Trust-wide Quality and Patient Safety Report for Quarter 3, 1 October to 31 December 2015. The Quality and Patient Safety Reports are submitted quarterly

82. This includes the 'Quality and Safety Dashboard' for the Trust which presents quantitative data about the number of, for example, Serious Incidents (60), and homicides (0), for the 2nd quarter, the third quarter, the total for the year to date and the total for the previous year. 20 key messages are identified, which include, in respect of Serious Incidents:
    - 60 serious incidents were reported
    - The three most common themes arising from the Serious Incident investigations in quarter 3 were:
        - failure to follow procedures
        - records not updated
        - lack of communication.

83. This indicates that, as expected, the themes identified in relation to the homicides are not peculiar to homicides but recur in more broadly defined Serious Incidents, and were happening between 1 October and 31 December 2015.

84. The report contains descriptive analyses of Serious Incidents by gender, by ethnicity, by service setting; by care group; and by CCG. 17 Serious Incident Reports were overdue (not completed within the required timescale) at the time the report was compiled.

85. Interestingly, the report includes details of 'changes to practice' as a result of learning from Unexpected Death investigations. However, on closer

inspection, these appear to be either recommendations as to what ought to be done; or process actions such as holding a workshop. There is no evidence of actual changes to practice. This report also identifies themes of learning for SI investigations.

86. Reporting on the classic and mental health safety thermometers showed that the Trust achieved 91.08 per cent of patient received Harm Free Care, which was below the national target of Harm Free Care for 95 per cent of patients and below the national average for this quarter of 94.2 per cent. The classic safety thermometer uses only physical health indicators. The mental health safety thermometer was launched in October 2014 and training is being rolled out across the Trust. This is a self-reporting tool using the safety thermometer website.

87. Compliance has been limited in community services (range from 11 – 18 per cent across the three months of the quarter; and, following a good start in the first month (80 per cent compliance) had dropped to 41 per cent in the third month of the quarter for inpatient services. The Trust's results were lower than the national average in terms of the proportion of service users reporting harm free care and feeling safe.

88. Issues arising from inquests for shared learning included communication with relatives; history taking; and concerns that clinical risk assessment and observation policies were not followed; documentation was not always of the standard required; understanding the Deprivation of Liberty Standards; and communication within the multi-disciplinary team. A number of examples were provided of process activities along with monthly audits of documentation. On the other hand, the coroner was impressed with clear lines of communication and excellent joined up care in another case.

89. This section of the report ends with an exhortation to staff and their service to 'learn from the learning themes identified above.

Trust Quality and Performance Report – January 2015

90. The Trust-wide Dashboard provides the number of Level 1 serious incidents reported during the previous quarter (56) and the number of Level 2 and 3 combined serious incidents reported (21). The dashboard also reports the per cent completed and submitted within 60 days – these figures were all rated 'red' and for the Trust as a whole the figure was 48 per cent.

91. In adult services, it was reported that good processes were in place in the governance arrangement for CDSs to share learning from Serious Incidents. The North West Sussex CDS held a successful 'Report and Learn' event including service user leaders and local partners.

92. It was also noted that there had been an increase in Level 1 incidents (causing moderate harm) in December and January in adult services and that this is being investigated. In specialist services, there were only 3 Level 1 SIs, all in Sussex, in January 2016.

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