VERITA

IMPROVEMENT THROUGH INVESTIGATION

Follow up review of a statutory mental health independent homicide investigation: Mr S, published in September 2014

Somerset Partnership NHS Foundation Trust

A report for NHS England, South region

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1. Introduction

NHS England (southern region) commissioned Verita to undertake follow-up reviews of five statutory mental-health independent homicide-investigations first published in 2014.

The purpose of the reviews is to provide assurance to NHS England that the recommendations from the investigations were implemented or are in the process of being implemented. Somerset Partnership NHS Foundation Trust ("the trust") is one of the trusts involved in the follow up reviews.

The trust provides community health, mental health and learning disabilities services in Somerset. The services promote independence and social inclusion for people of all ages. The trust's older person's multidisciplinary community mental health team (CMHT) provides a range of services that include assessing and treating emergency, urgent and routine referrals.

Mr S's GP referred Mr S to the older person's community mental health team (CMHT) in Bridgewater in January 2011. He received care and treatment from the CMHT and was discharged in February 2011. His GP referred him to the CMHT again in April 2011.Mr S remained in receipt of services from the CMHT until the time of the incident.

Mr S fatally stabbed Mr C in the neck on 21 June 2012 during an altercation in a car park outside Mr S's flat. Mr C was Mr S's landlord. Mr S was arrested on suspicion of murder. A court case took place but Mr S was not well enough to attend. In December 2012 the judge ordered Mr S to be detained without limit of time at a secure psychiatric hospital. Mr S died before the independent investigation.

Mr S's GP referred Mr S to the older people's CMHT in Bridgwater in January 2011. Mr S received care and treatment from the CMHT and was discharged in February 2011. His GP referred him to the CMHT again in April 2011. Mr S continued to receive CMHT services until the incident. The CMHT were aware that Mr S had previously served a two-year prison sentence for stabbing his wife. CMHT records said that Mr S had no remorse about stabbing his wife.

2. Context

Verita carried out an independent homicide investigation in 2014. They shared the report with the trust in August 2014 and the trust published it on NHS England website in September 2014.

The trust shared the report with Mr C's family before publication.

The independent investigation found that if the older people's community mental health team had told Mr C about Mr S's previous conviction and his lack of remorse about stabbing his wife, this incident might have been prevented.

Verita's independent investigation made these recommendations:

R1 The trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is at known risk from that service user.

R2 The trust should ensure that there are steps in place so that relevant staff in older people's services are able to gain advice and guidance from forensic services when needed.

R3 The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information.

R4 The trust should carry out an audit to ensure that accurate records are kept of all clinical reviews including the people present, the discussions and the outcomes of reviews.

R5 The trust should have a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:

- are provided with and consulted on the terms of reference of the trust internal investigation;
- know how they will be able to contribute to the process of investigation; and
- receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information.

3. Terms of reference

- To conduct an independent review on the implementation of the action plan following the homicide investigation.

- To inform NHS England and the clinical commissioning group of any concerns resulting from the audit.

- Produce a short report to be shared with stakeholders, including families and published by NHS England, the trust and the clinical commissioning group.

4. Methodology

We wrote to the trust on 5 November 2015 to tell them NHS England southern region had commissioned a follow up review and asked for an update of trust action plans following the independent investigation. The trust's director of governance sent us an updated action plan on 15 December 2015.

We adopted the following methodology in carrying out our review:

- Reviewed the action plan addressing the recommendations of the independent investigation. We reviewed several documents that the action plan referenced, listed in Appendix A. The trust approved the action plan in September 2014.

- Held a joint interview with the trust's head of risk and the trust's safeguarding lead for adults and children.

- Made a literature search on "google scholar" after the interview of trust initiatives that promoted family or carer inclusion.

- Performed a case review of a random sample of 10 patients receiving older-adult services. The case review examined the patients' electronic notes to assess if they had:

    - a clear record of latest clinical reviews;
    - that the notes included the people present at the review; and
    - that the notes included the discussion and the outcomes of reviews.

We describe the progress of actions that address the five recommendations in sections 6 to 10 of this report. Each section sets out the recommendation and then gives a summary of why the original independent homicide investigation considered it necessary. We then review the actions the trust has taken to address the recommendations of the original independent homicide investigation

Any recommendations for further action are given in each section and summarised below.

5. Summary of the trust's progress in implementing its action plan and the follow-up review's recommendations

Recommendations from the independent homicide investigation	Progress and specific findings
Recommendation 1 The trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is at known risk from that service user.	***Completed*** F1 The trust has amended key policies to inform staff when they can share personal patient information without the patient's consent. F2 The trust's mandatory training programme ensures staff know these policies. F3 The trust monitors staff attendance at these training programmes.
Recommendation 2 The trust should ensure that there are steps in place so that relevant staff in older person's services are able to gain advice and guidance from forensic services when needed.	***Completed*** F4 The trust has a forensic liaison team which offers specialist supervision for other trust professionals. F5 The older adult services have access to and have received training on how to obtain a forensic assessment of their patients. F6 We found no evidence that the older adult community service has made a referral to the forensic service for advice and support for any of their patients.
Recommendation 3 The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information.	***Completed*** F7 The trust monitors the inclusion of carers for new patients to services. F8 The trust's older adult services comply with local standards on carer inclusion. F9 The trust has a record of good practice in carer inclusion. F10 The case review carried out for this review showed that, for all ten patients, staff had considered family or carer involvement and that, where possible, discussions with carers had happened.

Recommendations from the independent homicide investigation	**Progress and specific findings**
Recommendation 4 The trust should carry out an audit to ensure that accurate records are kept of all clinical reviews including the people present, the discussions and the outcomes of reviews.	***Completed*** F11 The trust carried out a check of staff's recording of attendees at patient care programme reviews across all services. F12 The check indicated that staff recorded attendees at 87 per cent of patient care programme reviews. F13 Our own case review showed there was a good standard of recording attendees, discussions and outcomes of patient reviews for the older adult community services.
Recommendation 5 The trust should have a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family: • are provided with and consulted on the terms of reference of the trust internal investigation; • know how they will be able to contribute to the process of investigation; and • receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information.	***Completed*** F14 The trust has produced "guidance on working with families after a homicide" which addresses the recommendation of the independent homicide investigation and complies with government regulation on the "duty of candour" and is good practice.

5.1 Recommendations of this follow-up review

The trust has completed actions necessary to address the recommendations of the independent investigation.

However, to provide further assurance, we felt the following recommendation was needed.

R1 The trust's chief operating officer should oversee an audit of which services have made referrals to the forensic service for advice and support since the independent investigation and what were the outcomes for referrals. The audit should take place in the trust's next planned audit cycle after this report is published.

6. The implementation of recommendations 1 of the independent investigation

> “The trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is at known risk from that service user.”

The independent investigation found that both the trust and the police knew of Mr S’s previous conviction and imprisonment for stabbing his wife. In light of this, the trust consulted with the police about the recurring threats Mr S was making to his landlord, Mr C. The police advised workers at the community mental health team (CMHT) caring for Mr S that they should advise Mr C not to visit Mr S’s address alone. The workers did advise this, but, in line with police advice, did not tell Mr C about Mr S’s previous conviction for stabbing his wife.

The trust’s guidance at the time makes it clear that the trust had the authority to share information about Mr S without his consent to prevent harm to others. The investigation therefore found that the trust should have shared the information about Mr S’s previous conviction with Mr C independent of police advice. Avon and Somerset Police also carried out a review after the incident. They found that it was unclear who should have been responsible for making a disclosure to Mr C.

To gather evidence to determine if the trust has implemented recommendation 1 from the independent investigation we:

- reviewed the trust’s action plan;
- interviewed the trust’s head of risk and the trust’s safeguarding lead for adults and children;
- reviewed the trust’s confidentiality and data protection policy;
- reviewed the trust’s clinical assessment and management of risk policy;
- reviewed the trust’s safeguarding teaching materials; and
- conducted a case notes review of clients in the older adult services.

The trust’s action plan says the trust’s information governance manager carried out a review of the trust’s confidentiality and data protection policy after the incident. This review concluded that the “wording on disclosure without consent has not been changed but learning from the incident will be included in future training for clinical and records management staff”.

We reviewed the trust’s current confidentiality and data protection policy, which the senior manager’s operational group ratified in January 2014. It is due for review in December 2016. The policy objective is to ensure that all trust staff comply with data protection.

Appendix C of the policy has a section called “When is it acceptable to breach confidentiality”. This section says:

> "There is a clear public interest in the maintenance of confidentiality, breaching confidentiality can harm the patient, third parties and damage the patient-professional relationship and the public perception of professional. However, on occasions it is necessary to breach confidentiality where there is a greater public interest in doing so. This balancing test is sometimes referred to as the "Egdel test". A clear example of this is where a patient tells a staff member that a third party is at real risk of harm."

The policy details the process that allows staff to breach patient confidentiality in the public interest and says that such a breach should be clearly documented. The Egdel test comes from a common law court case that ruled in favour of a psychiatrist who disclosed a negative report about a patient without the patient's consent[1]. The policy does not give an account of the "Egdel" case, but does mention the outcome and what it means to clinical staff, i.e. that the courts found that clinicians could "breach confidentiality where there is a greater public interest in doing so."

The trust's action plan for the independent investigation says that the trusts "Serious Incident Requiring Investigation"[2] (SIRI) group reviewed the trust's clinical assessment and management of risk policy after the independent investigation report. This review led to an amendment so that "disclosure of information is set out in the policy".

We reviewed the trust's clinical assessment and management of risk policy. We found that the policy quoted the section from the trust's confidentiality and data protection policy about disclosing patient information without consent, which we described above.

The trust's clinical assessment and management of risk policy also says:

> "Where there is an identified public safety risk and the risk assessment shows that enactment of the identified risk behaviours will realistically cause significant to catastrophic harm then there is a duty to act and consider urgent disclosure to the police so that the risk can be contained if possible and that any identifiable individual at risk can be notified. Practitioners should seek the advice of their line manager who has access to formal legal advice, in any case where there is a doubt about a decision to share or not share information with other agencies."

The clinical assessment and management of risk policy also contains a "checklist for clinicians" constructing a risk management plan for a patient. This asks:

> "Have you considered the need to share information urgently and the possible need to breech confidentiality (including police referral) when someone/ the public is identified as being at significant risk of harm?"

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[1]Common law: W vs. Egdell 1989. See http://www.bailii.org/ew/cases/EWCA/Civ/1989/13.html

[2]The "Serious Incident Requiring Investigation" Group is responsible for effective governance and learning following a serious incident in the trust. See https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

When jointly interviewed, the trust's head of risk and the trust's safeguarding lead confirmed that the changes to the trust's clinical assessment and management of risk policy were made in response to the independent investigation report on Mr S's care.

The trust's head of risk and the trust's safeguarding lead also told us that the clinical assessment and management of risk policy is disseminated to clinical staff through the trust's mandatory training in clinical risk assessment and management. Trust staff are required to complete this training after joining the trust and repeat it every three years thereafter. The trust monitors staff attendance at this training and reports attendance to the trust's human resources and workforce development report, which is then presented at a public board meeting.

The report for the November 2015 public board showed that the trust had achieved a staff-attendance rate of over 92 per cent in September 2015.

The head of safeguarding told us that the training covered all aspects of risk assessment and that trust MAPPA[3] awareness training that covered the management of sexual or violent offenders was included in this training. The safeguarding lead told us that this training included case studies and discussed the sharing of information and liaison with the police. The trust sent us an agenda for a MAPPA-awareness training day that confirmed this.

We asked for and the trust gave us materials used for this training. These confirmed the policy was discussed in detail in the course.

F1 The trust has amended key policies to inform staff when they can share personal patient information without the patient's consent.

F2 The trust's mandatory training programme ensures staff know these policies.

F3 The trust monitors staff attendance at these training programmes.

[3] MAPPA stands for "Multi Agency Public Protection Arrangements". MAPPA requires the local criminal justice agencies and other bodies dealing with offenders work in partnership to manage these offenders.

7. The implementation of recommendation 2 of the independent investigation

> "The trust should ensure that there are steps in place so that relevant staff in older people's services are able to gain advice and guidance from forensic services when needed"

The independent investigation found that the CMHT did not make a referral or seek advice from a forensic psychiatry service when they first learned of Mr S's previous conviction for violent assault from April 2011. Threats to kill are uncommon in people in their 80s, and even rarer in men over 80 with a past conviction for violence. Despite the rareness of such events, they are not unknown and therefore good practice is generally to seek advice from experts.

To gather evidence to ensure that the trust has implemented recommendation 2 from the independent investigation we:

- reviewed the trust's action plan; and
- interviewed the trust's head of risk with the trust's safeguarding lead for adults and children.

The trust's action plan says the trust has a forensic service and care pathway for referring patients to forensic services. We confirmed this in our joint interview with the trust's head of risk and safeguarding lead for adults and children. In this interview, the head of safeguarding told us the trust has a "Forensic Liaison Service" located in Bridgwater.

The trust's website also has details of the trust's forensic liaison team[4]. The website lists the functions of the team and these include providing "advice and consultation to professionals" and "specialist supervision of professionals".

The head of safeguarding told us that the safeguarding team delivered a bespoke MAPPA awareness training course to older adult community healthcare teams after the incident, as mentioned in the previous section. He told us this session included information on obtaining a forensic assessment. He also told us that staff from the older adult services who had not attended this session were booked onto generic sessions. The trust also sent us attendance sheets for MAPPA training days for the 13 June 2013 and 20 June 2013. These showed that a variety of clinical personnel had attended, including staff from older adult services.

The action plan from the independent investigation also says that the trust's intranet webpage, which offers advice to staff, had been updated to include "clearer information for staff considering referral or contact with these services". The trust's head of risk showed us the trust's intranet site and the section on forensic referral.

[4] See http://www.sompar.nhs.uk/what-we-do/mental-health/forensic-service/

The trust also sent us a copy of a “Non-routine information request (AdHoc)” that was sent to the trust’s information department by the directorate led for the trusts action plan following the independent investigation. The request was for a report on the number of referrals to the trust’s forensic service from April 2012 until August 2015 for patients aged 65 or over at the time of referral. The information request said information was needed:

> “In order to action a recommendation arising from a SIRI[5] involving [Mr S] that “the trust should ensure that there are steps in place so that relevant staff in older people’s services are able to gain advice and guidance from forensic services when needed.””

The information department was to disclose the information to the trust’s head of research & clinical effectiveness and a trust review officer. The trust’s head of risk told us that the feedback from the information request was that there had been no referrals to the forensic service from the trust’s community older adult services asking for advice and guidance on any patients of the service.

F4 The trust has a forensic liaison team which offers specialist supervision for other trust professionals.

F5 The older adult services have access to and have received training on how to obtain a forensic assessment of their patients.

F6 We found no evidence that the older adult community service has made a referral to the forensic service for advice and support for any of their patients.

Recommendation

R1 The trust’s chief operating officer should oversee an audit of which services have made referrals to the forensic service for advice and support since the independent investigation and what the outcomes for referrals were. The audit should take place in the trust’s next planned audit cycle after this report is published.

[5] SIRI stands for a Serious Incidents requiring Investigation

8. The implementation of recommendation 3

> "The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information."

Mr S was estranged from his wife and daughters, but the independent investigation found it would have been useful if his care coordinator had discussed whether Mr S wanted other family or friends to be involved in his care. The investigators recognised that Mr S may not have wanted anyone else involved, but we found no evidence the trust consulted him about this.

To gather evidence to assess whether the trust has implemented recommendation 3 from the independent investigation we:

- reviewed the trust's action plan;
- jointly interviewed the trust's head of risk and safeguarding lead for adults and children; and
- carried out a case review of a random sample of 10 patients receiving older adult services.

The trust's action plan for the independent investigation says:

> "The trust has reviewed its 'Personalised Care Planning Policy' and set audit standards for them. This includes involvement of carers and relatives in the patients care in community as well as inpatient settings. Audit results have improved significantly in 2013/14 and the trust has scored well in the 2013/14 Community Mental Health patient survey."

The personalised care planning policy was ratified in February of 2013 and was due for review in January 2016.

Care planning is the process that sets out how services will meet patient care and support needs. It involves the creation of a time-limited care plan that clearly specifies the steps that will be taken by services to address the patient's care needs. The trust policy instruction to staff say that staff should:

> "Ensure the patient's priorities and concerns have been identified and that [they] fully understand the patient's wishes. Establish with the patient and relative/carer (with patient's consent) how these can be best met by the services available, ensuring the individuals privacy, dignity, wishes, personal values and beliefs are respected at all times." (trust policy section 5.6)

The policy also says:

> "The care plan document must be accessible to the patient/ and to their relative/care when appropriate" (trust policy section 6.8)
>
> "The care planning approach will be adopted at each stage of the patients care within each service. It will therefore continue to be a live working document which will be regularly updates, and therefore reflect the changing needs over time." (trust policy section 6.9)

The policy sets out that services should monitor compliance through an audit process. The trust's director of governance and corporate development sent us a copy of the audit of personalised care plans in community services for January of 2014. This audit had been supervised by the trust's Director of Nursing and Patient Safety.

This audit of community services, including older adults, had twelve separate standards. Four of the standards are subdivided into elements, each of which was audited separately and then combined to give an overall score for the standard.

Standard 4 of the audit assessed the patient's plan of care and was divided into three elements. These were:

"The plan of care should:

a) Recognise patient's strengths;
b) Seek to promote recovery/independence; and
c) Be drawn up in consultation with the patient (and carer where appropriate)."

The guidance notes for this standard further explain that the care plan should be:

> "drawn up in consultation with the patient (and carer where appropriate). Where informed valid consent is gained. Where patients lack capacity, consultation may only be with the carer."

We therefore looked at the audit results for standard 4c in the audit report as evidence for compliance with the recommendation of the independent investigation.

The audit report gives an overall compliance rating for all trust services with standard 4c of 89 per cent.

The trust has five CMHTs for older adults based across the county. These are:

- Mendip Older People's Mental Health Service;
- Minehead Area Older People's Community Mental Health Service;
- Somerset Coast Area Older People's Mental Health Services;
- South Somerset Older People's Mental Health Service; and
- Taunton Deane Area Older People's Community Mental Health Service.

Compliance of the older adult CMHTs to standard 4c in the audit in January 2014 was:

Older persons CHT area	Compliance with standard 4c
Mendip	80%
Minehead	80%
Somerset Coast Area	100%
South Somerset	100%
Taunton Deane	100%

The community mental health team looking after Mr S was one of the teams with 100 per cent compliance.

The trust's head of risk and the safeguarding lead for adults and children told us that the audit gives the trust board data on the recording of identified carers for patients who are new to mental health services.

In the trust's performance report to the trust board, there are two measures about carers that are audited and reported. These are:

- "For new mental health clients, an identified carer who provides regular and substantial care must be registered"; and
- "where there is a registered carer, a carer's assessment has been offered and, if not declined, this has been carried out."

In the annual trust performance report to the trust board on 16 September 2014[6] these measures were reported without concern because they met the 90 per cent standard.

In July 2015[7] identifying carers for new patients was reported to the board as being below the compliance target of 90 per cent.

Page 6 of the performance report says:

> "Of a total of 466 clients identified as having a carer, there were 49 clients where recording of the carer's details had either not been finalised with an onward referral to the carer's assessment service (32 cases), or details of the carers had not been formerly been registered (17 cases). Details of all 49 cases have been passed to the relevant heads of division for records to be reviewed and updated."

However, the same report also noted good performance for the measure for carers who had been identified receiving a carer's assessment:

[6] See http://www.sompar.nhs.uk/media/1377/enclosure-g-performance-report.pdf

[7] See http://www.sompar.nhs.uk/media/1271/enclosure-h-performance-report-july-2015.pdf

> "Where there is a registered carer, a carer's assessment has been offered and, if not declined, this has been carried out. A rate of 98.4 per cent was recorded during June 2015, against a compliance rate of 95 per cent or more." (performance report page 1)

The trust's action plan for the independent investigation also says that the trust has "developed its Patient and Public Involvement Strategy to enhance working partnerships with families and carers". The trust's head of risk told us that the trust had previously carried out other work on carer inclusion in services across the trust. She told us the trust had formed "a triangle of care" steering group in 2013 to help improve the inclusion of carers. The triangle of care[8] is a carers trust accredited national initiative that aims to improve carer inclusion in mental health services. The initiative involves services carrying out a self-assessment of carer inclusion to obtain a baseline. Good practice guidelines are also included for services to introduce positive carer inclusion.

The trust's head of risk told us that this work was built on previous good practice in the trust regarding family or carer inclusion. A search on "google scholar" we conducted found a series of publications[9] from clinicians in the trust that supported this view, including specific initiatives for older adult in-patient services.

The trust sent us the care quality commission's survey of people who use community mental health services for 2014. The survey is used as a benchmark of the quality of care for mental health trusts. It asks patients across all trusts a range of questions, including:

> "Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?" (Question 37)

The trust score for this question was 7.2 out of 10. Scores ranged from 5.9 to 7.6, making the trust one of the highest scoring. However, given the context of the recommendation, it should be noted that the CQC:

> "excluded people who said that 'my friends or family did not want to be involved', that they 'did not want my friends or family to be involved' or that 'this does not apply to me'."

Of the 263 individual patients that responded to the CQC Survey, 186 (71 per cent) gave a response to the question.

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[8] See https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health?gclid=Cj0KEQjw7-K7BRCkkIH3t_WwoskBEiQAD8oY3tav7-5-7WtMVPvX7lvgwxHeIFScsgq_X5qsCHZLUyQaAg9l8P8HAQ

[9] See http://www.swscn.org.uk/wp/wp-content/uploads/2015/12/ToC-Somerset-MH-Alliance-SW-30-4-14-Add-to-agenda-MHIG-1.pdf and http://onlinelibrary.wiley.com/doi/10.1111/j.1467-6427.2012.00584.x/full

We also carried out our own case review of a random sample of ten patients of the trust's older adult community services. To do this, we asked the trust for and received a list of all known clients of the older adult community services. From this list we randomly selected a sample of ten patients who were receiving care from the trust at the time of our investigation.

The case review examined the selected patient's electronic notes to assess if they had:

- a clear record of latest clinical reviews;
- that this included the people present at the review; and
- that this included the discussion and the outcomes of reviews.

We conducted the case review on 10 March 2016. Seven of the patents had a main carer, family member or members involved in their care. For the other three, staff had considered or discussed carer or family involvement with the patient but they were either estranged from their family or had no known living relative.

In six of these seven cases with carers, reviews were fully up to date. They also included the carer or family view about the patient's care and we found evidence that the carer or family view had been taken into consideration in previous reviews. In the one case, the meeting planned to review care had not taken place and was overdue, but previous meetings had taken the carer or family view into consideration.

F7 The trust monitors the inclusion of carers for new patients to services.

F8 The trust's older adult services comply with local standards on carer inclusion.

F9 The trust has a record of good practice in carer inclusion.

F10 The case review carried out for this review showed that, for all ten patients, staff had considered family or carer involvement and that, where possible, discussions with carers had happened.

9. The implementation of recommendation 4 of the independent investigation

> "The trust should carry out an audit to ensure that accurate records are kept of all clinical reviews including the people present, the discussions and the outcomes of reviews."

Prior to the independent investigation, the trust carried out its own serious incident review. This found that although the older adult community clearly reviewed Mr S's care on several occasions there was no evidence in his clinical record of a review taking place where all those involved in his care were able to have a face-to-face discussion. As a result of this finding, the trust sent a memo out to clinical team leaders reminding them of the need to record all those present at a patient's clinical reviews.

The subsequent independent investigation agreed with the findings of the trust's serious incident review and found that the recommendations and actions from the internal investigation report had been implemented. However, it found that in addition to the memo, there should be an audit to ensure accurate recording of the people present at clinical reviews, as well as documenting the discussions and outcomes of the reviews.

To gather evidence to assess whether the trust has implemented recommendation 4 from the independent investigation we:

- reviewed the trust's action plan;
- interviewed the trust's head of risk with the trust's safeguarding lead for adults and children; and
- carried out our own case review of patient's electronic records.

The action plan says that the trust carried out a check of patients' care planning approach (CPA) reviews recorded on the trust's electronic patient record. This check was separate to the trust's planned audit programme. The action plan says this check examined 885 CPA reviews during May 2014 to see if the records noted the participants at reviews.

The action plan said that of the 885 records, 13 per cent had not correctly identified the people who attended the review. We were sent the spreadsheet of this review and noted that 104 of the sample were from the trust's older adult community services. However, the spreadsheet does not identify which services had not correctly identified the people who attended the review.

The action plan says that the review did, however, result in an action plan being "developed and monitored through the older people's community mental health best practice group."

To make our own assessment of the records we considered the case notes of a random sample of ten patients, as already described above. The results of our case review are in Appendix B.

We found that, for all ten patients the participants of the CPA review were clearly recorded and that all ten records documented the discussion that took place with the family or carers. There was also clear recording of the outcomes of reviews. We found that, for one client, a planned CPA review meeting was overdue, but there was evidence of ongoing progress notes and summaries of care for this patient and previous care records clearly recorded attendees, discussion and outcomes for reviews when they occurred.

F11 The trust carried out a check of staff's recording of attendees at patient care programme reviews across all services

F12 The check indicated that staff recorded attendees at 87 per cent of patient care programme reviews.

F13 Our own case review showed there was a good standard of recording attendees, discussions and outcomes of patient reviews for the older adult community services.

10. The implementation of recommendation 5 of the independent investigation

> "The trust should have a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:
>
> - are provided with and consulted on the terms of reference of the trust internal investigation;
> - know how they will be able to contribute to the process of investigation; and
> - receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information."

The National Patient Safety Agency[10] good practice guidance *The investigation of serious patient safety incidents in mental health services* (2008) says that mental health trusts should provide an opportunity for the victim and their family to meet senior, appropriately experienced staff from the trust. Family involvement in the investigation process can be discussed at this meeting. The guidance also says that families should be consulted on the terms of reference for both internal and independent investigations, be provided with the terms of reference, and be informed how they could contribute to the investigation, for example by giving evidence. Subsequently, the findings of the internal investigation and the actions to be taken should be discussed with them.

The NPSA *Being open guidance: communicating patient safety incidents with patients, their families and carers* (2009) says that being open about what happened and discussing incidents promptly, fully and compassionately can help families to cope better with the after-effects.

Since the independent investigation report in 2014, the government has also introduced the "duty of candour" regulation as part of "The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014"[11].

The intention of the duty of candour regulation is to ensure that providers such as the trust, are "open and transparent" about patients' care and treatment. It also sets out specific requirements that must be followed when things go wrong with care and treatment. These include that "relevant people" such as victims' families should be given reasonable support, provided with accurate information and an apology when things go wrong.

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[10] The NPSA were described as an "arm's length" body of the Department of Health who provided guidance on patient safety. See http://www.npsa.nhs.uk/

[11] See http://www.legislation.gov.uk/uksi/2014/2936/contents/made

To gather evidence to assess whether the trust has implemented recommendation 5 from the independent investigation we:

- reviewed the trust's action plan; and
- interviewed the trust's head of risk with the trust's safeguarding lead for adults and children.

The head of risk and the safeguarding lead for adults and children told us that it has carried out work since the independent investigation to review the trust's "Being Open" policy. The director of governance and corporate development led the review.

As a result, the director of governance and corporate development oversaw the development of trust specific "Guidance on Working with Families after a homicide". The head of risk developed this guidance and it was ratified by the trust's Senior Mangers Operational Group in August 2015 as part of the trust's new "Being Open and Duty of Candour Policy". Therefore, although the guidance is a standalone document, it is also appendix G of this "Being Open and Duty of Candour Policy".

The head of risk told us that, in developing the guidance, the charity "hundred families" advised the trust. This charity supports families affected by homicides that mental health patients have committed.

Hundred families had directed the trust to work they had undertaken with a neigbouring trust, Avon and Wiltshire Partnership NHS Trust. The trust sent us a copy of this trust guidance. It says the trust provides workers to support families independently of investigations. The section on the identification of "Trust Family Workers" says:

> "The Trust Family Workers could be of any discipline but it is most likely to be a senior manager or senior clinician from within the Strategic Business Unit. Thoughtful consideration and sensitivity will need to be given to the identification of this person who should:
>
> - have sufficient authority to reassure the families on any internal investigations which will take place and explain the processes to them;
> - not be a person who could be the focus of anger from the relatives or may be implicated by the families in a complaint; and
> - genuinely be in a position to offer support, without experiencing any conflict due to other responsivities they may hold."

The guidance recognises that the trust needs to provide two such workers: "one to support the family of the victim and one to support the family of the perpetrator."

These workers meet the families, record their concerns and make sure these are addressed in the trust investigations.

Although the guidance does not specifically say that families will be provided with and consulted on the terms of reference of the trust's internal investigation, it does say the workers will:

> “Guide the family through the Trust’s internal investigation process, based on what they would find mist helpful. A root cause analysis investigation will always be undertaken in respect of a homicide and the families should be encouraged to, and advised on, how they may contribute to the investigation.”

The workers should also:

> “Ensure that the chair of the root cause analysis investigation is kept informed of the key issues that the family want to have addressed and convince meetings as required and requested by the family.”

The head of risk told us that this would include having access to and informing the terms of reference.

The guidance also says that “once the root cause analysis investigation has been completed, the report should be shared with the families”. We also found guidance on how to conduct a post-investigation meeting with the families where the trust shares the findings of the investigation, listens to further concerns from the family and plans for the report to be finalised and a hard copy given to the family.

The guidance also details the skills and training the trust family workers should have, how they should conduct meetings with families, how they should help the families to identify, articulate and resolve concerns they have in connection to the care the trust provided and gives an overview of what resources are available to support families and how to access them.

The guidance also outlines how the trust family workers should interact with family liaison officers the police provide and also how they should assist families through subsequent independent homicide investigations that NHS England commissions. The head of risk told us that the trust was considering making the family worker roles permanent positions because of time frames from initial homicide, police investigation, trust investigation and then independent homicide investigation are often long.

With regard to interactions with the police, the head of safeguarding told us of the “Somerset Safeguarding Hub”, which is an interagency group made up of individuals from the police, local authority social services and the trust. This group meets regularly and had, he felt, created a communication centre for all three agencies. As a result, the trust has a good working relationship with the Somerset police. Both the trust and Somerset police headquarters are located in the same business park. The safeguarding lead said that meant that face-to-face meetings between trust and police staff were easy to arrange.

The head of risk also told us that the guidance had been launched at a special event on 19 February 2015 and that the event had included a presentation on behalf of family victims by the founder of “Hundredfamilies.org.”

We therefore found that the trust guidance adhered to the NPSA good practice guidance, the “duty of candour” regulation and we considered the development of “guidance on working with families after a homicide” to be good practice.

F14 The trust has produced “guidance on working with families after a homicide” which addresses the recommendation of the independent homicide investigation and complies with government regulation on the “duty of candour” and is good practice

Appendix A

Amended ORGANISATIONAL ACTION PLAN: Actions completed September 2014

Lead for Organisational Action Plan

Key Date	Comments
3 September 2014	Draft action plan developed following the issue of the final version of the independent investigation report.
15 September 2014	Draft action plan revised following discussion with Somerset Clinical Commissioning Group
18 September 2014	Action plan approved by SIRI Group
12 November 2015	Review by Head of Risk

Recommendation Identified in Overarching Repot Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible	Target Date for Completion	RAG Rating See Key
Specific	Measurable	Specific and Achievable	Realistic		Timebound	
The Trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is a known risk from that service user	Revised policy approved and ratified Training delivered to relevant staff. This will include guidance that: 1) If staff become aware of a potential risk from a service user to another individual, staff must consider whether it would be reasonable and appropriate to share that information with the subject of the potential risk. 2) When considering whether it is reasonable and appropriate, staff must conduct a balancing exercise between the potential or actual risk and the service user's right for their sensitive personal information to be kept confidential. This will include considering the level and nature and likelihood of the perceived risk along with a potential impact on the service user. Each and every case must be considered on its own merits taking	The Trust policy on Confidentiality and Data Protection has been reviewed since the incident. The wording on disclosure without consent has not been changed but learning from the incident will be included in future training for clinical and records management staff to inform decisions where disclosure may be deemed necessary to prevent crime or harm.	The Trust will need to consider each instance as an individual case and act within the bounds of the Data Protection Act 1998 and other relevant legislation regarding patient confidentiality.	Information Governance Manager	31 December 2014	

	into account all relevant information available. 3) The staff member should consider whether it would be appropriate to obtain the consent of the service user for the disclosure. In doing so they would need to consider whether seeking consent would unnecessarily increase the presenting risk. 4) The rationale and outcome of the decision must be documented. 5) If there is any doubt whether the disclosure should take place, a senior member of staff should be consulted and, if necessary, legal advice sought.					

How (and to whom) have the lessons learnt relating to the recommendations above been disseminated

- Policy update advised to all staff through "What'sOn"
- SIRI Review Group

Evidence provided by the Trust

1. Data Protection and Confidentiality Policy
2. Clinical Assessment and Management of Risk Policy
3. Mandatory training achievement report
4. Practitioner Training in Clinical Risk Assessment and Management Slides September 2015

Recommendation Identified in Overarching Repot Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible	Target Date for Completion	RAG Rating See Key
Specific	Measurable	Specific and Achievable	Realistic		Timebound	
The trust should ensure that there are steps in place so that relevant staff in older person's services are able to gain advice and guidance from forensic services when needed	Referral form Training delivered	The Trust has in place a forensic service and a care pathway for referral to out of county forensic advice. The trust has introduced a training programme for staff in older person's services about the forensic team and the Multi-agency Public Protection Arrangements (MAPPA) process and how to access MAPPA via the trust safeguarding team. The trust has revised the MAPPA section of the Trust intranet site to include clearer information for staff considering referral or contact with these services	None identified None identified	Chief Operating Officer MAPPA Lead	Achieved Achieved	

	Intranet site updated		None identified	MAPPA Lead	Achieved	

How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:

- Staff in Older People's Mental Health services
- MAPPA and Safeguarding teams

Evidence provided by the Trust

1. MAPPA Awareness Training attendees
2. MAPPA Training Day Programme Blank.doc
3. Forensic Inquiry form

Recommendation Identified in Overarching Repot Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible	Target Date for Completion	RAG Rating See Key
Specific	**Measurable**	**Specific and Achievable**	**Realistic**		**Timebound**	
The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen	Policy in place Training package and attendance records Patient survey feedback	The Trust has developed its Patient and Public Involvement Strategy, incorporating its strategy to 'Enhance Working Partnerships with Families and Carers' The Trust is accredited by the Carers Trust for its Triangle of Care approach and provides a three-day whole-team training package to staff in all of its mental health inpatient wards and community mental health teams. The Trust was awarded a 'gold star' (only the second Trust in the country) for its implementation of the scheme.	Patients (and carers/families) may not always be willing or able to engage	Patient Experience Manager	Achieved	

only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information		The Trust has reviewed its 'Personalised Care Planning Policy' and set audit standards for them. This includes involvement of carers and relatives in the patients care in community as well as inpatient settings. Audit results have improved significantly in 2013/14 and the Trust has scored well in the 2013/14 Community Mental Health patient survey.	Patients (and carers/families) may not always be willing or able to engage	Head of Clinical Audit	Achieved		

How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:

- Policy update advised to all staff through "What'sOn."
- Standards and audit outcomes shared through Best Practice groups.
- Triangle of Care principles and approach shared with all mental health professionals, patients and carers

Evidence provided by the Trust

1. Care Planning Audit
2. Personalised Care Planning Policy
3. Patient and Public Involvement Strategy
4. Care Quality Commission Community Mental Health Patient Survey results (2014)

Recommendation Identified in Overarching Repot Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible	Target Date for Completion	RAG Rating See Key
Specific	**Measurable**	**Specific and Achievable**	**Realistic**		**Timebound**	
The trust should carry out an audit to ensure that accurate records are kept of all those present at service users reviews	Completion of audit and analysis Action plan to address any areas of improvement required	Commission an internal report looking at Care Planning Approach (CPA) Reviews recorded on RiO, the electronic patient record. The review covered 885 CPA reviews during May 2014. Initial review indicates that 13% of those reviewed did not include full details of who attended. An article will be published in What'sOn raising awareness of the need to record these accurately and a further review will be scheduled to identify improvements. There will be a review of audit arranged for the new year and the results of this audit have been shared with OPMH teams	None identified	Investigating Officer	31 May 2014	

		An action plan developed and monitored through the Older People's Community Mental Health Best Practice Group	None identified	Head of Inpatient Mental Health and Crisis Services	31 Dec 2014		

How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:

- All mental health inpatient and community care co-ordinators and other staff responsible for recording CPA reviews on RiO

Evidence provided by the Trust

1. Care Planning Approach (CPA) Reviews (Spreadsheet)
2. Recovery Care Programme Approach Policy (September 2012 – August 2015)

Recommendation Identified in Overarching Repot Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible	Target Date for Completion	RAG Rating See Key
Specific	**Measurable**	**Specific and Achievable**	**Realistic**		**Timebound**	
The trust should ensure that it has a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:	Revised policy in place and implemented Agreement and publication of guidelines Awareness raising event	Review the 'Being Open' policy to include guidance for staff on communications and support for families of victims	The policy will need to go through the Trust approval and ratification process and be disseminated in December 2014.	Director of Governance and Corporate Development	30 November 2014	
		Work with hundredfamilies.org on development of guidelines and approaches for staff as part of the investigation process	None identified	Head of Risk	31 December 2014	

• are provided and consulted on the terms of reference of the trust investigation • know how they will be able to contribute to the process of investigation and • receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information	Agreement with Avon and Somerset police	Work with hundredfamilies.org to undertake an awareness raising event around the communications and support for families during investigations	None identified	Patient Experience Manager	31 March 2015		
		Work with Avon and Somerset police to agree a protocol for communications and contacts with families of victims during and after police investigations Information Sharing Protocol developed for the Multi Agency Safeguarding Hub and wider Information Sharing Protocol in place. Update November 2015 - There is an information Sharing Protocol specific to the MASH and the Somerset overarching one that the trust are signed up to- this process could be used as a starting place for communications with Police	This will rely on agreement and cooperation of the police and regular liaison with regard to any implementation. This may be affected by the individual circumstances of any case.	Head of Risk	30 November 2015		

How (and to whom) have the lessons learnt relating to the recommendation above been disseminated: • Policy changes will be advertised to all staff through What'sOn and local team briefs • Awareness event with onehundredfamilies.org held in February 2015
Evidence provided by the Trust 1. "Hundred Families" guidance document (shared through Avon and Wiltshire Partnership NHS Trust) 2. Being Open and Duty of Candour Policy 3. Information Sharing Protocol 4. Joint Safeguarding Adults Policy

Key to RAG Rating:

Green	**Green**	Achieved
Green	**Amber**	Work is in progress in line with target date
Amber	**Amber**	Initial work has commenced appropriate to target date
Amber	**Red**	Minimal or no work has commenced in this area due to the long lead time
Red	**Red**	Actions have not been achieved by the target date
Grey	**Grey**	Responsibility allocated to agencies outside of the Trust

Appendix B

Verita Audit of Somerset Partnership NHS Foundation Trust Older Adult Services records: Patients randomly selected from a database supplied by the trust:

The trusts electronic records (Rio) accessed on 3 March 2016.

No	Patient	Type of review	Clear record review (s)?	Includes people present? (Evidence of carer/family inclusion)	Included the discussion and the outcomes?
1	75 year old male referred by GP for assessment	Assessment and outpatient follow ups	**Yes**	**Yes.** Includes details of when wife present and discussions with wife including her views. (Evidence of current and previous discussions with family.)	**Yes** Trust doctor making entries and includes outcome and action following risk assessment
2	76 year old female resident of a care home	Review of care with care home staff Latest review in care	**Yes** Includes downloads	**Yes** (Patient has no known family)	**Yes** Includes details of risks

		home June 2015	of Care Home documentation		(falls) and actions.
3	87 year old female under CPA	CPA review CPA review in January 2015 and August 2015	**Yes** Included updated care plan and risk assessment	**Yes** Care coordinator, family carer and a friend. (Evidence of current and previous discussions with family.)	**Yes** August review included update of plan made in January.
4	81 year old male initially admitted and then discharged under CPA.	CPA review CPA and 117 review August 2015	**Yes** Included section 117 review	**Yes** Care coordinator, GP and patient all present. (Patient estranged from family)	**Yes** Detailed record of discussion and plans.
5	87 year old female under CPA	CPA review CPA review in May 2015	**Yes**	**Yes** Patient, care coordinator and care worker. (Patient estranged from family)	**Yes** Details brief, but patient stable and care ongoing.

6	82 year old female resident of a care home and under CPA.	CPA review CPA review in May 2014 but no review for 2015	**No -** CPA review now overdue	**Yes** for previous reviews but CPA review overdue. (Evidence of previous discussions with family in May 2014.)	**Yes** for previous reviews but CPA review overdue
7	99 year old female under CPA and resident in an out of area care home due to special needs.	Out of area CPA review[12] with care home CPA reviews in May 2014 and June 2015	**Yes** Review with care home included care home documentation	**Yes** Care coordinator, care home staff and family. Daughters comments on care also recorded (Evidence of current and previous discussions with family.)	**Yes** Detailed care plan from care home.
8	86 year old female under CPA	CPA review CPA reviews in May 2014 and April 2015	**Yes** Patient has long history of psychosis	**Yes** Care coordinator, patient and main family carer (husband)	**Yes** Included care plan and risk assessment update.

[12] "Out of Area" means that the patient was being treated in a non-trust service (i.e. a specialist service e in a private healthcare facility) , but that the trust retained responsibility for care.

			and records reflect long term care.	(Evidence of current and previous discussions with family.)	
9	84 Year old male under CPA	CPA review CPA reviews in May 2014, February 2015 and March 2015	**Yes**	**Yes** Patient, care coordinator and main family carer (son). (Evidence of current and previous discussions with family.)	**Yes** Minimal progress notes, but additional notes and letters uploaded
10	82 year old male resident in a care home	Review of care with care home staff Review in May 2014 and May 2015	**Yes**	**Yes** Care coordinator, care home staff and main family carer (wife). Wife comments on care also recorded. (Evidence of current and previous discussions with family.)	**Yes** Detailed care plan from care home.