

External Investigation

into the Case of

Mrs G

Incident date: 4 September

2010

Author:

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Associate Caring Solutions (UK) Ltd



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EXECUTIVE SUMMARY

1. Incident description and consequences

1. On the 4th September 2010 Mrs G stabbed her husband Mr G in the chest at their home. He died from his injury.
2. At the time of the incident Mrs G was a 68 year old female, married to Mr G who had advanced Parkinson Disease.
3. In March 2006 Mr G had disclosed to Mrs G that 15 years previously he had an affair with her close friend. Following the disclosure significant marital problems developed which led Mrs G to needing periodic support from Surrey & Borders Partnership Foundation Trust and the Primary Care Mental Health Team Services. This occurred between 2006 and 2010.
4. Both Mr G and Mrs G were also known to Surrey County Council. Mr G was subject Surrey County Council to Safeguarding Adult Procedures in October 2006 and 2009.
5. Following the incident Mrs G was arrested and charged with causing the death of Mr G.

2. Background and Context

1. Mr G and Mrs G were married and lived together. They had an adult son and daughter, both married. The daughter lived locally with her husband and children, the son lived for a time in the USA. Mr G had a diagnosis of Parkinson's disease and was under the care of a Neurologist at University College London. Mr G had care management support for his condition from Guildford Social Care team.
2. In March 2006 Mr G disclosed to Mrs G that 15 years previously he had had an affair with her best friend. Mrs G found this difficult to accept and subsequently struggled to manage her anger whilst continuing to care for Mr G in the family home. Mrs G also struggled with fluctuating excessive alcohol consumption following the disclosure.
3. In May 2006 Mrs G was referred to Guildford Community Mental Health Team by her General Practitioner following a report from Mr G's that she was threatening suicide and had taken a combination of tablets with alcohol.
4. Following this contact Mrs G had sporadic contact as a patient with several mental health services within Surrey and Borders Foundation Trust from 2006 – 2010. The level and detail regarding each contact is set out as a timeline in Appendix 1.
5. Both Mr G and Mrs G were also know to Surrey County Council as Mr G was subject to Surrey County Council Safeguarding Adult Procedures in October 2006 and 2009, following threatening behaviour from Mrs G. Documents also show that Mr G accessed planned respite care with Surrey Social Services. Mr G and Mrs G were carers for one another. Mrs G due to Mr G's Parkinson's disease and Mr G due to Mrs G's mental health issues.
6. On the 6th September 2010 the Social Care team received notification that on the 4th September 2010 Mrs G had assaulted Mr G by stabbing him in the chest, tragically Mr G had died.

3. Terms of Reference

NHS South of England – the Strategic Health Authority - has set the following objectives for the external investigation which overall requires the external investigation to focus on Mrs G's contact, care and treatment with Surrey & Borders Partnership Foundation Trust FoundationTrust.

3.1 Objectives

1. To review the Trust's internal investigation and report to assess the adequacy of the findings, recommendations and action plan.
2. To review the progress made by the Trust in implementing the action plan arising from the internal investigation.
3. Assess the adequacy of risk assessment and consideration of safeguarding issues.
4. Consider such matters as the public interest may require
5. Complete an Independent desktop review report for presentation to NHS South East Coast within 12 weeks of commencing the investigation and assist in the preparation of the report for publication.

3.2 Key Questions

The key questions addressed within the external report and developed from the terms of reference are as follows:

1. Was the Trust's internal investigation adequate in terms of its findings, recommendations and action plans?
3. What progress has been made by the Trust in implementing the action plan arising from the internal investigation?
4. Are the Trust's systems adequate in terms of risk assessment and consideration of Safeguarding issues?
5. Are there public interest matters that need to be considered?

4. Level of Investigation

1. The investigation is a level 3 Independent Investigation

5. Findings of the External Investigator

1. The internal report clearly identifies the investigation team, the author and those involved in providing expert opinion.
2. The internal report was completed in a timely manner taking into account the review process being delayed due to a Police Investigation.

3. ¹A Root Cause Analysis approach was taken and the findings from this are clearly set out under the headings Root Cause factors & Contributory factors.
4. The analysis of information was completed and this included using tools such as a ²fish bone diagram ' also known as 'The Cause & Effect Diagram'. The process led to relevant and comprehensive recommendations and action points.
5. An extensive chronology of events is described from Mrs G's first encounter with the services. This includes information received from the Police and the General Practitioner when involved.
6. All areas of concern detailed within the report are based on fact and findings. Conclusions are clearly linked to evidence and relate back to the terms of reference. Recommendations are clearly linked to conclusions and findings.
7. A clear and well structured Executive Summary is provided at the front of the internal report. The headings within the report however are not numbered and there is an overuse of bullet points. Headings and paragraphs should be numbered to aid referencing.
8. A clear internal action plan has been developed from the recommendations. This is monitored via the Trust Scrutiny Panel which oversees the management and learning from all Serious Incidents.
9. The internal report identifies all reported episodes of actual and threats to self harm, however fails to address the clinical management of self harm in line with ³NICE Guidelines for Self Harm management (2004) and amended (2011).
10. Mrs G's behaviour in the community was clearly erratic and at times risky, although the Police were involved there is no evidence that Police Liaison Policies and Procedures were examined as part of the review.
11. There is no evidence that staff training was examined as part of the review although there is a recommendation stating that staff have a working knowledge of the Safeguarding Adult Procedures and a recommendation that staff have a working knowledge of the Carer's Assessment Procedure.
12. The suitability of Mrs G's care and treatment was examined. As set out in the chronology Mrs G threatened or actually self harmed, she also misused alcohol. These are not included as contributory factors, neither has a recommendation has been made with regard to her clinical management within these two areas.

¹ National Patient Safety Agency (NPSA) Root Cause Analysis Toolkit (January 2004)

² The Fish Bone Diagram was first used by Dr. Kaoru Ishikawa of the University of Tokyo in 1943 - This diagram is used to identify all of the contributing root causes likely to be causing a problem.

³ 'The short to long term physical and psychological management and secondary prevention of self harm in primary and secondary care'

13. The findings highlight system failures, particularly within Older Persons Community Mental Health Team. This raises a question about the effectiveness of clinical leadership.
14. The internal report sets out specific interventions within each service Mrs G was involved with and specifically highlights the lack of shared information across each service within Surrey and Borders Partnership Foundation Trust.
15. The internal report identifies that significant others (husband, children) were not involved in Mrs G's core assessment or risk assessment processes. This has not however, been translated to a recommendation. Whilst there is a recommendation in relation to staff having a working knowledge of the ⁴Carer's Assessment Procedure, this alone would not automatically ensure that staff involve significant others in assessment and care planning processes, or that they receive the support they need in order to take up the carer role.
16. On the 10.09.06 Mrs G took an overdose and then later in the day she set light to her summer house with herself in it. The internal report rightly states that the Community Mental Health Team duty assessment fails to identify the escalating risk, however does not include consideration of a referral, at that time to the Surrey County Council Safeguarding Team.
17. The internal report found there was no formal discharge letter from Older Persons Mental Health Team to the General Practitioner. However there is a recommendation that Older Persons Mental Health Team must update their discharge procedure to include sending a discharge summary to the General Practitioner.
18. There is evidence that staffing was considered in relation to the waiting time for psychology services, there is a recommendation to require a review of psychology input to the team.
19. Whilst there is more than one agency or service involved in a person's care there is no objective within the terms of reference to review communication, working practices and protocols across all services.
20. The internal report terms of reference which requires the reviewer to examine Mrs G's treatment, care and management did not include, as a context, 'against local and national policies and procedures'.
21. A member of the Surrey County Council Safeguarding team was not interviewed as part of the review process even though Safeguarding was a concern raised and considered due to Mrs G's risk behaviour towards Mr G.
22. The prevalence of self harming and alcohol misuse is stated throughout the chronology. These were not included as contributory factors within the internal report, even though Mrs G's lack of control and her escalating risk are associated with alcohol misuse.

⁴ Carers Assessment - Carers Equal Opportunities Act 2000 - duty to inform Carers of their right to an assessment

23. There is no recommendation within the internal report to explore staff awareness and consequent management with regard to self harm and alcohol misuse, though these were both prevalent factors of Mrs G's clinical presentations.
24. The adequacy of risk assessment and management was examined. The findings from the internal report showed that the Trust does have a Risk Assessment Tool but there was an inconsistency in information reported. This has been addressed by the development of standard agendas for clinical meetings which includes a section to discuss all new referrals.
25. The clinical response to the various risk incidents were not robust, for example the Duty Service failed to identify an escalating risk, particularly following the fire incident in 10.09.06. There is now an internal protocol for the Duty Service to address this and the Trust has a Clinical Risk Management Policy which was reviewed in May 2012.
26. Mrs G only engaged with services when in crisis and only for short periods. This is referred to within the internal report as 'all teams appeared to be more focussed on short term crisis management plans and did not work with Mrs G to formulate a longer term risk prevention and management plan'. This clinical practice has been addressed via the internal report action plan.
27. The Trust has now raised awareness in relation to Safeguarding via the Safeguarding Policy and staff training. This is evidenced via the Trust internal action plan.
28. There were many services within and external to the Trust involved with the care of Mrs G and/or Mr G. Ensuring robust and effective communication across all services involved with their care has not been established within the internal review process.

6. Contributory/Associated Factors

The findings of the external investigation does determine that, whilst the Trust has addressed key areas, there are several contributory factors which affected the delivery of safe and effective care to Mrs G and Mr G. These factors are:

Patient:

1. Mrs G had been supported by the Trust services since her husband disclosed in 2006 that he had an affair with her close friend 15 years previously. Following the disclosure significant marital problems developed which led to Mrs G needing support from the Trust's services at times.
2. In times of crisis Mrs G did self harm and/or carry out other behaviour which put both herself and at times Mr G and others at risk.
3. Mrs G failed to engage long term in any service offered to her by the Trust. She presented mainly in crisis and although was offered follow up did not take up the offer.
4. Mrs G often abused alcohol and many of her risk behaviours were carried out when she was under the influence of alcohol

5. Mrs G was the carer for her husband Mr G which at times she resented following his disclosure of infidelity.

Carer:

6. Mr G had advanced Parkinson's disease however was not offered a Carer's assessment which could have addressed his needs and given him support
7. There is no evidence that Mr G or their daughter were involved in Mrs G's core assessment or risk assessment processes. Neither did they contribute to providing any social or risk history on the part of Mrs G.

Communication:

8. There were failures in relation to sharing Mrs G's clinical history information during the periodic contact Mrs G had with the Trust, in particular her mental state; clinical and risk history. This is both across the Trust's services and across other services where Mrs G and/or Mr G were known.

Risk management:

9. There were failures in relation to risks being documented, escalated appropriately and/or shared across teams and services. This did not allow a comprehensive understanding by all services of the risks Mrs G posed to herself and Mr G. Whilst Mrs G presented in crisis several times there is no evidence that her risks to self or others was reviewed other than to manage the current crisis.

Safeguarding:

10. Whilst Mr G would have been considered vulnerable as he had advanced Parkinson's disease, there is no evidence that his safety was considered by Surrey and Borders Partnership Foundation Trust staff, even though there are several entries regarding Mrs G's extreme behaviour when in crisis.
11. There is no evidence that staff worked with the Safeguarding team within Surrey County Council to share information and develop a joint management approach to both Mrs G and Mr G.

Clinical leadership:

12. The findings from the internal review noted several system and clinical care failures which raises the question about the robustness of clinical leadership. Effective clinical leadership ensures that clinical practice delivers best care within a sound and effective system.

Documentation:

13. There is evidence that information was not always correctly completed and that discharge summaries were not sent to the General Practitioner. This potentially led to relevant clinical information not being available to other teams and/or services to support clinical decisions.

7. Root Causes/Causal factors

1. The external investigation has determined that there is no one fundamental contributory or causal factor. From 2006 to 2010 Mrs G had at times exhibited unpredictable and impulsive risk behaviour, usually when she had misused alcohol. Whilst Mr G was vulnerable and had previously been at risk as a result of Mrs G's impulsive risk behaviour; there is no evidence to suggest that she planned to harm him. Her risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that she would have killed her husband.

8. Lessons Learned

1. The internal report covered many lessons learned and have developed recommendations in relation to:
 - a. Improved Duty systems
 - b. Updating knowledge on safeguarding and working with Safeguarding teams as appropriate.
 - c. Improved systems to allow clinical risk concerns to be discussed and escalated as needed.
 - d. Information sharing and documentation.
 - e. Staffing levels in relation to Psychology input
 - f. Carer Assessments.
 - g. Clinical supervision
 - h. Communication with the General Practitioner.
 - i. Improved systems to review patients on waiting lists.
2. The findings were developed into recommendations which have been followed up as part of a Trust internal action plan.
3. The external Investigation adds:
 1. The recommendation in relation to staff having a working knowledge of Carers assessment should be developed further to include staff involving Carers in all aspects of assessment and care planning.
 2. The recommendation in relation to staff attending safeguarding meetings should be expanded to ensure clear and effective communication systems for all services involved in the care of a patient and where appropriate significant others and an assurance that staff are actively involved in all relevant aspects of the safeguarding process.
 3. Clinical Trust Staff having a working knowledge of alcohol misuse management

4. Clinical Trust Staff having a working knowledge of the management of self harm, particularly where this is part of a crisis clinical presentation.
5. Clinical Practice and policies to comply with National Policies and Procedures
6. Police Liaison Policies and Protocols are examined to ensure their effectiveness and staff compliance.
7. Clinical Leadership to be reviewed to ensure it is effective and accessible to all relevant staff.

9. Recommendations

1. Internal review terms of reference involving serious incidents to have an objective to compare clinical practice against national and local policies
2. The recommendation in relation to Carer assessments to be expand to ensure Carers are included in all aspects of clinical assessments and care planning.
3. The recommendation in relation to staff attending safeguarding meetings should be expanded to ensure clear and effective communication systems for all services involved in the care of a patient and where appropriate significant others.
4. A further safeguarding recommendation to ensure staff are actively involved in all relevant aspects of the safeguarding process
5. Police Liaison Policies, Procedures and staff compliance to be reviewed.
6. Clinical Leadership to be reviewed to ensure it is effective and accessible to all relevant staff.
7. A review to be carried out to assess clinical staff understanding and management of both alcohol misuse and self harm behaviour and management.
8. The internal action plan to continue to be monitored to ensure the Trust is satisfied that all actions are evidenced as completed.

MAIN REPORT

1. Incident description and consequences

1. On the 4th September 2010 Mrs G stabbed her husband Mr G in the chest at their home. He died from his injury.
2. At the time of the incident Mrs G was a 68 year old female, married to Mr G who had advanced Parkinson Disease.
3. In March 2006 Mr G had disclosed to Mrs G that 15 years previously he had an affair with her close friend. Following the disclosure significant marital problems developed which led Mrs G to needing periodic support from Surrey & Borders Partnership Foundation Trust and the Primary Care Mental Health Team Services. This occurred between 2006 and 2010.
4. Both Mr G and Mrs G were also known to Surrey County Council. Mr G was subject to Surrey County Council Safeguarding Adult Procedures in October 2006 and 2009.
5. Following the incident Mrs G was arrested and charged with causing Mr G's death.

2. Pre-investigation risk assessment

- 1 A risk rating was carried out at the commencement of the external investigation process within a framework which was first developed within the NHS Controls Assurance framework. Using this scoring system, risks can be allocated a score of between 1 and 25, with 1 reflecting negligible risk and 25 reflecting extreme risk. Table 1 set's out the framework.

Table 1 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			Impact (the potential impact to individuals or the organisation of the risk occurring)
Almost Certain	5	Multiplied by	5 Extremely
Likely	4		4 Very High
Possible	3		3 Medium
Unlikely	2		2 Low
Rare	1		1. Negligible

- 2 The pre investigation risks were rated at 15 with the potential likelihood of the incident occurring set at 3 and the potential impact set at 5. A post investigation risk assessment will be completed following the external investigation process. This will take into account the clinical and risk behaviour of Mrs G during her time with the mental health services; the incident and the events leading up to it and the Trust's response to her clinical and risk behaviour and the sharing of information with other services.

3. Background and Context

1. Mr G and Mrs G were married and lived together. They had an adult son and daughter, both married. The daughter lived locally with her husband and children, the son lived for a time in the USA. Mr G had a diagnosis of Parkinson's disease and was under the care of a Neurologist at University College London. Mr G had care management support for this from Guildford Social Care team.
2. In March 2006 Mr G disclosed to Mrs G that 15 years previously he had had an affair with her best friend. Mrs G found this difficult to accept and subsequently struggled to manage her anger whilst continuing to care for Mr G in the family home. Mrs G also struggled with fluctuating excessive alcohol consumption following the disclosure.
3. In May 2006 Mrs G was referred to Guildford Community Mental Health Team by her General Practitioner following a report from Mr G that she was threatening suicide and had taken a combination of tablets with alcohol.
4. Following this contact Mrs G had sporadic contact as a patient with several mental health services within Surrey and Borders Partnership Foundation Trust from 2006 – 2010. The level and detail regarding each contact is set out as a timeline in Appendix 1.
5. Both Mr G and Mrs G were also known to Surrey County Council as Mr G was subject to Surrey County Council Safeguarding Adult Procedures in October 2006 and 2009, following threatening behaviour from Mrs G. Documents also show that Mr G accessed planned respite care with Surrey Social Services. Mr G and Mrs G were carers for each other. Mrs G due to Mr G's Parkinson's disease and Mr G due to Mrs G's mental health issues.
6. Between 2006 and 2010 Mrs G was involved with the following services:
 1. Guildford and Waverly Primary Care Counselling Services; This service provided direct access for referrals from General Practitioners. It was set up as a psychological support and counselling service and has since been replaced by the Improving Access to Psychological Therapies (IAPT) Services. The Service was commissioned independently of Surrey and Borders Partnership Foundation Trust.
 2. Guildford Community Mental Health Team; The Service is managed within Surrey and Borders Partnership Foundation Trust, and is an integrated Health and Social Care team which provides community support to adults with severe and enduring mental health problems in the Guildford area. The Service provides a range of clinical interventions which can include, as an example, medication management, psychological support and interventions, clinical risk management and support with accessing other services such as housing, employment and vocational requirements.
 3. Duty System; This service is managed within Surrey and Borders Partnership Foundation Trust and is the referral route to Community Mental Health Teams. Health and Social Care Professionals undertake the Duty Officer role to ensure an expedient response when a referral to a Community Mental Health Team requires immediate action.

When a referral indicates immediate clinical risk to the service user or others, the Duty Officer is the Coordinator of care with other services to ensure the service user has an appropriate package of care – this could include admission to the mental health unit or more intensive home support.

4. Home Treatment Team – Guildford; was also known as the Crisis Resolution Home Treatment Team; This service is managed by Surrey and Borders Partnership Foundation Trust. The team provided the interface between Primary and Secondary care out of normal working hours. The team also support those service users currently being supported by Community Mental Health Team's who at times needed additional support to prevent relapse and possible admission to a mental health unit. The service/team was comprised of a Consultant Psychiatrist and medical team, health professionals, health assistants and administrative staff.
5. Older People Mental Health Team; This service is managed by Surrey and Borders Partnership Foundation Trust and provides a service for people over the age of 65 who have mental health problems, this includes early onset dementia. The service operates within a defined geographical area and works in Partnership with other NHS providers, Social Services, the local Borough Council and voluntary organisations. The service/team consists of Medical and Nursing staff, Occupational Therapists, Support Worker, and via sessional therapy input - Clinical Psychologist, Speech & Language Therapist and Dieticians.
6. On the 6th September 2010 the Social Care team received notification that Mrs G had assaulted Mr G by stabbing him in the chest on the 4th September 2010 and tragically Mr G had died.

4. Terms of Reference

NHS South of England - the Strategic Health Authority - has set the following terms of reference for the external investigation which overall only required the external investigation to focus on Mrs G's contact, care and treatment with Surrey and Borders Partnership Foundation Trust.

4.1 Objectives

1. To review the Trust's internal investigation and report to assess the adequacy of its findings, recommendations and action plans.
2. To review the progress made by the Trust in implementing the action plan arising from the internal investigation.
3. Assess the adequacy of risk assessment and consideration of Safeguarding issues.
4. Consider such matters as the public interest may require
5. Complete an Independent desktop report for presentation to NHS South East Coast within 12 weeks of commencing the investigation and assist in the preparation of the report for publication.

4.2 Key Questions

The key questions addressed within the external report and developed from the terms of reference are as follows:

1. Was the Trust's internal investigation adequate in terms of its findings, recommendations and action plans?
2. What progress has been made by the Trust in implementing the action plan arising from the internal investigation?
3. Are the Trust's systems adequate in terms of risk assessment and consideration of Safeguarding issues?
4. Are there public interest matters that need to be considered?

4.3 Key Deliverables

The external Investigation will deliver:

1. A full Report
2. An Executive Summary
3. A presentation to NHS South of England
4. An up to date position on the Internal Investigation Action Plan

4.4 Scope

1. The external investigation process will be completed 3 months after commencement.

4.5 Investigation type and process

This is a single incident external investigation which required one investigator with peer review to oversee the process. The process employed was:

1. An audit of the Internal Report using an audit tool that was originally developed in conjunction with a number of Mental Health Trusts in the North West of England and subsequently developed further by Caring Solutions UK Ltd. The findings from the audit tool was then brought together into a consolidated analysis of the Internal Report from which a number of conclusions are drawn and recommendations made.
2. An audit of the Trust's action plan, using the Trust evidence, (appendix 2) was produced to address the recommendations made in the Internal Report to assess if the action plan has captured all of its recommendations. The level of implementation of each action was considered.
3. To provide context, the desktop review includes details of the findings published in the Internal Report, and its recommendations. It will also include details of the action plan produced in response to the internal report recommendations.

4. The Report is written with reference to the ^{is}NHS Good Practice Guide for independent Investigations of Serious Patient Safety Incidents in Mental Health Services 2008.

4.6 Communication

1. The report will be presented to NHS South of England for consideration and subsequent publication.

4.7 Investigating Commissioner

1. The Investigation has been commissioned by NHS South of England in accordance with NHS SEC Guidance for Mental Health Independent Investigations (November 2009).

4.8 External Investigator

1. Pat Shirley is a RGN, RMN, DMS with significant knowledge of mental health services and systems, having recently retired as an Executive Director of Nursing and Governance, a post which she held for 6 years.
2. Prior to that she has worked as a senior Clinician and Manager in both inpatient and community mental health settings. The Investigator has also taken part in several investigations, both as an individual investigator and as a panel member.
3. Peer review was provided by Dr Colin Dale, Chief Executive of Caring Solutions (UK) Ltd. Dr. Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health.
4. Dr. Dale has successfully worked on a large number of projects and investigations in recent years. He is currently the Vice Chairman of a NHS Mental Health Foundation Trust, a member of the Mental Health Review Tribunal and a Senior Research Fellow at the University of Central Lancashire.

5. Level of Investigation

1. The investigation is a level 3 Independent Investigation

6. Involvement and Support of Patient & Relatives

1. Mrs G was offered but declined to be involved in the Investigation.

⁵ National patient Safety Agency – The Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health Services (2008)

7. Involvement and Support provided to staff Involved

1. The investigator met with designated staff members to establish the current position of the Internal Report action plan.
2. The Investigator will meet with senior members of the Trust to provide feedback on their analysis and provide an opportunity for the Trust to complete any remedial action prior to publication.

8. Information and Evidence gathered

1. Appendix 3 sets out the list of documents used to gather evidence for the external investigation.

9. Findings of External Investigation

This section has been considered within the framework of the key questions (4.2) developed from the external investigation terms of reference as follows:

9.1 Was the Trust's Internal investigation adequate in terms of its findings, recommendations and action plans?

Internal Review preparation and review:

1. The report clearly identifies the investigation team, the author and those involved in providing expert opinion.
2. The report was completed in a timely manner taking into account the review process being delayed due to a Police Investigation.
3. Whilst the report terms of reference clearly sets out an objective to review Mrs G's mental health and social care needs, it did not include an objective to review how effective communication is/was across all agencies.
4. There is no objective to review clinical practice against local and national guidelines and policies.
5. All witnesses interviewed were appropriate. However, no member of Surrey County Council Safeguarding team was not interviewed. Reference has been made to reviewing the minutes of a safeguarding meeting instigated by Surrey County Council Safeguarding Team.
6. The General Practitioner and a member of the Primary Care Counselling Service were not interviewed however the investigating team had access to their clinical notes and these were included within the tabular timeline and contributed to the findings.
7. ⁶A Root Cause Analysis approach was taken and the findings from this are clearly set out under the headings Root Cause factors & Contributory factors.

⁶ National Patient Safety Agency (NPSA) Root Cause Analysis Toolkit (January 2004)

8. The analysis of information was completed and this included using tools such as a ⁷'fish bone diagram' also known as 'The Cause & Effect Diagram'. The process led to relevant and comprehensive recommendations and action points.
9. An extensive chronology of events is described from Mrs G's first encounter with the services. This includes information received from the Police and the General Practitioner when involved. This is also set out as an appendix within the internal report and identifies care and service delivery problems which are developed into findings and recommendations.
10. All areas of concern detailed within the report are based on fact and findings. Conclusions are clearly linked to evidence and relate back to the terms of reference. Recommendations are clearly linked to conclusions and findings.
11. A clear and well structured Executive Summary is provided at the front of the internal report. The headings within the report however are not numbered and there is an overuse of bullet points. Headings and paragraphs should be numbered to aid referencing.
12. A clear action plan has been developed from the recommendations. This will be addressed in section 9.2.

Internal Report Findings:

13. The report identifies all reported episodes of actual and threats to self harm, however fails to address the clinical management of self harm in line with ⁸NICE Guidelines for Self Harm management (2004) and amended (2011).
14. The adequacy of risk assessment and management was examined. This will be addressed in more detail of 9.3 of this report.
15. The Trust systems, communication with others, and the clinical care and treatment of Mrs G were examined. Care and Service delivery problems in relation to these are clearly identified and notable practice detailed. However, both Mr G and the patient Mrs G had health needs and within the Care and Service delivery problem - Communication- it does not explicitly highlight the lack of communication across all agencies involved in their care. This is relevant as their poor relationship was the key issue impacting on Mrs G's mental health and subsequent risk behavior to both herself and Mr G.
16. Mrs G's behaviour in the community was clearly erratic and at times risky, although the Police were involved there is no evidence that Police Liaison Policies and Procedures were examined as part of the review.

⁷ The Fish Bone Diagram was first used by Dr. Kaoru Ishikawa of the University of Tokyo in 1943 - This diagram is used to identify all of the contributing root causes likely to be causing a problem.

⁸ 'The short to long term physical and psychological management and secondary prevention of self harm in primary and secondary care'

17. There is no evidence that staff training was examined as part of the review although there is a recommendation stating that staff have a working knowledge of the Safeguarding Adult Procedures and a recommendation that staff have a working knowledge of the Carer's Assessment Procedure.
18. The suitability of Mrs G's care and treatment was examined as part of reviewing the chronology of events. The findings highlight a lack of Carers assessment, the need for Surrey and Borders Partnership Foundation Trust to attend Safeguarding meetings and risk management concerns. These are developed into recommendations for the Trust. However as set out in the chronology, Mrs G threatened or actually self harmed, she also misused alcohol. These were not included as contributory factors and no recommendation had been made with regard to the clinical management within these two areas.
19. The internal report findings highlight system failures, particularly within Older People Mental Health Team. This raises a question about the effectiveness of clinical leadership which, if robust, would ensure responsive clinical management, effective communication, adhere to policies and procedures and timely clinical supervision. Effective clinical leadership and management are not considered within the internal report. The findings within the internal report which raises questions about effective clinical leadership are as follows:
 - a. Poor Communication
 - b. Staff not demonstrating awareness, knowledge and understanding of the Safeguarding Procedure and the Carers Assessment Procedure
 - c. Lack of clinical supervision
 - d. Poor compliance to the Trust Sharing of Information Protocol
 - e. Discharge procedure needing to be updated
 - f. Ensuring an appropriate system in place for the safe management and review of service users placed on waiting lists.
20. The report sets out specific interventions within each service Mrs G was involved with and specifically highlights the lack of shared information across each service within Surrey and Borders Partnership Foundation Trust.
21. The report identifies that significant others (husband, children) were not involved in Mrs G's core assessment or risk assessment processes. This has not however, been translated to a recommendation. Whilst there is a recommendation in relation to staff having a working knowledge of the ⁹Carer's Assessment Procedure, this alone would not automatically ensure that staff involve significant others in assessment and care planning processes, or that they receive the support they need in order to take up the carer role.
22. On the 10.09.06 Mrs G took an overdose and then later in the day she set light to her summer house with herself in it. The report rightly states that the Community Mental Health Team duty assessment fails to identify the escalating risk, however does not include consideration of a referral, at that time to the Surrey County Council Safeguarding Team.

⁹ Carers Assessment - Carers Equal Opportunities Act 2000 - duty to inform Carers of their right to an assessment

23. The report found that there was no formal discharge letter from Older People Mental Health Team to the General Practitioner. However there is a recommendation that the Older Persons Mental health Team must update their discharge procedure to include a discharge summary being sent to the General Practitioner.
24. There is evidence that staffing was considered in relation to the waiting time for psychology services, there is a recommendation that the Community Mental Health Team review the psychology input to the team.

Conclusion to section 9.1

The conclusion to 9.1 covers both the internal review preparations and actual findings. Where applicable this is also set out as service or care delivery problems in tables 2- 5.

1. Whilst there is more than one agency or service involved in a person's care there is no objective within the terms of reference to review communication, working practices and protocols across all services and agencies.
2. The terms of reference objective which required the reviewer to examine Mrs G's treatment, care and management did not include, as a context, 'against local and national policies and procedures'.
3. Whilst the report is well structured, numbered headings and paragraphs would have aided referencing for the reader.
4. No member of the Surrey County Council Safeguarding team was interviewed as part of the review process even though Safeguarding was a concern raised and considered due to Mrs G's risk behaviour towards Mr G. This is a missed opportunity.
5. The report did not include a section on the examination and findings in relation to staff training. It is unclear if staff had the knowledge to manage patients such as Mrs G.
6. Whilst the report identifies all reported episodes of actual and threats to self harm, it does not review the clinical response against national guidance, namely the NICE Guidelines for Self Harm Management (2004) and amended (2011) – see table 2.
7. The prevalence of self harming and alcohol misuse is stated throughout the chronology. These were not included as a contributory factor, even though Mrs G's lack of control and her escalating risk was associated with alcohol misuse.
8. There is no recommendation within the internal report to explore staff awareness and consequent management with regard to self harm and alcohol misuse, though these were both prevalent factors of Mrs G's clinical presentations.
9. The report states that 'significant others (husband, children) were not involved in Mrs G's core assessment or risk assessment processes'. This has not however been translated to a recommendation, although staff having a working knowledge of the Carer Assessment Procedure has. This however is not sufficient to ensure that staff involve Carers in all aspects of assessment and care planning.

10. The report did not explicitly state if Safeguarding was considered when Mrs G's risk was escalating, an example of this is when Mrs G set light to her summer house with herself inside, however the internal report does state as a recommendation 'staff having a working knowledge of Safeguarding'.
11. Although there were Clinical Care and Service Delivery issues a review of clinical leadership has not been included throughout the report or as a recommendation.

Table 2 – section 9.1

<p>Service Delivery Problem</p> <p>Terms of reference for the Internal investigation does not guide the internal reviewer to fully compare and contrast practice. This can minimise the opportunity to learn lessons.</p> <p>Internal investigations should seek to clarify and contrast practice in terms of working across agencies; comparison of clinical practice against local and national guidelines; the clinical competency of staff.</p>
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Table 3 – section 9.1

<p>Service Delivery Problem</p> <p>Staff awareness of the management of both self harm behaviour and substance misuse.</p> <p>Staff should be competent in the identification and management and/or onward referral for both self harm and alcohol misuse</p>
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Table 4 – section 9.1

<p>Care Delivery Problem</p> <p>Staff not involving Carers in all aspects of assessment and care planning.</p> <p>'significant others' (husband, children) were not involved in Mrs G's core assessment or risk assessment processes'.</p>
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Table 5 – section 9.1

<p>Service Delivery Problem</p> <p>The robustness and strength of clinical leadership</p> <p>The internal report documents Service and Clinical Care delivery failures. This raises the question about the strength and robustness of clinical leadership.</p>

9.2 What progress has been made by the Trust in implementing the action plan arising from the internal investigation?

1. The action plan is monitored via the Trust Scrutiny Panel which oversees the management and learning from all Serious Incidents. The Scrutiny Panel reports to the Trust Quality Committee which reports its findings to the Trust Board.
2. The Director of Risk and Safety has overall responsibility for ensuring all action points are taken forward via a designated lead for each action.
3. The external investigator applied a measurement framework to assess the status of the action plan. This framework is applied by the ¹⁰National Health Litigation Authority (NHSLA) which uses a set of risk management standards within Healthcare Organisations. These are set at 3 levels and the principle applied to each level can be applied to the action plan progress, as follows:

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

Appendix 2 sets out the internal report action plan; its current status in terms of evidence and progress; and the NHSLA level against each section.

Conclusion to section 9.2

1. The Investigator was able to evidence progress against each action point at NHSLA levels 1 and 2.
2. Assurance must be provided by the Trust that the internal review action plan will continue to be monitored and progressed. This will comply with the requirements of the ¹¹National Patient Safety Agency (2010) which requires ‘Commissioners, Providers and Managers of the NHS to ensure that there are systematic measures in place for safeguarding patients, property, NHS resources and reputation’.

¹⁰ The National Health Service Litigation Authority has developed a risk assessment framework underpinned by a range of NHSLA standards and assessments. Most Healthcare organisations are regularly assessed against these risk management standards.

¹¹ National Patient Safety Agency – Arms length body of the Department of Health – set up to lead and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

9.3 Are the Trust's systems adequate in terms of risk assessment and consideration of Safeguarding issues?

1. The findings from the internal report showed that the Trust does have a Risk Assessment Tool which was employed, however, there was an inconsistency in information reported. The internal report states 'there is no evidence of a shared assessment discussion'. This is a missed opportunity for the risk to be shared across the team and a considered approach taken forward. This has been addressed by the development of standard agendas for clinical meetings which includes a section to discuss all new referrals.
2. The clinical response to the various risk incidents were not robust, for example the Duty Service failed to identify an escalating risk, particularly following the fire incident on 10.09.06. There is now an internal protocol for the Duty Service to address this.
3. Risk sharing and documentation have also improved, this is evidenced via the internal review action plan. The Trust has a Clinical Risk Management Policy which was reviewed in May 2012.
4. Mrs G only engaged with services when in crisis and only for short periods. This is referred to within the internal report as 'all teams appeared to be more focussed on short term crisis management plans and did not work with Mrs G to formulate a longer term risk prevention and management plan'. This clinical practice has been addressed via the internal report action plan.
5. Consideration of safeguarding issues was not robust at the time of the incident either within the clinical care of Mrs G and Mr G or in working with Surrey Social services Safeguarding team. The Trust has now raised awareness in this area via safeguarding Policy review and staff training. This is evidenced via the action plan.
6. The risk impact of both service users self harming and misusing alcohol remains outstanding in that whilst these were a clinical presentational feature of Mrs G, there is no evidence that these were addressed via the internal review. This is addressed in section 9.1 and will form a recommendation within this report.
7. The family were not considered in terms of gaining information about Mrs G's risk behaviour. This is addressed in section 9.1 and will form a recommendation within this report.

Conclusion to section 9.3

1. The internal review explicitly identified the clinical and safeguarding risks posed to both Mrs G and Mr G and made appropriate recommendations in relation to these which have been followed up via the Trust's internal review action plan.
2. The external investigation has identified further recommendations in relation to self harm and alcohol misuse –refer to section 14.
3. The external investigation has identified that there needs to be a further recommendation in relation to involving significant others in risk management and care planning – see section 14.

9.4 Are there public interest matters that need to be considered?

1. There were many services both within and external to the Trust involved with the care of Mrs G and/or Mr G. Ensuring robust and effective communication across services has not been established within the internal review process. It is of paramount importance that staff work with all organisations involved directly or indirectly in the care of a patient and/or carer to share and escalate concerns to the appropriate services when necessary.
2. The process for enacting and deciding outcomes from safeguarding concerns must be based on information and involvement from all staff and agencies involved. The internal report stipulates attendance at a Surrey County Council safeguarding meeting when required. This alone may not lead to an effective outcome.

Conclusion to Section 9.4

1. There needs to be clear and effective systems in place to ensure staff work and communicate with all services involved in the care of a patient and where appropriate significant others, where not to do so could have potential impact on the patient, the carer or others. Table 6 sets this out as a Service Delivery Problem.
2. The process for enacting and deciding outcomes from safeguarding concerns must be based on information and involvement from all staff and agencies involved. Table 7 sets this out as a Service Delivery Problem.

Table 6 – section 9.4

Service Delivery Problem

Poor communication across all services and agencies both within and external to the Trust

There were many services within and external to the Trust involved with the care of Mrs G and/or Mr G. Effective communication across these services was not evident.

Table 7 – section 9.4

Service Delivery Problem

Poor involvement with the safeguarding process

Trust staff did not demonstrate active participation with the safeguarding process. Active involvement should take place at every point of the process and not just in attending a safeguarding meeting.

10. Contributory/Associated Factors

1. The National Patient Safety Agency(NPSA) determines “contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care Delivery or Service Delivery problems occurring. Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent an incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or ‘root causes’ will be expected to prevent or significantly reduce the chances of reoccurrence”.
2. The findings of the external investigation does determine that, whilst the Trust has addressed key areas, there are several contributory factors which affected the delivery of safe and effective care to Mrs G and Mr G. These factors are:

Patient:

3. Mrs G had been supported by the Trust services since 2006 when her husband disclosed that 15 years previously he had an affair with her close friend. Following the disclosure significant marital problems developed which led to Mrs G needing support from the Trust’s services at times.
4. In times of crisis Mrs G did self harm and/or carry out other behaviour which put both her and at times Mr G and others at risk.
5. Mrs G failed to engage long term in any service offered to her by the Trust. She presented mainly in crisis and although was offered follow up did not take up the offer.
6. Mrs G often abused alcohol and many of her risk behaviours were escalated out when she was under the influence of alcohol
7. Mrs G was the carer for her husband Mr G which at times she resented following his disclosure of infidelity.

Carer:

8. Mr G had advanced Parkinson’s disease however was not offered a Carer’s assessment which could have addressed his needs and given him support
9. There is no evidence that either Mr G or their daughter were involved in Mrs G’s core assessment or risk assessment processes’. Neither did they contribute to providing any social or risk history on the part of Mrs G.

Communication:

10. There were failures in relation to sharing Mrs G’s clinical history information during the periodic contact Mrs G had with the Trust, in particular her mental state; clinical and risk history, this to include self harm and substance misuse. This is both across the Trust’s services and across other services where Mrs G and/or Mr G were known.

Risk management:

11. There were failures in relation to risks being documented, escalated appropriately and/or shared across teams and services. This did not allow a comprehensive understanding by all services of the risks Mrs G posed to herself and Mr G. Whilst Mrs G presented in crisis several time there is no evidence that her risks to self or others was reviewed other than to manage the current crisis.

Safeguarding:

12. Whilst Mr G would have been considered vulnerable as he had advanced Parkinson's disease, there is no evidence that his safety was considered by Surrey and Borders Partnership Foundation Trust staff, even though there are several entries regarding Mrs G's extreme behaviour when in crisis.
13. There is no evidence that staff worked with the Surrey County Council Safeguarding team to share information and develop a joint management approach to both Mrs G and Mr G.

Clinical leadership:

14. The findings from the internal review note several system and clinical care failures which raises the question about the robustness of clinical leadership. Effective clinical leadership ensures that clinical practice delivers best care within a sound and effective system.

Documentation:

15. There is evidence that information was not always correctly completed and that discharge summaries were not sent to the General Practitioner. This potentially led to relevant clinical information not being available to other teams and/or services.

11. Root Causes/Causal factors

1. The NPSA determines a root cause as "a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future". Whilst there are several contributory or associated factors, which have been identified in section 10, the findings from the external investigation has determined that there is no one fundamental contributory or causal factor. From 2006 to 2010 Mrs G had at times exhibited unpredictable and impulsive risk behaviour, usually when she had misused alcohol. Whilst Mr G was vulnerable and had previously been at risk as a result of Mrs G's impulsive risk behaviour; there is no evidence to suggest that she planned to harm him. Her risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that she would have killed her husband.

12. Lessons Learned

1. The internal report covered many lessons learned and has developed recommendations in relation to:
 - a. Improved Duty systems

- b. Updating knowledge on safeguarding and working with Safeguarding teams as appropriate.
 - c. Improved systems to allow clinical risk concerns to be discussed and escalated as needed.
 - d. Information sharing and documentation.
 - e. Staffing levels in relation to Psychology input
 - f. Carer Assessments
 - g. Clinical supervision
 - h. Communication with the General Practitioner
 - i. Improved systems to review patients on waiting lists.
2. The findings were developed into recommendations which have been followed up as part of an action plan (see section 9.2)
 3. The external Investigation concur with these and the internal action plan developed from the findings, however adds:
 4. The recommendation in relation to staff having a working knowledge of Carers assessment should be developed further include staff involving Carers in all aspects of assessment and care planning.
 5. The recommendation in relation to staff attending safeguarding meetings should be expanded to ensure clear and effective communication systems for all services involved in the care of a patient and where appropriate significant others and an assurance that staff are actively involved in all relevant aspects of the safeguarding process.
 6. Clinical Trust Staff having a working knowledge of alcohol misuse management.
 7. Clinical Trust Staff having a working knowledge of the management of self harm, particularly where this is part of a crisis clinical presentation.
 8. Clinical Practice and policies to comply with National Policies and Procedures
 9. Police Liaison Policies and Protocols are examined to ensure their effectiveness and staff compliance.
 10. Clinical Leadership to be reviewed to ensure it is effective and accessible to all relevant staff.

13. Post investigation Risk assessment

1. In light of the findings from the external investigation, the post investigation risk assessment (table 8) remains at 15. Whilst it is recognised that there are many lessons to be learnt from this incident, due to the unpredictability of Mrs G's risk behaviour particularly associated with alcohol misuse, the incident in all probability could not have been predicted.

Table 8 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			Impact (the potential impact to individuals or the organisation of the risk occurring)
Almost Certain	5	Multiplied by	5 Extremely
Likely	4		4 Very High
Possible	3		3 Medium
Unlikely	2		2 Low
Rare	1		1. Negligible

14. Recommendations

1. Internal review terms of reference involving serious incidents to have an objective to compare clinical practice against national and local policies
2. The recommendation in relation to Carer assessments to be expanded to ensure Carers are included in all aspects of clinical assessments and care planning.
3. The recommendation in relation to staff attending safeguarding meetings should be expanded to ensure clear and effective communication systems for all services involved in the care of a patient and where appropriate significant others.
4. A further safeguarding recommendation to ensure staff are actively involved in all relevant aspects of the safeguarding process
5. Police Liaison Policies, Procedures and staff compliance to be reviewed.
6. Clinical Leadership to be reviewed to ensure it is effective and accessible to all relevant staff.
7. A review to be carried out to assess clinical staff understanding and management of both alcohol misuse and self harm behaviour and management.
8. The internal action plan to continue to be monitored to ensure the Trust is satisfied that all actions are evidenced as completed.

15. Acknowledgements'

1. The external Investigator would like to thank Senior staff at Surrey and Borders Partnership Foundation Trust for their responsiveness, openness and transparency. This has been invaluable in aiding this report to its conclusion.

Timeline of Mrs G Contacts with Surrey & Borders Partnership (extracted from Internal report)

Date	Description
2006	
<p>May</p> <p>10.05.06</p> <p>3</p> <p>0.05.06</p>	<p>5 contacts</p> <p>Referred to Guildford Community Mental Health Team by General Practitioner, husband reporting that Mrs G threatening suicide, had taken a combination of tablets with alcohol. Assessed by duty worker who referred her to A/E. Assessed by A/E doctor who noted no underlying mental health problems. Further assessed by duty worker from Community Mental Health Team. Mrs G stated that she had pastoral support and daughter staying with her. Further risk assessment indicated no suicidal thought or intention.</p> <p>Guildford Primary Mental Health Counselling Services: offered Anger Management following a referral from her General Practitioner stating that Mrs G was in acute distress – Mrs G declined and discharged. Service stated that she could be re-referred if required. General Practitioner informed</p>
<p>September</p> <p>08.09.06</p> <p>09.09.06</p> <p>10.09.06</p>	<p>Daughter contacted Guildford Community Mental Health Team stating that Mrs G has contacted her and stated that she planned to take an overdose. Duty worker advised daughter to call an ambulance who attended and reported back that Mrs G had not taken an overdose but was feeling suicidal. Mrs G visited the General Practitioner who reported that although Mrs G desperate there was no serious intent however she was impulsive and drinking a lot. General Practitioner stated that Mrs G was severely depressed.</p> <p>Mrs G formally referred to Community Mental Health Team who arrange weekend telephone support via the Crisis Team who contacted Mrs G by telephone, after several attempts Mrs G returned the call. Mrs G stated that still angry with Mr G's betrayal, had broken the phone and smashed ornaments and had taken extra tablets on the 8th. Stated that finding it hard to forgive husband's betrayal, resentful that she had to care for him. Community Psychiatric Nurse recorded that Mrs G not verbalising thoughts of self harm or intent.</p> <p>Phone call from Mrs G's neighbour to the Crisis Team reporting that Mrs G had taken a quantity of medication. Crisis Team advised calling an ambulance. Mrs G taken to A/E and admitted to a medical assessment unit.</p>

Date	Description
10.09.06 22.00hrs and onwards	The Crisis Team called the Unit and informed that Mrs G had discharged herself. 22.10hrs Crisis Team contacted Mrs G's daughter. She reported that Mrs G had set light to her summer house with herself in it in the afternoon. She had made an attempt to commit suicide. 23.33hrs Mrs G returned call to the Crisis Team. Informed the team she has discharged herself from the medical ward as she didn't want them to be involved in her care. Stated that she felt alright after expressing her anger, denied taking an overdose, had no intent or plans to harm herself. Agreed assessment with the Community Mental Health Team.
19.09.06	Mrs G seen by Duty worker at the Community Mental Health Team . Expressed ongoing feelings of anger towards husband but declared that she wanted to put it all behind her. Reported that she had been abstinent from alcohol for 1 week and adamant that she would stay off alcohol without the support of the Alcohol Services. Confirmed that she was taking an increased dose of antidepressants and felt better, denied suicidal ideation. Duty Worker felt Mrs G not suffering from a severe mental illness. It was suggested that she continue with counselling however Mrs G felt that counselling would not help. Plan as discussed with Mrs G noted as follows: Continue with General Practitioner support; Primary Care counselling; RELATE; AA. Mrs G declined the plan and confirmed that she had family, friends and pastoral support.
October 17.10.06	Surrey County Council Safeguarding Adult meeting convened for Mr G (Community Mental Health Team sent apology - submitted a report)
2007	
July 12.07.07	Mrs G referred again to PCMHS by her General Practitioner . It was reported that she was still struggling to come to terms with the problems that have resulted since her husband, who has severe Parkinson's disease, disclosed his affair. She had started smoking, drinking heavily and taking tablets to excess.
December 20.12.07	Mrs G seen by Assistant Psychologist, she reported that she could not get her husband's infidelity out of her head. She felt a sense of loss, betrayed and bereaved. Mrs G disclosed abuse towards him, stated that she had no feeling for him and was resentful that he was now disabled and she had to care for him. Mrs G stated that she had disclosed everything to their two children. Mrs G told counsellor that she was verbally but not physically abusive towards Mr G. Mrs G placed on a waiting list to see a counsellor.

Date	Description
2008	
March	
03.03.08	Telephone contact from counsellor. Mrs G stated that she was feeling better but will attend 1 session of counselling.
31.03.08	Seen by counsellor, Mrs G reported that she had stopped alcohol intake and smoking. She felt she did not need counselling as there was an improvement in her anger, mood and behaviour toward her husband. She was keen to get on with her life and was hoping in time to rebuild a better relationship with her husband. She reported that she had a good support network and her children to depend on. Mrs G was discharged.
2009	
October	
15.10.09	Mrs G referred urgently to GMHT by Social Care Team, detailed information from referral that Mrs G had attacked Mr G on the 14.10.09. Mr G had been taken to a place of safety. Mrs G threatened to take her own life and stated that she would not be home when Mr G returned from respite care. At 11.45 hrs Duty Worker spoke to Mrs G on the telephone. Mrs G denied suicidal ideation but stated that she was angry with Mr G and had to care for him. She was fixated with husband's affair and ongoing problems but showed little insight into her difficulties to cope. Duty Worker noted no signs of depression. Mrs G advised to continue with General Practitioner support, to consider counselling and for a further referral to the Community Mental Health Team if the General Practitioner required it.
20.10.09	15.30 Duty Worker spoke to General Practitioner who saw Mrs G at home. General Practitioner agreed that Mrs G not displaying signs of depression or current intent to self harm. General Practitioner will refer if required. Community Mental Health Team informed of arranged Surrey County Council Safeguarding planning meeting. Community Mental Health Team submitted report on the 19.10.09
28.10.09	Phone message from Social care Team to Community Mental Health Team requesting advice on how best to support Mrs G.
	Fax sent to Crisis and Home Treatment Team from a Community Mental Health Team alerting to a possible referral.

Date	Description
November	<p>Older Persons Services</p> <p>19.11.09 Mrs G visited by Community Psychiatric Nurse at home</p> <p>24.11.09 Community Psychiatric Nurse presented initial assessment feedback to Multi-Disciplinary Team meeting. Referral to Clinical Psychologist for Anger Management. Mrs G noted as keen to explore any form of treatment.</p> <p>26.11.09 Community Psychiatric Nurse contacted Mrs G, reported she was having on-going difficulties with herself and her husband. She was experiencing upsetting thoughts and unanswered queries from her husband's past affair which was distressing her. Mrs G was hopeful that psychological interventions would give her future direction on how to cope. Community Psychiatric Nurse planned telephone contact in March.</p>
2010	
January	<p>11.01.10 Mrs G seen by Clinical Psychologist for initial assessment. Plan formulated to provide necessary support and management. Put on 3 month waiting list. Note from Community Psychiatric Nurse: Mrs G did not want home visits between assessment and psychology sessions, believed they would involve too much reflection and conversation which Mr G would overhear. It was agreed to a telephone contact in March for ongoing review.</p>
March	<p>16.03.10 Community Psychiatric Nurse made telephone contact with Mrs G. She indicated that she did not want any further input from Older Persons Community Mental Health Team. Community Psychiatric Nurse discussed with General Practitioner and discharged Mrs G from caseload.</p>
May	<p>25.05.10 Clinical Psychologist contacted Mrs G via telephone to offer psychology support. Mrs G stated that she did not feel she needed psychology input at this time. She indicated that if she required it she would seek a re-referral via the Community Mental Health Team to Psychology. She was discharged from the Trust.</p>
September	<p>04.09.10 Mr G died from a stab wound to his chest, Mrs G was arrested by the Police on the same day.</p>
December	<p>12.12.10 A request for information was received from Surrey Police and a Forensic Psychiatrist, this was when the Trust was informed of the serious incident.</p>

External Review of Internal Action Plan

Recommendations	Actions to achieve recommendations	Level for Action (organisation, directorate, team etc)	Implementation by whom	Implementation by when	Evidence of completion	Monitoring and evaluation arrangement	Signed off by	How is learning to be shared trustwide	Evidence sign off by External review
1 All Team to ensure a representative will be in attendance to Safeguarding Adult meetings when invited and minutes of the meetings are obtained and filed accordingly.	1 All staff to have attended Safeguarding Adult Training. 2 All requests, both verbal and written, to attend safeguarding adult meetings to go to the Team leader who will allocate a representative from the team.	Team	Team Leader	Jun 11	Training matrix Minutes from weekly team meeting	Supervision records / team training database / individual PDP	Scrutiny Panel	Local Quality Action Groups	Safeguarding Policy(Sept 2012) statement to monitor training. Training Web allows monitoring of staff who have been on training. Safeguarding monitored via team meetings. NHSLA level 2

<p>2 All services to ensure adherence to trust Sharing Information protocol.</p>	<p>1 Consent to sharing information form to be sent out with initial appointments. 2 All staff to ensure that all correspondence is copied to the service user whom they have indicated that they wish to receive copies of letters.</p>	<p>Team</p>	<p>Team Leader</p>	<p>Jun 11</p>	<p>Minutes from Weekly Team meeting Record Keeping Audit Supervision</p>	<p>PSR / Monthly Team Record keeping audits</p>	<p>Scrutiny Panel</p>	<p>Local Quality Action Groups</p>	<p>Evidenced of learning via minutes of meetings Bench marking standards for Record keeping and sharing Information (2011) Template letter and form re: consent to share ideveloped</p> <p>NHSLA level 2</p>
<p>3 All teams to ensure where there is evidence that risk is fluctuating/ escalating the action taken should include Multi-Disciplinary Team review, psychiatrist review and regular reassessment and follow up.</p>	<p>1 All caseloads to be zoned. 2 Zoning to be an agenda item on the weekly team clinic meeting to ensure that those presenting with fluctuating risk are discussed with the Multi-Disciplinary Team and follow up arranged.</p>	<p>Team</p>	<p>Team Leader</p>	<p>Jun 11</p>	<p>Minutes from Weekly Team meeting Record Keeping Audit Supervision</p>	<p>Record Keeping Audit</p>	<p>Scrutiny Panel</p>	<p>Local Quality Action Groups</p>	<p>Zoning chart and criteria for zoning evidenced</p> <p>Agenda item in team meeting</p> <p>NHSLA level 2</p>

<p>4 All Team to ensure significant others (husband, children) are involved in the core assessment and risk assessment processes.</p>	<p>1 All staff to ensure that they obtain contact details for significant others at initial assessment and that they are contacted to ensure that they are involved within the core and risk assessments.</p>	<p>Team</p>	<p>Team Leader</p>	<p>Jun 11</p>	<p>Minutes from Weekly Team meeting Record Keeping Audit Supervision</p>	<p>Monthly Record Keeping Audit on RIO</p>	<p>Scrutiny Panel</p>	<p>Local Quality Action Groups</p>	<p>Care Programme Approach audit report (May 2012) details a comparison between 10/11 & 11/12. A re-audit to be carried out in 12/13 Bench marking standards for Record keeping and sharing Information (2011)</p> <p>NHSLA Level 2</p>
<p>5 Duty worker protocol to be updated to include Multi-Disciplinary Team review for service user who present regularly in crises.</p>	<p>1 To update duty protocol to ensure that those presenting in regular crisis through the duty system are reviewed throughout the Multi-Disciplinary Team</p>	<p>Team</p>	<p>Team Leader</p>	<p>Jun 11</p>	<p>Minutes from Weekly Team meeting Duty Protocol</p>	<p>PSR / Monthly Team Record Keeping audits</p>	<p>Scrutiny Panel</p>	<p>Local Quality Action Groups</p>	<p>Internal Protocol for managing Duty (2011) evidenced</p> <p>NHS Level 2</p>

6 Older persons staff to have a working knowledge of the Safeguarding Adult Procedure	1 To ensure all staff are up to date with safeguarding training. 2 To ensure all staff are competent in the reporting of safeguarding incidents.	Team	Team Leader	Jun 11	Training matrix Minutes from weekly team meeting	Supervision Records / team training database / individual PDP	Scrutiny Panel	Local Quality Action Groups	See recommendation 1 NHSLA level 2
7 staff to have a working knowledge of the Carer's assessment procedure.	1 All carers to be offered referral to the Social Care Team for a carers assessment and to ensure that it is documented on RIO.	Team	Team Leader	Jun 11	Minutes from Weekly Team meeting Record Keeping Audit Supervision	Supervision Records / team training database / individual PDP	Scrutiny Panel	Local Quality Action Groups	Standard agenda item for team meetings re: Social Care referrals Business meeting notes (March 2012) discussion NHSLA level 1

8 Older Persons staff to receive regular supervision.	1 All staff to receive 10 sessions of 1 supervision per year.	Team	Team Leader	Jun 11	Supervision records	Team supervision records	Scrutiny Panel	Local Quality Action Groups	Standard set out within Supervision Policy (2011) Annual supervision monitoring demonstrated NHSLA Level 2
9 Older Persons staff to update discharge procedure to include discharge summary to be sent to General Practitioner and ensure adherence Older Persons team to ensure appropriate system in place for safe management and review of cases on waiting list.	1 All staff to discuss discharges within the weekly clinical team meeting. 2 All staff to write to General Practitioner within one week of discharge. 3 Waiting list for psychology service to be reviewed at least monthly through the weekly clinical team meeting.	Team	Team Leader and Psychologist	Jun 11	Minutes from weekly team meeting	PRS	Scrutiny Panel	Local Quality Action Groups	Noted within minutes of meetings Standard agenda item for team meetings Pt survey result shows 69% compliance Point 3 Not a standard agenda item for team meetings. NHSLA level 1

10 Older Persons team to review psychologist input to the team.	1 Funding has been obtained for an additional psychologist for the South West Psychologist to attend the weekly team clinical meeting fortnightly once the additional psychologist is in post.	Directorate Team	Clinical Psychologist	Jun 11	Recruitment of additional psychologist / minutes from weekly team minutes	PSR/	Scrutiny Panel	Local Quality Action Groups	Evidence demonstrated re intention to recruit Psychologist recruited 23/1/12 NHSLA Level 3
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Documents Reviewed

Reports

1. Internal Investigation report – April 2011
2. Scrutiny Panel Report – May 2012

Policies & Protocols:

1. Internal Protocol for Managing Duty in the GUILDFORD COMMUNITY MENTAL HEALTH TEAM FOR OLDER ADULTS (JUNE 2011)
2. Safeguarding Adults Policy (2012)
3. Workforce Supervision Policy (2011)
4. Information Sharing Policy
5. Information for People who use services and Carers Policy and Procedure (May 2012)

Audits/ Surveys/Standards

1. Clinical Risk assessment Audit (May 2012)
2. National Patient Survey Results (2012)
3. Benchmarking Standards for Record Keeping and Information Sharing)

Records/Minutes of meetings

1. Annual records of clinical supervision
2. Minutes of Business Team meeting (March 2012)

Templates

1. Team meeting agenda
2. Psychology letter re: consent

Training

1. Example of training matrix (2011)

Other

1. Zoning Criteria
2. Email re: employment of Psychologist
3. Newspaper article (June 2011)