Assurance Report Somerset Partnership NHS Foundation Trust

STEIS: 2015 23056

Authors: Sancus Solutions

First published: 9th July 2019

Sancus Solutions' investigation team would also like to acknowledge the contribution and support of staff from Somerset Partnership NHS Foundation Trust and Somerset Clinical Commissioning Group

Date	Version	
24 April 2019	final amendments	

Contents

1. The incident

1.1. On 5 July 2015 the bodies of Claire and Tim were found.

1.2. A subsequent inquest concluded that after killing Claire, Tim then took his own life by suicide (self-strangulation).

1.3. At the time of his death, Tim's mental health diagnosis was Adjustment Disorder (ICD code[1] F43.2[2]). It was documented that "there may also have been a comorbid[3] more persistent depressive illness"[4].

1.4. Tim's GP initially prescribed the antidepressant medication citalopram[5] which was subsequently changed to mirtazapine[6] (45mg daily).[7]

2. Background information

2.1. Claire and Tim lived in Somerset and had been in a relationship since 2004. They had a brief separation in 2011.

2.2. Claire and Tim were parents to three children and at the time of the incident the children were all under the age of ten years. The family were living in a social housing property.

2.3. Claire and Tim separated on March 2015. After the separation Claire remained with the children in the family home and Tim went to stay with his parents who lived close by.

2.4. When Tim initially presented to mental health services (March 2015) he was on sick leave and Claire was working part-time.

3. Tim's contact with services

This section provides a very brief summary of Tim and his family's contact with the Somerset Partnership NHS Foundation Trust's mental health services (hereafter referred to as the trust). Information has been taken from the trust's Serious Incident Report (hereafter refered to as SIR) and Safer Somerset Partnership Domestic Homicide Review (hereafter refered to as DHR).

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[1] ICD The International Classification of Diseases
[2] ICD
[3] Comorbidity is the presence of one or more additional diseases or disorders co-occurring with (that is, concomitant or concurrent with) a primary disease or disorder Comorbidity
[4] SIR p17
[5] Citalopram
[6] Mirtazapine
[7] The date of this change was not documented in either Somerset Partnership NHS Foundation Trust's Serious Incident Report or Safer Somerset Partnership Domestic Homicide Review.

3.1. 22 March 2015: Tim first came to the attention of trust's mental health services when he was admitted to Taunton and Somerset Partnership NHS Foundation Trust's Accident and Emergency Department following an overdose of paracetamol and ibuprofen.

3.2. Between 5 April and 28 April 2015: the Crisis Resolution and Home Treatment Team (hereafter CRHTT) visited Tim on a number of occasions at the home of his parents, where he had been living since the break-up of his marriage. Tim and his parents reported to the CRHTT support workers that on several occasions Tim had previously made several attempts of death by suicide.

3.3. 23 April 2015: during a CRHTT visit it was documented that Tim had expressed feelings of jealousy towards Claire. A carers' assessment was offered to his mother. It is not documented if Claire was offered a carer's assessment.

3.4. 21 April 2015: members of Tim's family reported to the police their concerns that Tim had gone missing and that he had indicated that he may have gone to a local railway line to take his own life. The police subsequently located Tim and detained him under Section 136 of the Mental Health Act 1983.[8]

3.5. A Mental Health Act1983 assessment was undertaken and Tim was prescribed diazepam[9] and discharged the same evening. Neither Claire nor Tim's parents were spoken to as part of this assessment. The Serious Incident Report documented that Tim's mother reported that her son had found the experience in the 136 Suite[10] very distressing.

3.6. 2 June to 18 June 2015: Tim attended several stress management[11] and self-management[12] sessions.

3.7. 19 June 2015: Tim began to see a private therapist.

3.8. 30 June 2015: was Tim's last telephone contact with a member of the CRHTT team.

3.9. 3 July 2015: Tim last saw his GP and private therapist.[13]

[8] Section 136
[9] Diazepam
[10] DHR p19
[11] Group run by the trust's Talking Therapies Service (IAPT)
[12] At the time the course was open to patients of the community secondary mental health service
[13] Information from the DHR

4. Commissioning of an evidence based qualitative review

4.1. NHS England (South) commissioned Sancus Solutions to undertake an evidence-based qualitative review in order to:

"Independently assess the quality of Somerset Partnership NHS Foundation Trust's level 2 [root cause analysis] investigations into the care and treatment of [Tim], the subsequent action plan and the embedding of learning across [Somerset Partnership NHS Foundation Trust] and identify any other areas of learning for the trust and/or [Somerset Clinical Commissioning Group]"[14].

Terms of Reference

4.2. The agreed Terms of Reference (ToR) ask Sancus Solutions' review team(hereafter refered to as the review team) to:

"Review Somerset Partnership NHS Foundation Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan"[15].

4.3. The ToR also asks the review team to:

"Review Somerset Partnership NHS Foundation Trust and their Clinical Commissioning Group's action plans developed from the Safer Somerset Partnership Domestic Homicide Review Overview … and assess their quality … Review progress made against the action plan."[16]

Sancus Solutions' review team

4.4. **Grania Jenkins:** the author of this qualitative review. Grania is a senior mental healthcare, performance and quality professional who has worked in both the second and third sectors. Grania has extensive experience of undertaking investigations into suicides and unexpected deaths, critical and serious incidents, and complaints, as well as root cause analysis investigations and thematic reviews. Since 2014 Grania has been the lead investigator for independent mental health homicide investigations under NHS England's Serious Incident Framework. She is an associate director of Sancus Solutions.

Tony Hester: one of the directors at Sancus Solutions. Tony has over 30 years' Metropolitan Police experience in specialist crime investigations. Since 2009 Tony has coordinated and managed numerous domestic homicide

[14] Agreed ToR p1
[15] Full ToR are located in Appendix 2
[16] ToR p2

reviews where the mental health of the perpetrator and/or victim has been both a significant contributory factor. Tony provided the quality control and governance oversight for this review.

Sancus Solutions' review methodology

4.5. Sancus Solutions' methodology for this qualitative review involved:

Interviews: undertook interviews (either face to face or telephone interviews) with the following:

Somerset Clinical Commissioning Group (hereafter referred to as SCCG)[17]

- Assistant Risk and Patient Safety Manager
- Deputy Director of Quality Safety
- Patient Safety GP

Safer Somerset Partnership[18]

- Senior Commissioning Officer for Interpersonal Violence Public Health
- Specialist Community Safety Officer
- Author of the domestic homicide review

Somerset Partnership NHS Foundation Trust[19]

- Head of Clinical Governance and Clinical Risk
- Author of the serious incident report (Operational Service Manager of Eating Disorders and Personality Disorders). Hereafter refered to as the main author.
- Service Director for Adult Mental Health And Learning Difficulties
- Deputy Service Director for adult mental health and learning difficulties, who was at the time of the incident the Service Manager of the Home Treatment team and the SIR's commissioning officer

4.6. The review team obtained and reviewed evidence from:

- Somerset Partnership NHS Foundation Trust 's Serious Incident Report (hereafter refered to as SIR);
- Safer Somerset Partnership's most recent DHR and action plan monitoring;

[17] Somerset Clinical Commissioning Group
[18] Safer Somerset Partnership SSP
[19] Trust

- evidence of progress SCCG has made against its DHR's action plan;
- evidence of progress the trust has made against both their SIR and DHR action plans.

4.7. Where the trust's services, policies and governance structures have, since this incident, changed and/or been recommissioned, evidence was requested and reviewed to evaluate the impact of the changes and to ascertain what monitoring and governance structures are now in situ.

4.8. Reference within this report has been made to:

- Care Quality Commission (CQC) inspection reports – September 2015 and the most recent inspection, February-March 2017[20]
- Department of Health (DH) Guidelines on risk assessment and risk management in mental health (March 2009) [21]
- National Patient Safety Agency's RCA Investigation Evaluation Checklist[22]
- NHS Improvement's Learning from Patient Safety[23]
- NHS England Serious Incident Framework (2016)[24]
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016)[25]
- Tees Local Safeguarding Children Board – Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[26]
- Home Office Domestic Homicide Review: Key Findings from Analysis of Domestic Homicides (December 2016)[27]
- Royal College of Psychiatrists' guidance: Rethinking risk to others in mental health services (2016)[28]

[20] CQC summary report June 2017
[21] Guidelines
[22] National Patient Safety Agency (2008), "RCA Investigation: Evaluation, checklist, tracking and learning log"
[23] Learning From Patient Safety
[24] This framework describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again Serious Incident Framework
[25] Confidential Inquiry
[26] PAMIC This procedure is used when considering the likelihood and severity of the impact of an adult's mental ill health on a child
[27] Home Office
[28] Rethinking Risk

- BMC Psychiatry, “The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies” (2017) [29]

The National Institute for Health and Care Excellence (hereafter refered to as NICE):

- Guidelines on Domestic Violence and multi-agency working[30]
- Antidepressant treatment in adults[31]
- Guidelines on Improving Access to Psychological Therapies (IAPT)[32]

4.9. This review will also make reference to a previous independent homicide investigation commissioned by NHS England (South) which involved an intimate partner homicide[33] investigation.[34] The perpetrator, like Tim, had, prior to the incident, been a patient of the trust’s community mental health services and had been assessed under Section 136 of the Mental Health Act 1983.[35] It was noted that two of the recommendations from this investigation were similar to those in the trust’s SIR that is being reviewed in this report. The relevant recommendations were to:

- Increase the trust’s practitioners’ understanding and identification of domestic violence, and violence where jealousy may be a significant factor.

- Improve risk assessments and risk identification within the trust’s community mental health services regard to identifying and assessing the potential risk(s) of domestic violence.

4.10. One of the challenges that the review team faced in undertaking this review was the significant time that has elapsed since the incident and the subsequent completion of the SIR and the DHR. The trust has undergone significant changes in its community mental health service delivery and how internal serious incidents are investigated and how action plans are monitored. Therefore, a considerable number of the comments and recommendations that the review team would have made are no longer relevant.

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[29] National Audit
[30] NICE
[31] NICE
[32] IAPT
[33] Intimicide (intimate partner homicide) is the killing of a former, current or temporary intimate partner or a member of the intimate partner’s familial or social circle by another former, current or temporary intimate partner
[34] Published August 2016 NHS England Report
[35] A patient of the Crisis Resolution and Home Treatment Team, who was, prior to the incident, assessed utilising Section 136 of the Mental Health Act 1983. Section 136 is an emergency power which allows a person to be taken to a place of safety from a public place, if a police officer considers that a person is suffering from a mental illness and is in need of immediate care Section 136

4.11. Additionally, many of the individuals who were involved in Tim's care or in the completion of the SIR and DHR are either in different roles or no longer employed by the trust.

4.12. The trust is currently in the process of implementing a Sustainable Transformation Programme which involves an alliance with several local NHS foundation trusts that will form an Accountable Care Organisation (ACO).[36] It was reported by the Head of Clinical Governance and Clinical Risk that one of the functions that is currently being considered is the viability of operating a single serious incident framework across all the involved trusts.

4.13. Given the above changes, and to ensure that this review is helpful in developing and improving practices and lessons learnt for both the trust and SCCG, the review team will, where currently relevant, comment and present evidence on the progress that has been made with regard to the respective action plans and the impact such changes have had on the current services and/or governance structures.

4.14. Also, again where relevant, this report will identify and comment on any developments that have been introduced since the completion of the DHR summary and SIR. This will include a commentary on any care pathways and services that would be available to both Tim and his family if he was to present to services today.

5. Involvement of families

5.1. At the commencement of the review NHS England (South) Head of Investigations (Mental Health Homicide Lead) wrote to Tim's[37] parents inviting them to contribute to the ToR and participate in this review. At the point of the submission of this report there has been no response.

5.2. NHS England (South) Head of Investigations (Mental Health Homicide Lead) were unable to obtain the contact details of Claire's[38] parents.

5.3. At the end of this review both sets of parents will be given the opportunity to meet with the review team and NHS England (South) Mental Health Homicide Lead to discuss the findings and/or receive a copy of this report.

[36] Accountable care organisations (ACOs) result when NHS providers agree to merge to create a single organisation ACOs
[37] Patient referred to as Tim in DHR
[38] Pseudonym used by Safer Somerset Partnership's DHR
[38] Patient referred to as Claire in DHR

6. NHS England's Serious Incident Framework[39]

6.1. NHS England Serious Incident Framework (hereafter referred to as the framework) that was in situ at the time of this incident defined a serious incident as:

"Events in health care where the potential for learning is so great or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response"[40].

6.2. The framework also stated that although every incident should be considered on a case-by-case basis, there was an expectation that the healthcare provider would commission a level 2 investigation in instances where there had been an:

"Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death and/or [a] homicide by a person in receipt of mental health care within the recent past."[41]

6.3. A level 2 investigation is a:

"Comprehensive investigation – suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators"[42].

6.4. The key principles for all levels of NHS investigations were that they were:

- "Open and transparent
- Preventative
- Objective
- Timely and responsive
- Systems based
- Proportionate
- Collaborative"[43].

[39] The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again Serious Incident Framework
[40] Serious Incident Framework p12
[41] Serious Incident Framework p13 This includes as a guide those in receipt of care within the last six months, but each case should be considered individually
[42] Serious Incident Framework p21
[43] Serious Incident Framework pp22-24

6.5. The framework identified root cause analysis (RCA) as the methodology to be used in investigations. This is an investigation methodology/tool which provides a systematic process for conducting an investigation. It provides a process for looking beyond the individuals involved, seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It also assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.

6.6. The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.

7. Domestic Homicide Review

7.1. On 10 August 2015 the Chair of the Safer Somerset Partnership[44] made the decision that the death of Claire was an intimate homicide which met the Home Office's (HO) criteria for a DHR. The purpose of DHRs is to:

"Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims; [and] identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result"[45].

7.2. The aim of this DHR was to:

"Enable lessons to be learned from Claire's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future"[46].

7.3. The DHR panel comprised senior managers from the involved statutory and voluntary sectors and the NHS England (South) Mental Health Homicide Lead.

7.4. All agencies and services involved with Claire, Tim and their children were asked to complete an Individual Management Review (IMR) which identified and reviewed their involvement with the family and also based on the IMR

[44] Safer Somerset Partnership SSP
[45] DHR p4
[46] DHR p7

findings, recommendations and action plans were submitted to the DHR panel.

7.5. SCCG's Patient Safety GP submitted an IMR on behalf of the involved GP practices.

7.6. Following the initial submission of the DHR to the HO, further amendments were made, and the final report was submitted on 14 August 2016. The author of the DHR reported that due to safeguarding concerns regarding the impact on Tim and Claire's children, which were raised by one of the grandparents, only a summary was available to the public via Safer Somerset Partnership's website.[47]

7.7. This review will look at the progress and reporting/monitoring structures of the DHR with regard to both SCCG and the trust.

The following sections will review the trust's SIR against NHS England's Serious Incident Framework and their incident policy that was in situ at the time. Where a section is related to a particular NHS England ToR, this will be highlighted in **bold**. Where reference is made to a specific trust's SIR ToR, this will be in *italics*.

8. Post incident and the commissioning of the serious incident report

"If the investigation was completed in a timely manner."[48]

8.1. The SIR reported that following the incident, Avon and Somerset Police Authority notified the trust's on-call duty mental health manager that there had been a serious incident which they believed involved one of their patients.

8.2. The on-call duty mental health manager informed the trust's directors and the incident was immediately classified as a "major incident".

8.3. The incident was then reported, as per NHS England's Serious Incident Framework, to SCCG via the electronic Strategic Executive Information System (STEIS).[49]

8.4. Following notification of the incident:

- A 72-hour report was completed by the managers from the involved services.

[47] Safer Somerset Partnership website DHRs
[48] ToR p1
[49] STEIS: Strategic Executive Information System, NHS England's web-based serious incident management system STEIS reporting criteria

- The involved staff were notified of the incident and immediate support was provided.

- Staff debriefing sessions were provided to the relevant staff groups/services.

Commissioning of the SIR

8.5. The trust's commissioning officer for the SIR was the Head of the Adult Mental Health Inpatient and Assessment Division.[50]

8.6. The authors of the SIR were:

- Operational Services Manager – Eating Disorders and Personality Disorders Service.

- Specialty Doctor – general adult psychiatry.

The investigation team received additional support and guidance from a Consultant Psychiatrist from the trust.[51]

8.7. The SIR investigation was commissioned on 20 July 2015. The SIR documented that the report was initially due for submission to SCCG on 18 September 2015.[52] The authors of the SIR requested an extension of one week and the report was submitted internally for approval on 26 September 2015.[53]

Analysis and commentary

8.8. The review team concluded that the trust's initial response to the incident was proportionate and fully concordant with NHS England's Serious Incident Framework (published 27 March 2015), which stated that:

"Serious Incidents must be declared internally as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff and to secure all relevant evidence to support further investigation."[54]

8.9. With regard to securing the relevant evidence as soon as the trust were notified of the incident, Tim's RiO patient records were locked and only the authors of the SIR had access. However, as the SIR noted, this resulted in the

[50] Now the Deputy Service Director for Adult Mental Health and Learning Difficulties
[51] SIR p5
[52] The timescale for level 2 investigations is 60 days
[53] SIR p5
[54] Serious Incident Framework p7

"Staff participating in the interviews [being] unable to access the RiO notes to remind themselves of their contact [with Tim] because the record had been locked"[55].

One of the SIR/DHR's recommendations was:

"To provide read only Rio access to notes to involved staff prior to interview"[56].

8.10. The SIR/DHR action plan documented that this recommendation is "on-going" and "will be implemented through the Corporate Governance Team"[57].

Changes in the commissioning of SIRs

8.11. The Head of Clinical Governance and Clinical Risk confirmed to the review team that this access is now in place and all interviewees, prior to their interview and where deemed relevant, have read-only access to a patient's RiO notes in order to review their involvement.

8.12. The Head of Clinical Governance and Clinical Risk, who was interviewed as part of Sancus Solutions' review, reported that since her appointment (June 2017) there have been a significant number of changes introduced with regard to the commissioning, supervision and internal approval of processes of SIRs. These include:

- When an incident is initially reported, the Head of Clinical Governance and Clinical Risk, alongside the Serious Investigation Lead, will review the trust's incident database (Datix)[58] and, where relevant, the patient's RiO notes. Based on the information available, they will agree what level of investigation is required as prescribed in NHS England's Serious Incident Framework and the trust's serious incident policy.

- The Head of Clinical Governance and Clinical Risk and the Serious Investigation Lead oversee the allocation of the investigator(s).

- The Head of Clinical Governance and Clinical Risk and the Serious Investigation Lead monitor the SIR investigation to the point of completion and submission to both the Serious Incident Review Group (SIRG) and SCCG.

[55] SIR p7
[56] SIR p3 recommendation 13
[57] Action plan p7
[58] DATIX incident and safety management system used by NHS trusts DATIX

- The Head of Clinical Governance and Clinical Risk reported that she reports, on a regular basis, to the trust's board and SCCG on the progress of all investigations being undertaken.

8.13. The Head of Clinical Governance and Clinical Risk also reported that until very recently the trust had consistently failed to meet the 60-days submission target. This has also resulted in considerable delays in reporting the SIR's findings, recommendations and associated action plans to the involved families. In order to address this issue, several changes have been introduced:

- SIRs are now reviewed at the 45- to 50-day stage, thus enabling amendments to be completed in a timely fashion.

- Previously the SIRG met monthly, which often resulted in delays in SIRs being approved and submitted to SCCG. From May 2018 SIRGs are convened every two weeks.

8.14. The membership of the SIRG consists of the Serious Investigation Lead, the Head of Clinical Governance and Clinical Risk, a consultant psychiatrist, and representatives from safeguarding and the three operational directorates. SCCG are also invited to the SIRG meetings but are not part of the core membership.

8.15. The Head of Clinical Governance and Clinical Risk also reported that the new ongoing monitoring and scrutiny of SIRs aims to ensure that by the time the report is submitted to the SIRG, it has already been extensively reviewed, resulting in fewer amendments being required at the later stages of the internal approval process.

8.16. Once the SIR has been submitted to the SIRG, it is shared with the involved families. The target timescale for this is within a month of the investigation being completed.

8.17. Clearly, as these changes have only recently been introduced, it has not been possible for the review team to assess their impact with regard to improvements in the internal monitoring of SIRs or in the timeliness of the trust's submission of their SIRs to SCCG. In order to assess if there have been any improvements, the following recommendation is made:

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG) and NHS England (South)

Recommendation 1

A 12-month audit review should be undertaken to review the timescales of Somerset Partnership NHS Foundation Trust's submissions of their serious incident reports to both the families and SCCG.

The results of this audit review should be reported to the NHS England (South) Mental Health Homicide Lead.

9. Training and allocation of investigators

9.1. The lead author of the SIR reported to the review team that this had only been his second RCA investigation and that it was the speciality doctor's first RCA investigation.

9.2. He also reported that prior to this investigation he had not received any RCA training. However, since this SIR he has completed RCA and Human Factor training[59] and attended a number of additional follow-up training days. The impact of this training has, he reported, been significant, as he now feels more confident and skilled to undertake such complex investigations.

9.3. The Head of Clinical Governance and Clinical Risk confirmed that she had commissioned this training and that it is now mandatory for all investigators to have completed this training prior to undertaking any level 2 investigations.

9.4. The main author of the SIR also reported that since the restructuring of the commissioning and monitoring of SIR investigations, there was now considerably more support and supervision for investigators available both administratively and throughout the course of an investigation. However, he also reported that it was still very challenging and time consuming, as the investigators are still expected to manage the demands of their managerial/clinical responsibilities alongside complex SIR investigations.

Analysis and commentary

9.5. Clearly, the main author of the SIR reported lack of training and experience is concerning, as it is difficult to see how any members of an investigation panel could have been expected to have completed a robust and thorough RCA investigation without sufficient training, especially in such a complex case. The lack of training of both of the investigators might explain why there were

[59] The principles and practices of Human Factors focus on optimising human performance through better understanding of the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, Human Factors offers ways to minimise and mitigate human frailties, so reducing medical error and its consequences Human Factors in Health Care

some significant deficits in both the report and the recommendations, which will be highlighted later in this report.

9.6. The review team were also informed and saw evidence of the trust's revised Serious Incidents Requiring Investigation (SIRI) Policy, which was introduced in February 2017. This policy outlines the SIR process and the allocation of investigators. It states:

"It is the responsibility of each Head of Division to maintain a pool of staff with the right skills to undertake SIRI investigations. The Head of Division is responsible for allocating investigators when requested for a new SIRI … For the investigation of unexpected deaths, there must be two investigators, one of whom must be a doctor. Each investigator will be expected to undertake, on average, two investigations a year to maintain competence."[60]

9.7. However, the review team noticed that there was no direct reference within this policy to any required RCA training or supervision for investigators. Therefore, they suggest that the policy be revised to include the required training and supervision of investigators.

Somerset Partnership NHS Foundation Trust

Recommendation 2
Somerset Partnership NHS Foundation Trust's Serious Incidents Requiring Investigations (SIRI) Policy and Procedure should be amended to include details of:

- root cause analysis training available to investigators
- investigators' supervision arrangements.

9.8. The Head of Clinical Governance and Clinical Risk reported to the review team that despite the improvements that have been implemented, one of the main ongoing challenges is the difficulty in sourcing enough trained investigators. Currently, operational managers who are Band 7[61] and above are usually the allocated lead investigator; however, due to the trust's extensive geographical area, it can be challenging to be able to allocate two investigators who have not had any previous direct contact with the involved services.

9.9. Additionally, investigators are expected to undertake what are, at times, very complex and time-consuming SIRs alongside their daily responsibilities, as

[60] Serious Incidents Requiring Investigation (SIRI) policy (February 2017) p13
[61] Pay scales for NHS nursing staff in England

there are no available resources to fill their posts during the course of an investigation.

9.10. It was reported, and the review team agree, that it would be ideal if the trust was in a position to recruit a core team of investigators, who did not have affiliation to any services. Clearly such a resource would provide both a rigour and a level of independence that is currently lacking and would resolve the burden that is currently being placed on the investigators.

9.11. If this is not a financially viable option, then the current Accountable Care Organisation negotiations may offer an alternative solution, as all the involved trusts operate within NHS England's Serious Incident Framework and therefore a joint process and protocol for serious incident investigations could be agreed which would, at least, increase the pool of investigators available.

9.12. Given that this significant development is currently near completion, the review team does not intend to make any specific recommendation with regard to the trust reviewing the viability of developing a team of independent investigators. However, the team suggests that once the arrangements have been finalised, the trust reports to NHS England (South) Homicide Lead the impact that the new arrangements will have on their serious incident processes.

Somerset Partnership NHS Foundation Trust, NHS England (South)

Recommendation 3
Once the Accountable Care Organisation Programme has been completed, Somerset Partnership NHS Foundation Trust should report to the NHS England (South) Homicide Lead the impact that these changes will have on their serious incident investigations.

10. Lessons learnt

"**If the investigation has satisfied its own terms of reference. If all root causes and lessons learnt [had] been identified and actions identified and shared."**[62]

10.1. The SIR's ToR is provided for reference in Appendix 2.

10.2. The SIR sourced information to inform their report and analysis from the following sources:

[62] NHS ToR p1

- “Review of 72 hour report
- Review of Trusts’ patient electronic records, including Rio and IAPTus[63]
- Staff interviews
- Review of Primary Care Root Cause Analysis Investigation Report
- GP interview
- Family involvement interview [only Tim’s parents]”[64].

10.3. The SIR documented that apart from the initial notification from the police, “No further information was provided by the police in spite of requests by the trust as part of the investigation process”[65].

10.4. The main author of the SIR reported to the review team and also provided email evidence that he escalated this issue to the consultant psychiatrist, who was acting as an adviser and who was also unable to obtain any further information about the incident from the police. The main author of the SIR reported that they were therefore reliant on information supplied by Tim’s parents during their interview and the primary care’s IMR that was submitted to the DHR.

10.5. The SIR included a comprehensive chronology, beginning with Tim’s initial presentation at A&E (22 March 2015) and both CRHTT and IAPTs’ subsequent involvement.

10.6. The chronology highlighted where there were, in the SIR authors’ opinion, areas of:

- good practice
- problems and/or omissions in care delivery.

10.7. The SIR included:

- an executive summary;
- a narrative of the involvement of the trust’s services;
- a summary of good practice identified;
- a summary of contributory factors;

[63] IAPTus is the patient management system for Improving Access to Psychological Therapies (IAPT) services, which collects and reports therapy outcome data IAPTus
[64] SIR p5
[65] SIR p6

- 15 recommendations (see Appendix C).

10.8. The following arrangements for shared learning were documented:

- "Provide Tim's family a copy of the final report
- Provide GP with copy of final report
- Provide Safeguarding team with report
- Disseminate findings directly to involved staff through operational managers
- Learning points to be included in 'What's On'[66]
- Learning Points to be included in mandatory risk training"[67].

Analysis and commentary

10.9. It was evident that the ToR for this case included some generic questions that were not relevant to the case: for example, references to assessments of the patient's capacity, ligature points and inpatient discharge planning. Also, in the section related to the Duty of Candour, the involvement of not only the family but also the "patient"[68] is cited, which is clearly not relevant to this case.

10.10. The review team would suggest that the unrelated ToR should have been removed at the point of the commissioning of the SIR in order to ensure that the ToR was pertinent and specific to the case being investigated. This would have:

- provided greater clarity to the SIR authors as to what key lines of inquiry they were being expected to review and comment on;
- communicated to the involved families that the investigation was sensitive and relevant to the incident that they had been so affected by.

10.11. The Head of Clinical Governance and Clinical Risk reported that she and the Serious Investigation Lead now reviews all incidents and, based on the evidence/information that is available and any questions posed by the families (this will be explored in more depth in the Duty of Candour section) A bespoke ToR is then developed and agreed with the author(s) of the SIR and the involved family members or carers.

[66] "What's On": Sancus Solutions' review team were informed that this was a staff newsletter which is no longer used.
[67] SIR p29
[68] SIR p3

10.12. The review team were informed and shown evidence of the revised investigation report pro forma that has now been introduced. This will provide greater consistency as to what needs to be included in the trust's SIR reports.

10.13. The revised pro forma also requires documented evidence of both the Duty of Candour and the evidence collated as part of the investigation.

Root cause

10.14. The SIR concluded that the root cause was:

> "An observable pattern that fluctuations in Tim's mental state and risk of suicide appear directly linked to hope of reconciliation with his wife and family rather than any treatment or care he received. Tim's wife was very supportive and offered him hope of being reunited if he received help. It is probable his help seeking was based upon this rather than any need of his own.
>
> The immediate direct causal factors on the day of the incident could not be determined by the investigation. The nature of Tim's relationship with his wife is not known in the days preceding the incident.
>
> The root cause appears to be the breakdown of marriage and loss of hope of reconciliation. Without this the incident would be highly unlikely to have occurred.
>
> No act or omissions by Somerset Partnership NHS Foundation Trust services appear to have been causal to the incident."[69]

Analysis and commentary

10.15. The review team would caution against investigators making subjective statements that utilise words such as "probable"[70], as, based on the information within the SIR, there was not enough evidence to conclude what Tim's motivation was for seeking support.

10.16. The review team would suggest that rather than cite a comprehensive list of probable and related causes it would have been sufficient for the SIR authors, based on the information that was available to them, for the SIR author to have concluded that: "The root cause appears to be the breakdown of marriage and loss of hope of reconciliation."[71]

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[69] SIR p25-26
[70] SIR p26
[71] SIR p6

Sancus Solutions' review team noted that the authors of the SIR failed to consider and/or comment in any detail on the following areas.

11. Carer's assessment

11.1. The SIR documents that Tim's mother was offered a care assessment but makes no reference to whether Claire was also offered an assessment.

11.2. The evidence indicated that although Claire had separated from Tim, she continued to be involved, attending meetings with Tim's GP and was often documented as being present when he was in crisis. Clearly, the relationship between Claire and Tim was, at the time, complex, but there was evidence available to the involved practitioners that she was still actively involved in supporting her husband as well as being the main carer for their three young children, and therefore she was also in need of support.

Analysis and commentary

11.3. The review team would suggest that the findings of the SIR should have highlighted that Claire had not been offered a carer's assessment and should have commented about the lack of support that she was given.

11.4. There should also have been an associated recommendation within the SIR to improve the involved practitioners' understanding of complex family dynamics and their duty of care towards all family members who are involved in caring for someone within their family unit who is experiencing mental health issues.

11.5. The review team requested a copy of the trust's carer's policy and were informed that carers' involvement and support is embedded within the Integrated Care Planning Approach Policy. They were provided with a copy of the 2016 policy, which states:

"Carers form a vital part of the support required to aid a patient's recovery and staff should encourage family/carer involvement with the consent of the patient. The carers' own needs should also be recognised. The ICPA is underpinned by the principles embedded within the 'Triangle of Care'[72], and wherever possible and appropriate, collaboration between Trust Staff, Patients and their Families and / or Carers … carer's needs should be considered and recorded … support for carers can be accessed through the carer's assessment service or signposted as appropriate … Where a carer is

[72] Triangle of Care: refers to collaborative working between patients, professionals and families/carers Triangle of Care

providing regular and substantial support, they should be made aware of their right to an individual assessment of their own needs."[73]

11.6. Although the needs of a carer are highlighted within this policy, it was noted that in the section "The Role of the Care Coordinator, Lead professional, named Nurse and Key Worker"[74], an understanding of and expected response to the needs of carers was not identified.

11.7. In order for the assessment and identification of the appropriate support pathway for carers to be embedded within the role of care coordinators. The review team suggest that this is highlighted when the policy is revised in April 2019.

Somerset Partnership NHS Foundation Trust

Recommendation 4
The revised Integrated Care Planning Approach Policy should identify that it is the responsibility of either the care coordinators, lead professional, named nurse or key worker to assess carers and to signpost them to the appropriate support.

The revised policy should provide details of what support is available together with the relevant hyperlinks.

12. Safeguarding children

12.1. The SIR chronology documented only one reference to consideration of safeguarding issues, and that was during the initial assessment by CRHTT on 22 March 2015. It is unclear if this was referring to safeguarding issues relating to Tim, his wife and/or his children.

Post incident

The SIR documented that following the police's notification of the incident, the immediate action that was taken by the trust was to develop "An immediate strategy to care for Tim and [Claire's] three children by the Emergency Duty Team (EDT)"[75].

[73] Integrated Care Planning Approach Policy 2016 p6
[74] Integrated Care Planning Approach Policy 2016 p17
[75] SIR p2

12.2. The SIR documented that:

> "The safeguarding of the children was a prime consideration of the investigating team and evidence of their welfare was established early in the investigation and subsequently followed up with the GP and Tim's parents."[76]

12.3. The authors of the SIR documented that:

> "It was understood from Tim's parents that bereavement counselling for the children had been arranged through the education service."[77]

Analysis and commentary

12.4. Although not doubting the report by Tim's parents that the children were receiving ongoing support, the review team would suggest that rather than relying solely on information that had been reported by one set of grandparents, it would have been prudent for the authors of the SIR to have sought to validate this information by liaising with the trust's children's safeguarding team/Local Safeguarding Children's Board (LSCB) and/or the relevant education service that was providing the support to the children.

12.5. Such an inquiry would have provided assurance to the authors of the SIR that the safety, that the wellbeing and support needs of the children were being identified and/or adequately met.

12.6. Such action(s) would also have provided assurance to the trust' and SCCGs' governance groups, which had the responsibility for the approval of the SIR report, of the involvement of children's services and helped all relevant agencies to assess if there were any potential child protection issues that required action.

12.7. Since this incident, the trust has introduced a revised Serious Incidents Requiring Investigation (SIRI) Policy and Procedure (issued February 2017). In the review of the policy, it was noted that there is only one direct reference to children. The policy states:

> "If the SIRI involves a child, the Head of Risk or SIRI Investigation Lead will notify the Trust Safeguarding Lead who will in turn notify the Local Safeguarding Children's Board (LSCB)."[78]

12.8. There is no further reference or guidance provided as to how the SIR author should manage information with regard to either reporting potential

[76] SIR p6
[77] SIR p8
[78] Serious Incidents Requiring Investigation (SIRI) Policy and Procedure (issued February 2017) p11

safeguarding children issues that they become aware of during the course of the SIR investigation, or liaising with the trust's safeguarding team and/or the LSCB. Also, there was no guidance as to what action(s) they are expected to take when a child /or children may not be directly involved but maybe affected by the incident being investigated.

12.9. It was also noted that although there is a reference in the "Cross reference to other procedural documents" section (p21), there is no reference or hyperlink to the trust's safeguarding policies.

12.10. The review team have made the following recommendation with regard to a revision of the trust's Serious Incidents Requiring Investigation (SIRI) Policy and Procedure in order to ensure that the wellbeing and safety of children involved in/ or affected by a serious incident is at the forefront of every SIR investigation.

Somerset Partnership NHS Foundation Trust

Recommendation 5
Somerset Partnership NHS Foundation Trust 's Serious Incidents Requiring Investigation (SIRI) Policy and Procedure should be amended to include:

- a specific section on child protection which clearly outlines the investigator's safeguarding responsibility throughout the course of their investigation;
- guidance as to how an investigator should respond with regard to children who may be affected by a serious incident.

The cross reference to other procedural documents section should identify and provide a hyperlink to the trust's safeguarding policies.

13. Think Family

13.1. It was well documented that although separated from his wife, Tim continued to have ongoing parental responsibility and was, at times, looking after his children alone. The children were cited as a protective factor for Tim.

Analysis and commentary

13.2. The review team noted that there was no evidence that the involved practitioners assessed or gave any consideration to the children's needs and/or the potential impact on them during what was clearly a very complex time, when their parents had separated and their father was experiencing a significant mental health crisis.

13.3. This issue was not identified within the SIR report and was, the review team suggest, a significant failure of the report, as it was a missed opportunity to highlight that the Think Family Agenda[79] must both underpin clinicians' practice and be highlighted in the relevant trust's policies.

13.4. It appears that based on the evidence of the support offered to Tim, there needed to have been greater understanding of the impact of both the familial situation and Tim's mental health in order to assess the support needs and risk factors of the whole family. As it was, practitioners' focus was solely on the risks and support needs of Tim.

13.5. The Think Family Agenda recognises and promotes the importance of a whole-family approach, which is built on the principle of 'Reaching Out: Think Family'[80]. Its underpinning principle is the need for all practitioners to be:

"Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities."[81]

13.6. The National Confidential Inquiry into Homicides and Suicides supports this, stating that there "needs to be greater awareness for patients who are parents and especially those with severe mood disorders"[82].

13.7. There are a number of frameworks and assessment tools available that assist practitioners to view the family as a unit who may require support, and highlight the need to assess the impact of parental mental health on the children. For example:

- The Crossing Bridges Family Model[83] is a conceptual framework that aims to support staff to consider the parent, the child and the family as a whole unit when assessing the needs of and planning care packages for families where a parent is suffering from a mental health problem. The framework illustrates how the mental health and wellbeing of the children and adults, in a family where a parent is mentally ill, are intimately linked:

[79] The Think Family Agenda (2010) was a cross-governmental programme that funded both adult and children's services to work more closely together and take a whole-family approach to secure better outcomes for children from families with complex needs. Think Family
[80] Reaching Out
[81] Thinking Family
[82] Confidential Inquiry
[83] Crossing Bridge

"Parental mental health problems can adversely affect the development, and in some cases the safety, of children

Growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood"[84].

- Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[85] is an assessment tool that can be utilised:

"When considering the likelihood and severity of the impact of an adult's mental ill health on a child. It involves the practitioner thinking about the nature of risk and also the protective factors for the child so it brings into being the practitioner's professional judgement."[86]

13.8. PAMIC provides assessment tools to assess the potential risks and protective factors when there is a parent who is presenting with mental health issues. It also provides guidance on record keeping, interagency working, information sharing, and where and when disclosures, without consent, are necessary.

13.9. The review team suggest that the trust considers introducing such an assessment tool in order to increase and prompt practitioners' awareness of the needs and potential risks to children when a parent has mental health issues.

Somerset Partnership NHS Foundation Trust

Recommendation 6
Somerset Partnership NHS Foundation Trust should consider introducing an assessment tool, such as PAMIC and/or the Crossing Bridges Family Model, in order to increase its practitioners' awareness and understanding of the Think Family Agenda and the potential impact of parents' mental health on their children.

14. Risk assessments

"*To review the adequacy and frequency of the relevant risk assessments undertaken in relation to the care needs for the patient/client and that the consequence actions from the assessment were appropriate*."[87]

[84] Crossing Bridge
[85] PAMIC is a suggested assessment tool that has been developed by Tees Local Safeguarding Children Boards to assess the impact of parental mental health on children PAMIC
[86] PAMIC
[87] SIR p2

14.1. A core assessment and a risk screen were completed by the CRHTT following Tim's admission to A&E. The risk screen identified that Tim was at low risk of suicide and that he denied being a risk to others. His mitigating/protective factors were identified as being his family. No previous psychiatric or forensic histories were identified. The discharge plan was that Tim was to self-refer to Somerset Partnership Talking Therapies Service[88] and he agreed to see his GP to discuss medication options.

14.2. The SIR chronology documented that Tim's risk assessment was updated by CRHTT on most visits.

14.3. IAPT completed their own risk assessment on 23 April 2015.

Analysis and commentary

14.4. Although the SIR chronology makes reference to when the risk screen was revised by CRHTT and IAPT, there was no analysis of either the content or the standard of the risk screen within the main narrative of the report. There was also no cross-referencing within the SIR to the trust's risk policies that were in situ in order to assess the involved practitioners' compliance.

14.5. The review team were provided with a copy of Tim's risk screens from:

- 23 April 2015: Completed during Tim's initial admission to A&E. Despite Tim having just taken a significant overdose that required admission to A&E, his risk was assessed as "medium".

- 28 April 2015: Completed as part of the IAPT assessment. Despite Tim's disclosure of having taken several recent overdoses, his risk was assessed as "low".

14.6. Although the review team have not had access to all of Tim's risk assessments, they would suggest that based on the information that was available to the assessors, i.e. Tim's multiple recent suicide attempts, his risk score should have been assessed as high. Additionally a safety plan should have reflected this high level of risk.

15. Change in antidepressant medication

15.1. Both the SIR and the DHR documented that from his initial contact with mental health services (April 2015) to the incident (July 2015), Tim's antidepressant medication was changed from citalopram to mirtazapine, which was increased to the maximum dose of 45mg daily. He was also

[88] Somerset Partnership Talking Therapies

prescribed diazepam following his Section 136 and subsequent Mental Health Act 1983 assessment.

15.2. Tim's compliance and any reported potential side effects were not noted in the SIR, so it is unclear if he was being asked about this by the CRHTT team.

15.3. The relevant NICE [89] clearly identified that the time following commencement of antidepressant medication, as well as following any changes to this medication, is a "high risk period"[90] for patients. Both requiring periods of close monitoring by the prescribing clinician.

15.4. The failure of the involved practitioners to consider the increase in Tim's potential risk during these periods was not considered within the SIR report.

15.5. It was also not evident within the information available, nor was it highlighted within the SIR, who was responsible for monitoring Tim's compliance as per the NICE guidelines, which states:

"For people who are considered to be at increased risk of suicide or are younger than 30 years, normally see them after 1 week and then frequently until the risk is no longer clinically important."[91]

15.6. Clearly, Tim was in this particular category of risk, as it was known that during a very short period of time, he had, on at least three occasions, attempted to take his life by suicide. He also had his antidepressant medication changed and then increased within a relatively short period of time.

15.7. Although it appears that the prescribing clinician was Tim's GP, his trust notes indicate that his medication regime was known by the involved trust clinicians. However, there was no indication in the SIR of whether they were ensuring that Tim was being monitored by the GP or whether they were liaising with his GP.

15.8. The review team would suggest that the authors of the SIR should have been identifying this failure of the involved practitioners to assess and respond to this potential risk. The review team would also have expected the SIR report to have:

- highlighted this deficits in practice;
- Made reference to the relevant NICE guidelines on the prescribing and management of antidepressant medication:

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[89] NICE
[90] NICE guidelines
[91] NICE guidelines

- If appropriate/relevant cross-referenced the deficit to the relevant trust policies;

15.9. This is an example of how the SIR failed to provide a comprehensive commentary and analysis of the assessments and support being offered to Tim against clinical and best practice guidelines and also the trust's policies. Where remedial action was required, for example a revision of the policy and/or training for staff, this should have been highlighted within the SIR contributory factors and lessons learnt.

15.10. In this case there should have been a specific, measurable, agreed, result- and time-focused (SMART) recommendation that resulted in improving future risk assessment practices. As it was, the only SIR recommendation that related to improving the standards of risk assessment was recommendation 4:

"Ensure all staff are aware that it is everyone's business to ensure risk information is updated with new information. Action – 'What's on' Learning Point. Inclusion of examples in staff mandatory risk training and HCR-20 training. ICPA Best Practice Group."[92]

15.11. The review team were provided with evidence of the HCR-20 advanced risk training PowerPoint presentation and the entry on What's On (dated 24 March 2017) and noted that there was a section on when risk information must be updated.

15.12. The review team would suggest that using the trust's intranet communication was not a SMART recommendation as there is no process that can monitor if the relevant practitioners have accessed the relevant What's On entry. The review team were informed that this method of communicating the findings of SIRs to the trust's staff is no longer used.

15.13. The review team would also suggest that there should have been the following specific recommendations in the SIR for the CRHTT:

- an audit of CRHTT files should be undertaken to evidence if this was a systemic issue within the team

- in order to address the deficits in regard to the risk assessments the involved members of the CRHTT should attend HCR-20 training.

15.14. The review team would suggest that when a significant deficit has been identified in a SIR with regards to risk assessments and care planning that

[92] SIR p28

there should be a standard recommendation that a file audit be undertaken to ascertain if it is a systemic issue within the team that requires addressing.

Somerset Partnership NHS Foundation Trust

Recommendation 7
When a serious incident report highlights that there has been a significant deficit in either risk assessments or care planning this should always prompt a comprehensive service file audit.

15.15. The review team have concluded that the SIR's authors failed to satisfy the ToR:

"*To review the adequacy and frequency of the relevant risk assessments undertaken in relation to the care needs for the patient/client and that the consequence actions from the assessment were appropriate*."[93]

16. Duty of Candour[94]

"*Review the application of the Duty of Candour and involvement with the patient/family within 10 days of the incident, in line with the regulation*." [95]

16.1. The only reference in the SIR to the trust's Duty of Candour is as follows:

"Every reasonable and sensitive effort has been made to convey the offer of involvement and support to [Claire's] parents but they declined."[96]

16.2. The author of the SIR reported to the review team that he did not provide any direct feedback from the SIR to either family. He recalled that Tim's family had requested a copy of the SIR, but he was uncertain if this had occurred. He thought that, at the time, it might have been the responsibility of the trust's Serious Incident Group (SIG) to provide feedback from SIRs to families.

[93] SIR p2
[94] Duty of Candour: Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, and providing truthful information and an apology when things go wrong. This came into effect in November 2014. The introduction of the Duty of Candour was a significant step in ensuring a more honest and open culture in the NHS, particularly when things go wrong. It was one of the government's responses to the Francis report into Mid Staffordshire, which called for a more open culture in the NHS Duty of Candour
[95] SIR p 1
[96] SIR p6

16.3. The author of the SIR also reported that at the time there was a lack of clarity and processes, but he thought that it had been the SIG's responsibility to communicate with families.

Analysis and commentary

16.4. Duty of Candour (Regulation 20) at the time of this incident requires providers to:

- "Ensure that one or more appropriate representatives of the provider gives a meaningful apology, in person, to relevant persons. An apology is defined in the regulation as 'an expression of sorrow or regret in respect of a notifiable safety incident'.
- Providers must give the relevant person all reasonable support necessary to help overcome the physical, psychological and emotional impact of the incident, providing the relevant person with details of specialist independent sources of practical advice and support or emotional support/counselling.
- Providing the relevant person with information about available impartial advocacy and support services, their local Healthwatch and other relevant support groups, for example Cruse Bereavement Care and Action against Medical Accidents (AvMA), to help them deal with the outcome of the incident.
- Arranging for care and treatment from another professional, team or provider if this is possible, if the relevant person wishes.
- Providing support to access the complaints procedure."[97]

16.5. Based on the evidence available in the SIR, the trust clearly failed in their statutory obligations under Duty of Candour.

16.6. Since this incident, the trust has revised its Serious Incidents Requiring Investigation (SIRI) Policy and Procedure and its Duty of Candour Policy (February 2017). This clearly outlines the responsibilities of the trust, services who are involved in an incident and authors of SIRs. It states:

"The Being Open principle is now a statutory requirement, which places a Duty of Candour on providers to advice patients and/or their family of a serious incident, to apologise and offer them the opportunity to be advised of the outcome. The local team must contact the patient (if applicable) and/or their family/carer to discuss the incident that has occurred/or is suspected to have occurred and let them know an investigation will be undertaken. This must be done within 10 working days after the SIRI is reported. The

[97] Regulation 20 Reg. 20

patient/family/carer should be offered support, and invited to contribute to the investigation. They should also be offered feedback on the findings and action plan, following the investigation. The wishes of the patient/family/carer must be documented in the patient's record and communicated to the investigator.

If the patient/family/carer wishes to be involved in the investigation, and/or receive feedback they should be contacted at the earliest opportunity by the investigator to determine how this should take place. Where contact with the patient/relatives may not be indicated, for example in safeguarding incidents or where a criminal investigation is in progress, the Duty of Candour may be withheld following discussion with the relevant agencies e.g. safeguarding team.

When logging incidents on STEIS, the Duty of Candour field must confirm that the patient/family members have been informed and the extent of planned involvement of the patient/family in the investigation."[98]

16.7. The revised RCA investigation pro forma requires the investigator to document evidence of the actions taken to involve families and of compliance with the trust's Duty of Candour.

16.8. The author of the SIR confirmed that in his opinion there is now greater clarity as to the responsibilities in relation to involvement of families in SIRs.

16.9. The Head of Clinical Governance and Clinical Risk reported that now as a matter of course the Serious Investigation Lead and/or somebody from the involved service will, as part of the trust's Duty of Candour, make contact with families at the point that the ToR are being agreed. They will explain to families that an internal investigation is to be undertaken and invite them to contribute any specific questions that they may wish to be included in the ToR.

16.10. In the review team's extensive experience of involving families in mental health or domestic homicide investigations, one of the main difficulties, and one that has caused additional distress to families, is that they are often asked to recall and reflect on what are very difficult recent memories, often even before the inquest and/or the funeral have taken place. Families are also asked to contribute to a ToR and be involved in an unfamiliar process when they are understandably in a state of deep bereavement and may be experiencing post-traumatic stress.

16.11. In this case, both sets of grandparents were not only having to manage their own complex feelings of trauma and grief but presumably trying to negotiate

[98] Serious Incidents Requiring Investigation (SIRI) Policy and Procedure p12

the practical arrangements of looking after Tim and Claire's three young children, who would undoubtedly have been deeply traumatised by the loss of both their parents.

16.12. It is difficult to see how, in the midst of such trauma, the grandparents would have felt able to contribute to the terms of reference and/or to read SIR report within the time frame that was being prescribed to them.

16.13. The review team suggest that, in future, every effort should be made by the trust to involve the families of both the victims and the perpetrators at a time that is sensitive to their situation and not dictated by a time frame imposed by the trust's commissioners, even if this results in their being unable to meet the 60-day target for submission of the SIR to SCCG.

16.14. The review team would also suggest that the trust considers the option of recruiting a family liaison post, who is trained and experienced in supporting bereaved and traumatised families. Their role would be to act as the point of contact with families and also provide support to families throughout the SIR process.

Somerset Partnership NHS Foundation Trust

Recommendation 8
Somerset Partnership NHS Foundation Trust should consider recruiting a family liaison officer who would be the single point of contact and support for families throughout the course of a serious incident investigation.

16.15. With regard to contacting the parents of both Claire and Tim , the review team have concluded that:

- The trust failed to meet its Duty of Candour post incident and there was no explanation within the SIR as to why this was the case.
- The SIR failed to comment on the trust's "application of its Duty of Candour"[99] and therefore failed to meet this ToR.

17. Training and professional development

"*To examine the appropriateness of the training and development of those involved in the care of the client/Serious Untoward Event in relation to assessment, risk*

[99] SIR p4

assessment, care planning, observations and planning for discharge if the patient has recently been an inpatient."[100]

17.1. The SIR makes no reference to the training of the practitioners involved in the assessment and care of Tim, therefore, it has failed to meet this ToR.

Good practice

17.2. The review team recognises that identifying good practice is an important part of an SIR, as it highlights, acknowledges and values actions taken by staff.

17.3. The SIR identifies a very extensive list of areas of good practice, such as the standard of record keeping and risk assessments, and the liaison between services and agencies. However, these areas were also cited within four of the recommendations (recommendations 1, 2, 3 and 4) as requiring improvements. Given that the deficits were significant enough to require specific recommendations; it is difficult to comprehend how they could also be areas of noticeable practice.

17.4. The review team would caution against authors of SIRs citing particular areas of good practice that are in fact what is expected as standard practice by professional clinicians and practitioners. For example: "the care and treatment of Tim appeared caring and responsive. Tim was treated with dignity and respect."[101]

17.5. Caution should also be taken when using emotive language, such as caring and responsive, as not only is it unquantifiable, but it may cause a negative and/or adverse reaction from families, as this may not have been their experience.

17.6. The review team suggest that this section of an SIR should only be used to document and comment on any specific and outstanding actions that are beyond what would be expected or required from either an individual or a service provision.

18. Somerset Partnership NHS Foundation Trust's action plan

"Review progress made against the action plan."[102]

18.1. An action plan was included with the SIR that identified 12 recommendations, which each cited:

[100] ToR p1
[101] SIR p25
[102] NHS ToR p1

- action(s) to be taken;
- person(s) responsible for each action;
- target date for completion;
- allocation of a Red, Amber, Green (RAG) rating.

18.2. The review team were provided with the most up-to-date action plan, which indicated that all actions had been completed.

18.3. It appears from the evidence supplied to the review team that the action plan had been updated on the following occasions:

- 18 February 2016 – draft action plan developed;
- 6 May 2016 – updated;
- 24 October 2016 – updated;
- 15 February 2017 – additional evidence embedded within the action plan
- 13 April 2017 – updated.[103]

Analysis and commentary

18.4. The following recommendations were not included within the action plan:

- Recommendation 1: "Share good practice identified in this report. Action – disseminate through operational managers."[104]
- Recommendation 12: "To share the report with GP highlighting concerns of parents around the reaction to Tim's use of an 'emergency appointment' at the surgery."[105] The SIR report notes that as part of the shared learning the GP was provided with a copy of the SIR report.)

  The review team were unable to ascertain why these two recommendations, along with what actions were taken by the trust to ensure that the recommendations were adequately implemented, were not included.

18.5. It was recognised by both the SIR author and the operational managers who were interviewed by the review team that there were too many recommendations in the report were not SMART. For example, a number of

[103] Information obtained from local action plan dated 13 April 2017: lead officer the same as the SIR
[104] SIR p28
[105] SIR p28

recommendations were to be communicated to staff via the trust's staff newsletter.

18.6. The review team would suggest that there were a number of significant deficits in using this method of communication as there were no processes in place to:

- ensure that the relevant staff had viewed the information
- monitor and evaluate the impact on practice and services.

18.7. The review team were informed that since the incident, this form of intranet communication has ceased and that there are now the following systems/structures in place to ensure that SIR learning is cascaded in a more focused way:

- All team meetings have a standard agenda item for learning from SIRs. Minutes of this agenda item are taken so that it is available to staff who are unable to attend the meeting.
- The Mental Health Directorate sends "lessons learnt" briefings to the teams.
- It was reported that the SCCG and the trust have also recently started convening learning events where the findings and learning from SIRs are highlighted. These events are open to all trust staff.

18.8. Additionally, since 2017 the trust has introduced an immediate and service-focused learning process that commences at the point of the 72-hour report is completed.

18.9. The Serious Incidents Requiring Investigation (SIRI) Policy and Procedure outlines the following processes:

- "The local team should identify learning and good practice at the time of the incident and through the 72 hour report. The local action plan (LAP) should be started at this stage, with SMART actions and any necessary actions put in place.
- The Team/ward manager must arrange a multidisciplinary review of the incident approximately two weeks after it occurred. This review should involve medical staff and staff from services who have contributed to the patient's care within the previous 6 months. If possible the investigator(s) should also attend. The review should identify good practice, practice issues, contributory factors, root causes and lessons learned.
- This review should be used by the investigator(s) to form the basis of the subsequent Investigation.

- Once the investigation has been completed, the LAP should be updated, and submitted with the draft SIRI report."[106]

18.10. The review team noted that policy does not identify who maintains responsibility for monitoring this service-level process. It was reported to the review team that it is the responsibility of the SIRG to monitor SIR LAPs.

18.11. The review team suggest that the Serious Incidents Requiring Investigation (SIRI) Policy and Procedure needs to be revised to include who holds the responsibility for the monitoring of both local post-incident investigations and LAPs.

Somerset Partnership NHS Foundation Trust

Recommendation 9
Somerset Partnership NHS Foundation Trust should revise their Serious Incidents Requiring Investigation Policy to identify who has responsibility for the monitoring of post-incident action plans.

The following section provides a commentary/update on the recommendations that have not been highlighted elsewhere in this report. The information is based on the SIR action plan that was updated on 13 April 2017.

18.12. "**Recommendation 1:** All staff to be made aware of the importance of clear and comprehensive record keeping, including the impact of spelling and grammar mistakes on meaning.

Recommendation 2: All hand written scanned documents need to be legible."[107]

Both completed 31 May 2016

Evidence supplied to the review team:

- "What's On" Learning Point entry
- Record Keeping policy (August 2015)
- Memo to ward managers

[106] Serious Incidents Requiring Investigation (SIRI) Policy and Procedure p14
[107] Action plan 13 April 2017

- Email from the Deputy Head of Division for the adult mental health inpatient community and crisis service to Community Mental Health (CMHT) managers with a list of learning points from SIRs. This list includes:

  "Team managers to ensure that staff are made aware of the importance of clear and comprehensive record keeping, paying particular attention to spelling and grammar."[108] This email includes hyperlinks to the trust's record keeping policy and Nursing and Midwives Code of Practice (NMC).[109]

- HCR-20 training PowerPoint presentation (September 2015) identified various findings from SIRs including inadequate record keeping.

18.13. **Recommendation 5:** "Learning point: Jealousy is a specific risk factor for violence. The presence of jealousy towards a partner should trigger a proactive enquiry about violent thoughts or intentions ideally without the partner or spouse being present. Action – 'What's on' Learning Point and inclusion of examples in staff mandatory risk training and HCR-20 training. ICPA Best Practice Group."[110]

Evidence supplied to the review team:

- What's On entry 24 March 2017
- HCR-20 training PowerPoint presentation (September 2015).
- The action plan (13 April 2017) notes that "risk of harm to others is covered in the Risk and Management policy"[111].

18.14. The review team noticed that:

- The PowerPoint presentation makes no direct reference to jealousy being a potential risk factor for domestic violence.
- Neither the trust's Domestic Abuse Policy (October 2017) nor the Risk and Management Policy (February 2017) makes any direct reference to jealousy being a potential risk factor.
- This issue was not highlighted in the email from the Deputy Head of Division for the adult mental health inpatient community and crisis service to

[108] CMHT BP Group – SIRI local action plan – learning points
[109] NMC
[110] Action plan 13 April 2017
[111] Action plan 13 April 2017

Community Mental Health (CMHT) managers that contained a list of learning points from SIRs.

18.15. In 2015 Grania undertook an intimate partner homicide[112] investigation commissioned by NHS England (South Central)[113] on a case in which, like Tim, the perpetrator had, prior to the incident, been a patient of the trust's community mental health services.[114] The investigation made a similar recommendation relating to increasing the trust's practitioners' understanding and identification of domestic violence where jealousy may be a significant factor and improving risk assessments with regard to identifying and assessing the potential risk(s) of domestic violence.

18.16. The review team concluded that the actions taken by the trust in response to increasing practitioners' understanding of jealousy being a potential risk indicator of domestic violence was not adequate and that further immediate action is therefore needed.

Somerset Partnership NHS Foundation Trust

Recommendation 10

Somerset Partnership NHS Foundation Trust must take immediate action to highlight the potential risks of jealousy and domestic violence by :

- providing specific training for practitioners
- revising the Domestic Abuse, Safeguarding and Risk Management policies.

18.17. **Recommendation 6:** "to consider as standard sharing the outcome of Section 136 assessments with GP and appropriate others. Action – Memo to all appropriate medical staff to request that they write to inform the GP when they have undertaken a Section 136 or a Mental Health Act assessment in the community."

[112] Intimicide (intimate partner homicide) is the killing of a former, current or temporary intimate partner or a member of the intimate partner's familial or social circle by another former, current or temporary intimate partner
[113] NHS England Report
[114] A patient of the Crisis Resolution and Home Treatment Team, who was assessed utilising Section 136 of the Mental Health Act 1983. Section 136 is an emergency power which allows a person to be taken to a place of safety from a public place, if a police officer considers that a person is suffering from a mental illness and is in need of immediate care Section 136

Recommendation 15: "If Somerset Partnership is informed about a patient death then the GP should be informed by the appropriate manager or duty manager."[115]

Evidence provided: Memo from Medical Director and Responsible Officer (25 February 2016) requesting that a memo be sent to all consultant psychiatrists "Asking that when they undertake a Mental Health Act assessment (including section 136) in the community that they also inform the patient's GP as standard practice"[116].

18.18. In order to assess current compliance with these two actions, the review team suggests that the following recommendation is actioned:

Somerset Partnership NHS Foundation Trust

Recommendation 11
Somerset Partnership NHS Foundation Trust should undertake an audit of a random sample of patient records to ascertain whether:

- consultant psychiatrists are informing a patient's GP when a Mental Health Act (1983) assessment (including section 136) has been undertaken.
- the appropriate manager or duty manager are informing a GP when one of their patients has died.

18.19. **Recommendation 7:** "Somerset Partnership Talking Therapies Service to review record keeping of Step II interventions with a view to including attendance details."

Evidence provided: to the review team were provided with the IAPTus Record Keeping for Groups Procedure, which included very brief guidance on assessing risks and attendance.

18.20. **Recommendation 8:** "Review Place of Safety provision including use of service user and carer feedback to improve the patient experience particularly for those people who have had no previous contact with inpatient and other services for severe mental illness."

[115] SIR p3
[116] Memo dated 25 February 2016

Evidence provided: It was reported to the review team that there has been a refurbishment of the place-of-safety suite in the summer of 2015.

18.21. **Recommendation 9:** "CRHTT's to review service model from the perspective of staff consistency. There should be personalised care for those service users who would benefit from consistency; consideration should be given to provision of a named CRHTT keyworker for all patients under this service."[117]

Evidence provided: It was reported to the review team that due to the nature of the service, i.e. a 24-hour, 7-day-a-week service and shift pattern, it is not possible to provide patients with a single key worker. It was also reported that there had been a recent quality improvement project which reviewed how the service could improve the involvement of families and carers.

The fact that this recommendation was not achievable was not updated on the action plan, which documented that it was completed on 30 June 2016.

18.22. **Recommendation 10:** "To develop clear information on Self-Management Groups including criteria, referral pathway and team protocols."[118]

Evidence provided: the review team were provided with the Self-Management Course Referral Protocol; however, they were informed that this group is no longer run by the CRHTT. It is now run by secondary mental health services.

18.23. **Recommendation 11:** "To review the interface and transition protocol between [Somerset Partnership Talking Therapies Service] and CRHTTs"[119]

Evidence provided: the review team were provided with a copy of the Home Treatment Team (HTT) Referral Procedure Protocol[120], which outlines the referral pathway and relevant contact details. It also documents what action(s) should be taken if the referral is out of hours. They were also informed that HTTT's operating policy now outlines the referral protocol and HTT engagements with other services both within the trust and externally.[121]

18.24. **Recommendation 14:** "The CRHTT Discharge Summary Proforma should include a formulation or diagnosis and the Psychotropic Change Notification Form should be amended to include Diagnosis. Ideally both these documents should only be 1 side of A4."[122]

[117] SIR p3
[118] SIR p3
[119] SIR p2
[120] NB the CRHTT is now called HTT
[121] Sections 7 and 13
[122] SIR p3

The action plan mentions a “draft CRHTT discharge proforma” and states that this was completed on 31 May 2016. However the review team were informed that:

“No current template [is] used across CMHT currently – although local templates [are] in use. Development work underway to have an electronic GP discharge summary to be in place by 1 Oct 2018.”

The latest DHR updated action plan (31 January 2018) documented in a footnote that:

“Update [XX] confirming this is in planning stages, so is ongoing.”[123]

18.25. The review team were concerned as to the reason why this relatively simple action has taken over three years to be completed and have made the following recommendation.

Somerset Partnership NHS Foundation Trust

Recommendation 12
Somerset Partnership NHS Foundation Trust should develop a Crisis Resolution Home Treatment Team discharge summary proforma.

18.26. Furthermore, the review team would suggest that the trust must ensure that all their SIR and DHR action plans accurately reflect the progress of all actions and are not signed off until all actions have been completed.

19. Current care pathways

“Review processes in place to embed lessons learnt and whether those changes have had a positive impact on the safety of the trust’s service.”[124]

19.1. The review team concluded that based on the current care pathways, if Tim presented today at the Accident and Emergency department, the involvement and responses of the trust’s services would be similar. Although not directly related to this SIR, the following changes/processes have since this incident been introduced:

[123] DHR action plan 31 January 2018 p5
[124] NHS ToR p1

- The Psychiatric Liaison Team at A&E is now provided by Home Treatment Team (HTT). This allows for more seamless care to be provided across the acute and community services.

- Both IAPT and HTT have read-only access to each other's patient record systems. This enables information, such as risk and attendance, to be shared.

- Regular team and managerial meetings take place between CRHTT and IAPT services.

- There are now bimonthly and annual audits taking place of care plans, risk assessments and record keeping within both inpatient and community mental health services.

- A case management tool has been introduced within the CMHT which is utilised by front-line practitioners and reviewed in their supervision.

- The Integrated Care Planning Approach Group (ICPAG) is currently considering how to develop personalised care plans for patients who are involved in more than one service.

- A new care plan template has been introduced across the trust.

- A risk screen to be used when moderate to severe risks have been introduced that prompts the practitioner to complete an escalation plan

19.2. However in the review team's review of the IAPT risk assessment that is being used in the trust they had concerns that it was very minimal in content and that it does not relate to the trust's own risk assessment policy

19.3. Although IAPT services are required to complete a prescribed number of IAPT assessment and monitoring forms in the most recent IAPT Operating Procedure[125], there is only one specific reference to risk, and that is in relation to what action(s), dependent on their assessed of a patient's risk level, should be taken if the patient disengages from the service.[126] Other than this, there was no reference/guidance as to:

- How IAPT therapists should assess, document and monitor risk.

- What action(s) the practitioners expected to take if during the course of an assessment there are concerns regarding emerging risk(s) to either the patient or others.

[125] Operating procedure
[126] Standard Operating Procedure p11

19.4. The review team have concluded that the risk assessment tool being used by the trust's IAPT service is inadequate. They would suggest that the trust considers either making IAPT use the same risk assessment as their community mental health services, or to develop a bespoke IAPT risk assessment.

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG) and NHS England (South) Homicide Lead.

Recommendation 13
Somerset Partnership NHS Foundation Trust should introduce either their community risk assessment tool in their IAPT service or developing a IAPT risk assessment tool that includes:

- the identification and assessment of all potential current risks, including the patient's risk to self and others;
- documentation of all historical risks and a narrative of all risk(s) identified;
- an IAPT risks management plan, which includes both a contingency and a crisis plan.

SCCG and NHS England (South) Homicide Lead should seek assurance and evidence from Somerset Partnership NHS Foundation Trust that the IAPT's

risk assessment tool adequately identifies potential risks and safeguarding issues.

20. Domestic homicide review

"**Review the Trust and CCG action plans developed from the Safer Somerset Partnership Domestic Homicide Review: Overview Report Into the death of Clare and assess their quality.**
Review progress made against the action plan.
Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.
Review whether the Trust Clinical Governance processes in managing the DHR Action Plan were appropriate and robust."[127]

Somerset Partnership NHS Foundation Trust

[127] NHS England ToR p1

20.1. The trust submitted their SIR to the DHR panel as their IMR, which included 12 of the SIR recommendations. The two recommendations that were omitted were:

Recommendation 1: “Share good practice identified in this report.”
Recommendation 12: “To share the report with GP highlighting concerns of parents around the reaction to Tim’s use of an ‘emergency appointment’ at the surgery.”

20.2. The review team were provided with a number of updated action plans from Safer Somerset Partnership, and, as this report has already identified in only one action currently remains outstanding – that is the GP discharge pro forma.

Analysis and commentary

20.3. It was reported to the review team that neither the Safer Somerset Partnership, who commission the DHRs, nor the chair of the DHRs require evidence from agencies of the completion of their action plans.

20.4. Safer Somerset Partnership continues to audit the DHR’s action plan, on an annual basis, until all actions have been reported as completed.

20.5. When questioned by the review team, the involved practitioners and managers reported that although they had been aware that a DHR was being undertaken, they were not aware of its outcomes nor did they receive any feedback from the trust. The review team would suggest that DHRs should be viewed as a valuable source of learning for the trust, as they provide a multi-agency perspective.

20.6. The newly appointed Head of Clinical Governance and Clinical Risk reported that as there had not been a DHR investigation since her appointment so she is not aware of the internal governance and reporting processes for DHRs.

20.7. It was noted that the most recent Serious Incidents Requiring Investigation Policy and Procedure only makes one reference to DHRs:

“Wherever possible, SIRI investigations should continue alongside criminal proceedings, Serious Case Reviews and Domestic Homicide Reviews.”[128]

In order to address this and the lack of a governance structure for monitoring and reporting findings from DHRs, as well as to optimise the learning opportunities within the trust, Sancus Solutions have made the following recommendations:

[128] Serious Incidents Requiring Investigation Policy and Procedure p15

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG)

Recommendation 14
Following a domestic homicide review (DHR), Somerset Partnership NHS Foundation Trust in partnership with SCCG should convene learning event for all the involved managers and practitioners.

Somerset Partnership NHS Foundation Trust

Recommendation 15
Somerset Partnership NHS Foundation Trust should revised their Serious Incidents Requiring Investigation Policy and Procedure so that it documents the governance arrangements for:

- domestic homicide review's (DHR) individual management reports (IMRs)
- monitoring arrangements of DHR's action plans.

21. Somerset Clinical Commissioning Group

21.1. SCCG submitted the following four recommendations to the DHR on behalf of primary care:

- **Recommendation 1:** Feedback and debrief to be offered to the GP practices prior to publication.

  Key actions: Learning to be shared with the two GP practices involved as part of a Protected Learning Time session.

  Key outcomes: Feedback and debrief to Practice. Learning shared with 2 Practices.

  Target date for completion: December 2016.

  RAG rating green (completed).

- **Recommendation 2:** For GP and practice training to reiterate the need to include social history and care-frontational questions[129] in consultations.

[129] Challenging a patient sensitively, and considering the implications of their life choices and behaviours

Key actions: To review the training programme for GP practices in respect of what is covered in consultations.

Evidence: This is now included in safeguarding training and also discussed as part of training case studies. A section on professional curiosity is a part of the training.

Target date: March 2017.

RAG rating: green.

- **Recommendation 3:** Develop and adopt a risk assessment tool for GP practices to include: Risk to self, risk to others, risk of self-harm, risk of violence, consultation with family or others to inform decision-making process.

Where the tool is piloted and if proved useful, the tool should be embedded in the all computer systems to enable all primary care providers to use such a tool nationally.

Key actions: To work together with other GP practices locally to develop this tool.
Somerset CCG to share the outcome of the pilot with NHSE to consider the implementation of this tool within Primary Care.

Evidence: A pilot project is currently underway of the new national tool from Connecting with People. This is under consideration for commissioning for Primary Care and possibly Secondary care also. This tool is EMIS friendly and being developed for RiO electronic records.

Target date: March 2017.

RAG rating: Green.

- **Recommendation 4:** Ensure there is prompt communication to GP practices after Section 136 or other mental health assessments.

Key actions: Work with Somerset County Council AMHP team and Somerset Partnership NHS Foundation Trust to put a process in place to ensure timely communication is sent to a patient's GP of any mental health assessments.

Evidence: This was actioned immediately following this incident.

Key action: This should continue to be monitored.

Target date: March 2017.

RAG rating: green.

21.2. All of SCCG's recommendations have been signed off as completed by Safer Somerset Partnership in their action plan monitoring.

Analysis and commentary

21.3. The most recent Third Progress Report of the Cross-government Outcomes Strategy to Save Lives (2017)[130] cites the government and NHS England's continued commitment to reducing deaths by suicide and increasing support for people who are at most risk. The strategy states:

"NHS England's mental health programme across the life course is centred on the importance of early intervention so people of all ages have timely access to evidence-based services as close to home as possible with clear pathways to support recovery … Training for GPs and GP surgery staff in awareness of suicidality and safety planning can play a crucial role in suicide prevention."[131]

21.4. It was reported to the review team that it is common practice for SCCG's Patient Safety GP to complete an IMR for a GP practice. In this case, the Patient Safety GP accessed both Tim's and Claire's patient records and also discussed with the GPs their involvement.

21.5. The SCCG's Patient Safety GP reported to the review team that, unlike with serious case reviews, Safer Somerset Partnership do not convene a learning event where the findings of the DHR are discussed with the agencies who submitted IMRs. However in 2017 SCCG convened eight meetings where learning from SIRs was discussed; these sessions were open to GPs and other SCCG-funded providers of services.[132]

21.6. The SCCG's Patient Safety GP also reported that his focus in the last five years has been suicide prevention, and since this incident a suicide prevention assessment tool has been introduced to primary care services in SCCG's locality in partnership with Somerset County Council. This assessment tool is called the SAFE Tool[133] which is an assessment and

[130] Cross governmental outcomes strategy to save lives
[131] Third Progress Report of the Cross-government Outcomes Strategy to Save Lives p13 Cross governmental outcomes strategy to save lives
[132] CCGs are not the lead commissioner for their GP services (this is NHS England's function), but they are responsible for the quality of these services
[133] SAFE Tool

planning tool that provides a guided formulation and a compassionate approach to assessing patients who are disclosing to their GPs that they feel suicidal.

21.7. The SAFE Tool is specifically designed to be used by GPs and is used to assist in identifying and assessing a patient's:

- continuum of suicidal thoughts at the time they are presenting to the GP;
- evidence-based risk factors and red-flag warning signs – for example assessing their personal background, clinical factors, mental state examination, demographics and social situation (for example, a male under 25 years, homeless are often significant risk factors).

Having made the assessment, the patient is placed in one of four categories of suicidal risk:

- passive
- active
- dangerous and imminent.

According to which category a patient is assessed as being in, the assessment tool provides a guided approach as to how the assessor should respond: for example, arranging specific community support or a Mental Health Act 1983 assessment.

21.8. Apart from the assessment and classification sections, the tool also has a safety plan section which requires the assessor to document support information and a de-escalation plan as well as a specific suicide prevention safety plan.

21.9. It was suggested to the review team that the SAFE Tool provides a more accurate and personalised assessment of a patient's risk of suicide than the tool currently utilised by the trust which utilises the SAD PERSONS assessment and scoring system.[134]

21.10. It was reported that one of the benefits of GPs using such a tool is that it forms part of the referral information which they send to primary/ secondary mental health services. Thus providing essential and comprehensive information on which mental health services can then take prompt action from the point of the initial referral: for example, fast-tracking the patient to the

[134] SAD PERSONS is an acronym that stands for the following – S: Sex. A: Age (<19 or >45 years). D: Depression. P: Previous attempt. E: Excess alcohol or substance use. R: Rational thinking loss. S: Social supports lacking. O: Organized plan. N: No spouse S: Sickness

appropriate service(s). However it is currently not mandatory for the GPs in the SCCG locality to use this tool.

21.11. Suicide prevention training is provided by the council and SCCG Patient Safety Lead also provides a half day training module in suicide prevention for GPs.

21.12. Currently suicide prevention is not including it in the GP's Commissioning for Quality and Innovation (CQUIN).[135]

21.13. It was reported that in order to facilitate learning, every three to six months, SCCG use their newsletter, 'Safety Net', to publish the findings and recommendations from DHRs, SIRs and serious case reviews. This newsletter goes out to all services that the SCCG commissions, such as GPs, practices and pharmacies. The review team were provided with evidence of SCCG's 'Safety Net' (August 2018) which provided a hyperlink to End The Silence End Suicide publication, learning points from recent events and suicide awareness and information about training provided by SCCG.

21.14. With regard to domestic violence and safeguarding training for GPs, it was reported to the review team that:

- Safeguarding training. In 2014 there was an adult safeguarding training programme was commissioned by Somerset County Council for GPs. However, unlike children and young people safeguarding training, which it is mandatory for GPs to undertake annual Level Three training, adult safeguarding training is not a mandatory requirement.

- In 2015 as part of SCCG's contract with GPs, it was introduced that GPs had to undertake annual training on the Bournemouth National Safeguarding Adults Competency Framework (levels one, two and three), which includes areas such as domestic abuse and mental capacity.

- In 2016 a domestic abuse training programme was widely introduced in Somerset and GPs were invited to attend.

- In 2018/19 there are plans to commence further safeguarding training for GPs, which includes domestic violence.

21.15. It was also reported to the review team that as yet SCCG have not specially identified the learning form the SIR and DHR with regard jealously as being a

[135] CQUIN is an acronym for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement, while delivering better outcomes for patients CQIN.

potential trigger for domestic violence. However following this review it is their intention to highlight this issue in the next edition of 'Safety Net'.

22. Care Quality Commission

22.1. In the CQC's inspection of the trust in 2015, it was concluded that:

"Investigation of incidents was thorough but shared learning was not reliable."[136]

However in their inspection in 2017, CQC concluded that:

"The trust had made significant progress in addressing the concerns we raised following our inspection in September 2015. We have changed the overall trust ratings in the key questions of effective, responsive and well-led from requires improvement to good."[137]

22.2. During Sancus Solutions' review considerable evidence was provided of the significant changes that have occurred since this incident within the trust's management of their SIRs and governance processes which was indicating that the standard of their SIRs should now be significantly improved in comparison to the SIR for this case. There was also evidence that the trust's governance processes now provide a greater degree of rigour in the evaluations and monitoring of their SIRs and their action plans

22.3. However as it was not in the ToR for this review to assess the current quality of trust's SIRs and overarching governance processes the review team would suggest that in order for the NHS England (South) Homicide Lead to be satisfied and have evidence of the improvements that have been made that they consider undertaking a qualitative audit of a random number of more recent SIRs.

Somerset Clinical Commissioning Group (SCCG)

Recommendation 16: Somerset Clinical Commissioning Group should consider undertaking a qualitative audit of a random number of recent Serious Incident Reports that involve Somerset Partnership NHS Foundation Trust's mental health community services- including the IAPT service- in order to review:

- the standard and quality of the reports.

[136] CQC inspection 2015
[137] CQC inspection 2017

- reports contain the identification of any care and service delivery problems, an analysis of any contributory factors and identification of any root cause.
- recommendations are SMART
- how learning is being shared and embedded within practitioners' practice.

23. Concluding comments

23.1. This incident and the subsequent SIR and DHR occurred several years ago, so one of the main challenges for both the trust and the review team had been to obtain and review the relevant information on the progress that has been made in implementing the recommendations and associated action plans. Also, since 2015 there have been considerable changes in the trust's service delivery and care pathways within their community mental health services.

23.2. In conclusion the review team suggest that one of the future challenges for both the trust and SCCG is that if the proposed Accountable Care Organisation development is completed that there continues to be improvement and rigour, with regard to SIRs, DHRs and associated governance processes is maintained and developed by all the involved trusts.

23.3. Sancus Solutions' review team would also suggest that SCCG will have a significant role in ensuring and monitoring that the trust continue to develop and improve the standards of their SIRs and their internal governance processes. Additionally, SCCG should be requiring, on a regular basis, that the trust is evidencing the progress they are making on the implementation of action plans from both SIRs and DHRs.

24. Recommendations

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG) and NHS England (South)
Recommendation 1
A 12-month audit review should be undertaken to review the timescales of Somerset Partnership NHS Foundation Trust's submissions of their serious incident reports to both the families and SCCG. The results of this audit review should be reported to the NHS England (South) Mental Health Homicide Lead.

Somerset Partnership NHS Foundation Trust
Recommendation 2
Somerset Partnership NHS Foundation Trust's Serious Incidents Requiring Investigations (SIRI) Policy and Procedure should be amended to include details of:

- root cause analysis training available to investigators
- investigators' supervision arrangements.

Somerset Partnership NHS Foundation Trust, NHS England (South)
Recommendation 3
Once the Accountable Care Organisation Programme has been completed, Somerset Partnership NHS Foundation Trust should report to the NHS England (South) Homicide Lead the impact that these changes will have on their serious incident investigations.

Somerset Partnership NHS Foundation Trust
Recommendation 4
The revised Integrated Care Planning Approach Policy should identify that it is the responsibility of either the care coordinators, lead professional, named nurse or key worker to assess carers and to signpost them to the appropriate support.
The revised policy should provide details of what support is available together with the relevant hyperlinks.

Somerset Partnership NHS Foundation Trust
Recommendation 5
Somerset Partnership NHS Foundation Trust's Serious Incidents Requiring Investigation (SIRI) Policy and Procedure should be amended to include:

- a specific section on child protection which clearly outlines the investigator's safeguarding responsibility throughout the course of their investigation;
- guidance as to how an investigator should respond with regard to children who may be affected by a serious incident.

The cross reference to other procedural documents section should identify and provide a hyperlink to the trust's safeguarding policies.

Somerset Partnership NHS Foundation Trust
Recommendation 6
Somerset Partnership NHS Foundation Trust should consider introducing an assessment tool, such as PAMIC and/or the Crossing Bridges Family Model, in order to increase its practitioners' awareness and understanding of the Think Family Agenda and the potential impact of parents' mental health on their children.

Somerset Partnership NHS Foundation Trust
Recommendation 7

When a serious incident report highlights that there has been a significant deficit in either risk assessments or care planning this should always prompt a comprehensive service file audit.

Somerset Partnership NHS Foundation Trust
Recommendation 8
Somerset Partnership NHS Foundation Trust should consider recruiting a family liaison officer who would be the single point of contact and support for families throughout the course of a serious incident investigation.

Somerset Partnership NHS Foundation Trust
Recommendation 9
Somerset Partnership NHS Foundation Trust should revise their Serious Incidents Requiring Investigation Policy to identify who has responsibility for the monitoring of post-incident action plans.

Somerset Partnership NHS Foundation Trust
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- providing specific training for practitioners
- revising the Domestic Abuse, Safeguarding and Risk Management policies

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Somerset Partnership NHS Foundation Trust should undertake an audit of a random sample of patient records to ascertain whether:

- consultant psychiatrists are informing a patient's GP when a Mental Health Act (1983) assessment (including section 136) has been undertaken.

- the appropriate manager or duty manager are informing the GP when one of their patients has died.

Somerset Partnership NHS Foundation Trust
Recommendation 12
Somerset Partnership NHS Foundation Trust should develop a Crisis Resolution Home Treatment Team discharge summary proforma.

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG) and NHS England (South) Homicide Lead.
Recommendation 13
Somerset Partnership NHS Foundation Trust should introduce either their community risk assessment tool in their IAPT service or developing a IAPT risk assessment tool that includes:

- the identification and assessment of all potential current risks, including the patient's risk to self and others;
- documentation of all historical risks and a narrative of all risk(s) identified;
- an IAPT risks management plan, which includes both a contingency and a crisis plan.

SCCG and NHS England (South) Homicide Lead should seek assurance and evidence from Somerset Partnership NHS Foundation Trust that the IAPT's risk assessment tool adequately identifies and addresses potential risks and safeguarding issues.

Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group (SCCG)
Recommendation 14
Following a domestic homicide review (DHR), Somerset Partnership NHS Foundation Trust in partnership with SCCG should convene learning event for all the involved managers and practitioners.

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- domestic homicide review's (DHR) individual management reports (IMRs)
- monitoring arrangements of DHR's action plans.

Somerset Clinical Commissioning Group (SCCG)
Recommendation 16:
Somerset Clinical Commissioning Group should consider undertaking a qualitative audit of a random number of recent Serious Incident Reports that involve Somerset Partnership NHS Foundation Trust's mental health community services- including the IAPT service- in order to review:

- the standard and quality of the reports.
- reports contain the identification of any care and service delivery problems, an analysis of any contributory factors and identification of any root cause.
- recommendations are SMART
- how learning is being shared and embedded within practitioners' practice

Appendix A: Terms of reference

Appendix A NHS Englnad Terms of Re

Appendix B SIR Terms of Reference

Appendix B SIR ToR.docx

Appendix C SIR Recommendations

Appendix C SIR recommendations.doc

Appendix D SIR Action plan

Appendix C SIR recommendations.doc

Appendix E Trust's DHR action plan

Appendix E Trust DHR action plan.docx

Appendix F SCCG's DHR action plan

Appendix F SCCG action plan.docx