An independent review of the Level 2 RCA investigation into the care and treatment provided to mental health service users DH and AC in Sussex

Final Report

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

This report was commissioned by NHS England and cannot be used or published without their permission.

Our Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of two service users (DH and AC) in Sussex. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other overseas auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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1 Summary

1.1 According to police reports, officers were called to a house at approximately 20:15 on 29 May 2017 following reports of a disturbance. They checked the occupant of the property and found a 52-year-old man (AC) previously known to Sussex Partnership NHS Foundation Trust (the Trust or SPFT hereafter) who had suffered a minor injury to his arm, but was otherwise unharmed, and then left in search of the suspect. Police returned to the man's home around an hour later and discovered he had suffered a serious head injury. He was taken to the Royal Sussex County Hospital and died from his injuries the next morning.

1.2 DH, a 44-year-old man also previously known to Trust services, was charged with the murder of AC. He was arrested early on the morning of 30 May 2017 and remanded into custody, appearing at Crawley Magistrates Court on 2 June 2017. He was convicted of murder and sentenced to a minimum of 21 years in prison.

1.3 An internal investigation into the care and treatment given to AC and DH by SPFT was undertaken by the Trust shortly after the event. This found evidence of excellent communications and shared care working by the agencies involved. The investigation did not identify any root causes, care or service delivery problems which may have led to the incident. Instead, contributing factors were linked to the chaotic lives of the victim and perpetrator.

1.4 NHS England South have now commissioned Niche Health and Social Care Consulting (Niche) to carry out an assurance review of the internal investigation. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.5 The assurance review follows the NHS England Serious Incident Framework (March 2015),[1] the Department of Health guidance on Article 2 of the European Convention on Human Rights[2] and the investigation of serious incidents in mental health services. The terms of reference for this review are given in full in Appendix A.

Duty of Candour

1.6 DH was admitted to a secure hospital following an assessment of his mental health by a Consultant Psychiatrist while in police cells. He had been a very recent service user of the Trust; however, we can find no record of Duty of Candour being applied.

1.7 His family do not fulfil the criteria of the definition of a "relevant person" within the Duty of Candour regulations. However, the NHS England Serious Incident Framework confirms that families of both the deceased and the perpetrator

[1] NHS England Serious Incident Framework March 2015.
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious- incident-framwrk-upd.pdf
[2] Department of Health Guidance ECHR Article 2: investigations into mental health incidents.
https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

should be at the centre of the investigation, fully involved and have appropriate input into the process.

1.8 The internal investigator determined that DH had no recorded relatives, this is despite several references in the chronology to his son and daughter. Our review of DH's care plans and risk assessments has also found commentary about an ex-partner and there is information about DH's mother being in residential care although we are unsure if this information remains current. DH's family were therefore not afforded the opportunity to be involved in the internal investigation or be informed of its findings. The Trust will need to liaise with NHS England to determine how this should now be approached and how the findings from this assurance review can be fed into the process.

Internal investigation

1.9 The homicide took place on 29 May 2017, and the Trust undertook an internal investigation that was completed on 3 July 2017. This was 24 working days after the event and within required standards.

1.10 We have provided an assessment of the internal report against the 25 Niche Assurance Review Standards that we have developed. This identified some areas of good practice but also found that the investigation did not align to best practice for a number of the standards reviewed. In summary:

- 6 standards were met;
- 4 standards were partially met;
- 10 standards were not met; and
- 5 standards were not applicable.

1.11 The investigation also omitted to identify some care and service delivery problems for the perpetrator and the victim. In our view there were missed opportunities;

1. To fully explore and risk assess DH's expression of harm to self and others, exacerbated by a limited understanding of DH's forensic history and an assumption by both the GP and the Adult Community Mental Health Services (ACMHS) that DH was making 'threats' without intent.
2. To safeguard members of the public by sharing this detail with the police.
3. For services to complete a follow up assessment of DH or to initiate a period of assessment.
4. To employ a more proactive approach in supporting DH, and also AC, to engage in specialist drug and alcohol services although we are unclear to what extent this would have affected the outcome of this incident.

5. To fully assess AC's health and social care needs and risk of self-neglect; however, this may not have been causal or contributory towards the incident.

1.12 The Trust's procedures for reviewing and assuring the quality of an investigation have been revised since this event and our review of current practice suggests that internal investigation processes are now more robust. However, the Trust will need to provide ongoing assurance that recent and future investigations identify appropriate system learning.

Action plan and clinical commissioning group oversight

1.13 The internal investigation made no recommendations, and an action plan was therefore not required. The report was closed by NHS Brighton and Hove Clinical Commissioning Group (CCG) on 21 September 2017, who added that 'this is subject to other investigation processes.' There was an expectation that an independent external investigation would be commissioned given this was a homicide.

1.14 We have been told that it was unusual for SPFT not to identify any care and service delivery problems, particularly for an incident of this nature. However, in our view, if a CCG accepts a reduced threshold for closing locally led homicide investigations on StEIS (attributed to the expectation that an independent investigation team will complete a more robust review and subsequent action plan), there is a risk that any immediate learning and safeguarding measures would not be implemented in a timely manner. Therefore, assurance that all areas of learning have been addressed to reduce the likelihood of reoccurrence is significantly impaired.

1.15 Since this event there have been significant organisational and governance changes in relation to oversight of the SPFT contract by the CCG. A Serious Incident closure checklist has been introduced which would have tested some of the shortfalls in the internal investigation that we have identified. Monthly Clinical Quality and Performance Group meetings have also been established with serious incidents as a standing agenda item and specifically the implementation of learning and action plans from resultant investigations. This is supplemented by the submission of bi-monthly SI Reports from the CCG to their Quality and Safety Committee. These reports include thematic updates on SPFT's SIs and evidence of learning from incidents which have been closed.

Recommendations

RECOMMENDATION 1:

The Trust needs to ensure appropriate application of Duty of Candour in cases of homicide.

RECOMMENDATION 2:

The Trust/NHS England need to establish contact with the family of DH and inform them of the findings of the internal investigation report and this assurance review.

RECOMMENDATION 3:

The Trust and CCG need to ensure that all sources of evidence (i.e. clinical care records, General Practitioners and the police) have been checked when investigators report an absence of family members for perpetrators and/or victims of serious incidents or homicides.

RECOMMENDATION 4:

The Trust needs to review the clinical care records of AC and determine if he had any relatives who may need to be informed of the findings of the internal investigation report and this assurance review.

RECOMMENDATION 5:

The CCG must ensure that incidents are only closed once full assurance has been gained that an appropriate investigation has been undertaken.

RECOMMENDATION 6:

An annual audit programme is required which tests the effectiveness of the Trust's investigation processes against best practice and national guidance. This should include a review of the application of RCA methodology, the panel review process, and the quality assurance of the final report.

2 Assurance Review

Approach to the review

2.1 The external quality assurance review has focussed on the internal investigation report that was undertaken by Sussex Partnership NHS Foundation Trust. The review commenced in August 2019 and was completed in October 2019. It was carried out by:

- Emma Foreman, Associate Director, Niche;
- Rebecca Gehlhaar, Clinical Governance Specialist, Niche.

2.2 The report was reviewed by Kate Jury, Partner of Governance and Assurance, Niche. The external review team will be referred to in the first-person plural in the report.

2.3 The investigation comprised of a review of documents and telephone interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[3] We were unable to interview the lead investigator as they have retired from post; however, as part of our review we spoke with and undertook telephone interviews with the following staff members:

- Associate Director of Nursing Standards and Safety (SPFT);
- Clinical Co-Director, Coastal and North West Sussex Clinical Delivery Services (SPFT); and
- Head of Quality and Nursing (Brighton and Hove CCG).

2.4 This independent assurance review is working on the basis that the internal serious incident investigation panel reviewed all relevant documents in appropriate detail in drawing their conclusions.

2.5 We used information from SPFT and the CCG to complete this review.

2.6 The draft report was shared with NHS Brighton and Hove CCG, and SPFT. This provided opportunity for those organisations involved to review and comment upon the content.

Structure of the report

2.7 Section 2 describes the process of the review;

2.8 Section 3 provides an overview of the victim and perpetrator's mental health care and treatment.

2.9 Section 4 describes the Trust's execution of its Duty of Candour.

2.10 Section 5 provides a summary of the Trust internal investigation report.

[3] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

3 Summary of The Victim and Perpetrator's Mental Health Care and Treatment

The victim

3.1 The internal investigation report states the following: 'AC (referred to as Pt2) was a 52-year-old gentleman known to mental health services on an occasional basis since October/November 2014 following the death of his wife. He had moved from the Oldham area some years previously where he was known to the local mental health team when, working as a fireman, he was called to a car crash where his ex-partner and three-year-old son died at the scene (2006). He was later seen in police custody and assessed on several occasions by Police and Court Liaison and Diversion Services (PCLDS) due to harassment, verbal threats to kill and altercations with others. Most incidents were linked to excessive alcohol consumption. He was provided signposting and reablement via the Prevention Assessment Team who connected him to other support services as required. His most recent contact was when he called Shoreham Adult Community Mental Health Services on 15 May 2017 to cancel an assessment appointment later that day. He said that a friend had asked him to visit the council with them regarding housing and he was also going to hospital to see his consultant regarding his epilepsy. He stated that he was "getting life back on track", had various supports in place and his landlord was helping with forms regarding his move to a smaller property. AC confirmed he did not require any further appointments with Shoreham ACMHS at that time. His assessor spoke with his GP who was agreeable to him being discharged back to their care. The assessor confirmed that AC was difficult to engage with but that the GP could re-refer him in the future if the need arose and if AC expressed a willingness to engage'.

The perpetrator

3.2 The report describes DH (Pt1) as a '44-year-old gentleman who had been known to SPFT mental health services on an occasional basis since September 1999, with identified issues regarding drug induced (cannabis) psychosis, alcohol misuse and multiple social stressors. He had a well recorded history of offending (13 offences, seven of which were violent convictions and cautions) and was seen by Shoreham ACMHS, Forensic and PCLDS. Most recently he was assessed by a senior social worker from ACMHS on 9 May 2017 after telling his GP on 13 April 2017 (repeated at the ACMHS assessment) that he would kill himself and take some people with him. Due to similar comments in the past, both the GP and assessor were not unduly alarmed. On further assessment the main precipitating risk factor appeared to be that DH was due to be evicted from his council house on 10 May 2017. He was assessed and found not to have an active mental illness. Following assessment DH was sent contact details for the Housing Options team for support and advice. The assessment was discussed at a full team meeting on 16 May 2017 when it was confirmed that DH would be discharged back to the care of his GP. A telephone call was made to DH and his GP informing them of the outcome of the assessment'.

Duty of Candour

3.3 Duty of Candour applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred. The Regulation is also a contractual requirement in the NHS Standard Contract.

3.4 We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour, introduced in April 2015.

3.5 In interpreting the regulation on the Duty of Candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- ***"Openness*** *– enabling concerns and complaints to be raised freely without fear and questions asked to be answered.*
- ***Transparency*** *– allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.*
- ***Candour*** *– any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."*

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

- *"Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.*
- *Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification.*
- *Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.*
- *Advise the relevant person what further enquiries the provider believes are appropriate.*
- *Offer an apology.*
- *Follow up the apology by giving the same information in writing and providing an update on the enquiries.*
- *Keep a written record of all communication with the relevant person."*

3.7 The regulations are clear that the "*relevant person*" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

3.8 NHS England's 2015 Serious Incident Framework also confirms the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the investigation process and must be involved and supported throughout. The developing Patient Safety Incident Response Framework supports this principle.

Application of Duty of Candour

3.9 DH was reviewed by a consultant psychiatrist while in police cells. He was subsequently admitted to a secure hospital given that this post incident assessment clearly described an abnormal mental state with evidence of thought disorder, bizarre beliefs with religious content, and possibly responding to hallucinations and psychotic behaviours. Further reviews by the same Consultant on 7 June (8 days later) concluded that DH was suffering from a psychotic illness likely to be a paranoid psychosis. He had been a very recent service user of the Trust, however, the internal investigation report does not state whether Duty of Candour was applied to the him (i.e. the service user or 'relevant person'), and our review of the care records has not identified any entries in relation to this.

Recommendation 1: The Trust needs to ensure appropriate application of Duty of Candour in cases of homicide.

3.10 In relation to the families involved, the report states that '*according to Trust records the victim has no living relatives identified. The perpetrator also has no recorded relatives; General Manager discussed further with Police Liaison officer for guidance on this matter and due to the ongoing police investigation, no further information was shared*'. It is not clear from the internal investigation report what guidance was required. We note, however, that the internal investigation chronology includes entries from 2010 about the perpetrator having a son and daughter, and an entry on 9 May 2017 stating that 'DH married after leaving prison and had two children – a son and daughter'.

3.11 Our review of DH's records has confirmed reference to a deceased father and brother (both committed suicide), but also documentary evidence of his son (JH) age 18 and his daughter (SH) aged 13 years old. Records go on to state that his ex-partner was also still in contact with DH and that he had a mother who was in residential care.

3.12 Family members do not fulfil the criteria of the definition of a "relevant person" within the Duty of Candour regulations. However, the NHS England Serious Incident Framework confirms that families of both the deceased and the perpetrator should be at the centre of the investigation, fully involved and have appropriate input into the process. DH's family members therefore should have been given the opportunity to be involved and supported throughout the investigation process.

Recommendation 2: The Trust/NHS England need to establish contact with the family of DH and inform them of the findings of the internal investigation report and this assurance review.

3.13 We have not reviewed the clinical records for the victim who moved to Sussex from Oldham in 2008. A further review of these may be required to ensure that he has no living relatives given our findings in relation to DH.

Recommendation 3: The Trust and CCG need to ensure that all sources of evidence (i.e. clinical care records, General Practitioners and the police) have been checked when investigators report an absence of family members for perpetrators and/or victims of serious incidents or homicides.

Recommendation 4: The Trust needs to review the clinical care records of AC and determine if he had any relatives who may need to be informed of the findings of the internal investigation report and this assurance review.

4 Internal Investigation Report

Internal investigation report process

4.1 The Trust undertook an internal investigation after the incident was reported. This was allocated to a reviewer on 5 June and completed on 3 July 2017, 24 working days after the incident occurred on 30 May 2017, and 19 days after allocation.

4.2 The report was signed off by the Clinical Co-Director (Coastal and North West Sussex Clinical Delivery Services), the Deputy Chief Nurse and the Serious Incident (SI) Panel. At the time of this event, SI Panel minutes were retained by the investigator who has since retired from post and these were not available as part of this assurance review. The process has since changed, and minutes of these meetings are now retained centrally.

4.3 The internally approved report was submitted to the CCG on 5 July 2017 and closed on 21 September 2017. Submission was therefore in line with the NHS England Serious Incident Framework requirement of within 60 working days of the incident being reported.

4.4 Terms of reference for the internal investigation can be found in Appendix C.

Internal investigation report findings

4.5 The internal investigation report concluded that there had been excellent communications and shared care working by ACMHS, child and family services, police, Police and Court Liaison / Diversion Service and primary care. Regarding interventions by Trust staff specifically, home visits, assessments and reviews were carried out as planned and as per policy where the patients were able to co-operate; flexibility with requests exceeded the expected requirements for the services involved. The investigator identified no root cause(s) for the incident, and no care or service delivery problems. Instead they appear to have attributed the event to the chaotic lives of the perpetrator and victim (linked to past trauma and losses), substance misuse and a history of police/court involvement as contributing to the outcome of their meeting without full discussion or consideration of these as

underlying psychological, social and interpersonal contributory factors. This meant an absence of recommendations and lessons learned.

Analysis of the internal investigation report – Niche Investigation and Assurance Framework (NIAF)

4.6 We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[4] NHS England Serious Incident Framework (SIF)[5] and the National Quality Board Guidance on Learning from Deaths.[6] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

4.7 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA[2] (or Root Cause Analysis and Action, hence 'RCA Squared')[7] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

4.8 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.
- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete.

[4] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services
[5] NHS England (2015) Serious Incident Framework Supporting learning to prevent recurrence https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf
[6] National Quality Board: National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
[7] National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analyses and Actions to Prevent Harm –published by Institute of Healthcare Improvement, United States of America

4.9 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g. lack of patient/staff involvement;
- inappropriate use of serious incident process e.g. doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g. too much focus on process related statistics rather than quality;
- lack of time/expertise e.g. clinicians with little training in investigations trying to do them in spare time;
- inconsistent use of evidence-based investigation methodology e.g. too much focus on fact finding, but not enough on analysing why it happened.

4.10 We evaluated the guidance available and constructed 25 standards for the assessing the quality of serious incident reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice. We have developed these into our own '**credibility, thoroughness and impact**' framework.

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

Standard		Niche commentary
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident:	The Trust's Incidents and Serious Incidents Policy and Procedure (2017) requires a homicide to have a comprehensive level 2 or 3 RCA managed by a multi-disciplinary team involving experts and/or specialist investigators (this reflects SIF guidance). The policy also states that a serious incident will be reviewed by a trained investigator using root cause analysis methodology. Terms of reference for the internal investigation indicate that this was assigned as a Level 2 single incident comprehensive RCA Panel Review. This was appropriate at that time, however, the way the investigation was conducted does not reflect the level required. The internal investigation team consisted of a single investigator (an Operational Project Manager) with oversight from a serious incident panel for approval and sign-off;

		however, the investigator does not appear to have consulted any other specialty clinicians or team members despite both the victim and perpetrator being recent service users. There is also no evidence of any staff or GP interviews being undertaken in order to support the investigation findings (other than a review of the draft report). Instead, the investigation was a 'full record review' without reference to interviews, policies, procedures or any other documents. This is inadequate practice given the severity and complexity of the homicide that occurred.
		Standard partially met
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The terms of reference for this investigation are generic for a Trust Level 2 (SI) Review Report (RCA) with no link or reference to findings of any provisional fact-finding exercise or initial management review which may have extended the scope given the severity of the incident and the complexity of having two recent service users involved in the event. Additionally, these terms of reference omitted to specify the requirement for the investigator to review the care and treatment of the two service users while also examining the risk assessment and risk management. Inclusion would have been in line with good practice and may have ensured that weaknesses were identified, and lessons learned. We note that the Trust has now introduced a Homicide Investigation template with comprehensive terms of reference which are aligned to requirements of the SIF.
		Standard partially met
1.3	The person leading the investigation has skills and training in investigations	The SI Policy that was current at the time of this event states that a level 2 full RCA will be 'conducted by a RCA trained investigator, usually not involved in the incident in which service it occurred and can involve the multidisciplinary team, or experts / expert opinion / independent advice'. The lead investigator was an operational project manager who was trained in RCA and used to lead on the RCA training for the Trust. She was also a Registered Mental Health Nurse (RMN) and had the clinical skills necessary to undertake the investigation.

		Standard met
1.4	Investigations are completed within 60 working days	The investigation was completed and submitted to the CCG 24 working days after the event occurred (19 days after allocation to the investigator).
		Standard met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The investigation is written in clear English and narrative is easy to understand. However, the way the chronology is written is confusing. This includes the clinical details and timelines of the perpetrator and victim who are referred to as Pt1 and Pt2, with text about Pt2 written in bold. We have noted an error in one of the references on p3 (event date 9 May) about Pt1 who is referred to as Pt2.
		Standard partially met
1.6	Staff have been supported following the incident	The report states that those staff most recently involved with the perpetrator and victim were contacted and informed of the incident and provided with support in the form of a formal debrief on 13/06/17. They were also offered ongoing support via supervision. In addition to this the Trust has an employee support service that includes one to one counselling that was available if needed.
		Standard met
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	A brief description of the incident and the outcome are included in the report. The homicide was, however, incorrectly categorised as a violent incident causing unexpected death; instead it should have been categorised as an unexpected unnatural death (with a sub-category of suspected homicide) as per the Trust's Incidents and Serious Incidents Policy and Procedure (2017).
		Standard partially met
2.2	The terms of reference for the investigation should be included	Terms of reference are included in the report and can be seen at Appendix C.
		Standard met
2.3	The methodology for the investigation is described,	The description of the methodology states 'Standard RCA review including a tabular

	that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	timeline. Review of all health records for both victim and suspected perpetrator'. A chronology is available, however, there is no evidence of root cause methodology or any other analysis to support the findings. The report references a 'full record review' as opposed to a comprehensive investigation i.e. also comprising interviews and policy/procedural document review which was warranted given the outcome of the incident. Also, the victim and perpetrator were recent SPFT service users. A combined investigation was undertaken but separate care and treatment reviews may have provided a more comprehensive understanding of each.
		Standard not met
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The report states that 'according to Trust records the victim has no living relatives identified. The perpetrator also has no recorded relatives; General Manager discussed further with Police Liaison officer for guidance on this matter and due to the ongoing police investigation, no further information was shared'. This is despite the internal investigation chronology including entries from 2010 about the perpetrator having a son and daughter, and an entry on 9 May 2017 stating that 'DH married after leaving prison and had two children – a son and daughter'. Our review of DH's records has confirmed reference to a deceased father and brother, but also documentary evidence of his son (JH) age 18 years old and his daughter (SH) aged 13. Records go on to state that his ex-partner was also still in contact with DH, that he had a mother who was in residential care, and that he denied intent of suicide citing his family as protective factor. We have not reviewed the clinical records for the victim who moved to Sussex from Oldham in 2008. A further review of these may be required to ensure he has no living relatives given our findings in relation to DH.
		Standard not met

2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	The investigator determined that the victim had no living relatives, and the perpetrator had no relatives recorded.
		Not applicable
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of DH and the victim's mental health history and care has been given.
		Standard met
2.7	A chronology or tabular timeline of the event is included	A chronology is embedded within the report. However, this is hard to follow as both service user timelines have been incorporated and the only differentiator is bold text and reference to Pt1 and Pt2. The chronology does not help to clearly identify any of the key events and there is no analysis of these (either positive or highlighting any shortfalls).
		Standard met
2.8	The report describes how RCA tools have been used to arrive at the findings	The report does not describe how root cause analysis or other tools have been used. Instead the investigator has used the chronology to arrive at her conclusions but without any overt analysis of events.
		Standard not met
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	No care or service delivery problems have been identified by the investigator despite evidence of missed opportunities for both patients (see Section 4.12-4.27 below).
		Standard not met
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	No contributory or human factors have been identified by the investigator despite both the perpetrator and victim having long histories of involvement with mental health services, social and interpersonal risk factors. Instead the investigator concluded that the chaotic lives of the perpetrator and victim (linked to past trauma and losses), substance misuse and a history of police/court involvement may have contributed to the outcome.
		Standard not met
2.11	Root cause or root causes are described	The root cause should be identified as the earliest issue that, had it been different, would have resulted in a different outcome.

		The investigator identified no root cause for the homicide. Recognising that there may be occasions when this is the case, we can see no evidence of RCA methodology being utilised in arriving to this conclusion.
		Standard not met
2.12	Lessons learned are described	Lessons learned were not identified given that the investigator concluded that there were no root causes, care or service delivery problems.
		Not applicable
2.13	There should be no obvious areas of incongruence	In our view there were several areas of incongruence within the report: - The investigation that was undertaken was a Level 2 RCA Report, yet no root cause methodology was apparent. - No care or service delivery problems were identified despite there being several missed opportunities to engage with both the victim and perpetrator. - The report references no recorded relatives despite there being multiple references to a son and daughter in the chronology and care records. - There are several omissions of facts including, for example, in the Executive Summary. The perpetrator stated on his final assessment prior to the homicide that he would kill himself if he didn't get help, but he also said he would 'take some people with him'. The assessment also failed to highlight the perpetrator's forensic history, and this was not identified as an omission by the internal investigator.
		Standard not met
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	It is clear how some elements of the terms of reference have been met. However, there is less clarity for other elements including: – any root causes to the incident (RCA methodology has not been evidenced other than through a chronology of events); – any identifiable service/care delivery problems given the lack of analysis of key events from the chronology;

		– how risk of a recurrence may be reduced given that no root causes, service/care delivery problems or contributory factors (other than those attributed to the patient and victim) have been identified; and – to answer appropriate questions raised by family/carers given that the investigator stated that there were no recorded relatives for the victim and perpetrator (despite reference to family members of the perpetrator in the chronology)
		Standard not met
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	As above, the terms of reference were generic rather than aimed at ensuring a comprehensive investigation proportionate to the severity and complexity of the incident. The homicide involved two recent service users, both of whom were known to have chaotic lives (linked to past trauma and losses), substance misuse and a history of police/court involvement.
		Standard not met
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report includes a chronology of events (including a brief history of the perpetrator and victim), however, there is no supporting analysis or evidence of root cause methodology. There is a description of what happened but little to support why or how to prevent a recurrence.
		Standard not met
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	No recommendations were made.
		Not applicable
3.4	Recommendations are written in full, so they can be read alone	No recommendations were made.
		Not applicable
3.5	Recommendations are measurable and outcome focused	No recommendations were made.
		Not applicable

4.12 A Confidential Psychiatric Report completed in October 2017 concluded that at the time of the homicide DH was suffering from an abnormality of mental functioning but, in their opinion, this was due to his intoxication with alcohol and anger/rage. Subsequently DH's plea of manslaughter on the grounds of diminished responsibility was not upheld. However, the record of the Assessment and Treatment Service (ATS) assessment three weeks prior to the event indicated that the practitioner believed DH *'exhibited a range of possible psychotic experiences'* at the time of assessment. Therefore, although potentially not causal, we are of the view that there were missed opportunities and areas for learning in DH's care. Our review of the chronology and clinical care records for DH suggest that there were several key facts that have not been drawn out or fully analysed in the internal investigation report particularly in relation to:

- risk assessments of harm to self and others;
- lack of communication with the police and local service escalation when patients reference harm to others;
- provision of support to engage with drug and alcohol services; and
- lack of consideration of a further assessment given DH's risk profile and complex presentation at the time of assessment.

DH's risk assessment and care provision at the time of the incident:

4.13 There was a missed opportunity for a further assessment by the ATS given DH's risk history in combination with his expression of harm to others. Also, that the practitioner indicated that the assessment had been difficult due to DH's presentation at that time; 'stream of consciousness often random / tangential made assessment difficult'. This could have been facilitated by accepting DH onto ATS services for a follow-up or prolonged period of assessment of clinical need and risk prior to discharging DH back to the care of the GP. This service could have supported DH with psychoeducation in respect of taking prescribed medication and the monitoring of medication compliance. It is, however, unknown if DH would have engaged with services and complied with a medication regime or whether this would have affected the outcome of the incident.

4.14 DH also had a significant forensic history that was not included in either the GP referral to the ATS or referenced in the ATS letter to the GP following the assessment. DH's forensic history included; five offences against persons 1991-1999, these were two assault convictions occasioning in actual Bodily Harm (ABH) 1991; assault on another 1992; grievous bodily harm (GBH) 1996; common assault 1999). DH was also convicted of three offences against property (theft), a number of public disorder offences, five offences relating to the police/courts/prisons, and DH stabbed his former partner in the hand following a domestic argument 2012. There was a previous child protection order against DH when initially referred into adult secondary mental health services in 2010, although the details of this are not provided.

4.15 The ATS assessment outcome letter and risk assessment documentation only included that DH had made threats to kill after an incident in a pub in Newhaven (15/07/2016) and was kept in custody overnight. Also, that DH had been in prison twenty years ago and served a sentence for GBH. The context

included that whilst he was in prison he had been assaulted by another inmate, being hit in the head with a large battery in a sock. However, there is no detail of the index offence or DH's complete forensic history.

4.16 The nature of DH's forensic history and offences was violence towards others and historically in the context of substance misuse. It is unclear if the GP was aware of DH's forensic history or if DH's historic risk towards others was known, as this information was not included in their referral to the ATS service. Neither was this information included in the mental health assessment and we are unable without interview to determine if either of these practitioners were aware of this information at the point of assessment, although this was readily available via the clinical records.

4.17 We note, however, that when DH had previously been supported by the Crisis Resolution Home Treatment Team (CRHT), he was visited by two members of staff due to the perceived potential risk of violence towards others. The ATS assessment was completed by an individual practitioner who did not reference his forensic history and previously completed risk assessments by mental health services.

4.18 There is also no evidence in the outcome letter by ATS that DH's expression of harm to others was explored further with DH or escalated to the police. The information contained within the GP's referral to the ATS may have minimised the seriousness or need to further assess DH's references to harming himself or others. The language used was suggestive that the risks of self-harm/suicide were perceived as low, *'I note from previous consultations both with his GP and the CMHT that he has made similar comments and so I was not unduly alarmed'.* The GP had also requested a 'routine' assessment, and this may have further compounded any initial thoughts that DH's risk of harming himself and/or others was minimal/low. This is further evidenced by the outcome of the ATS assessment which included that, in relation to 'threats to kill', the practitioner reported, *'Like his GP before him on the 13th April 2017, I was not unduly alarmed by this statement, feeling it was an attempt to get a reaction rather than a statement of serious intent'.*

4.19 There were, however, risk markers of harm to self and/or others that were not included in the ATS' 'difficult' assessment (see comments below in bullet point three). Therefore, the quality of this assessment and subsequent management plan is likely to have been adversely impacted due to insufficient information being considered. These included;

- DH's forensic risk history. His previous risk assessment and formulation that was completed in 2010 identified that his risk of harm to self and/or others increased when DH used alcohol and illicit substances. DH's risk was also exacerbated by non-compliance of a prescribed antipsychotic type medication (olanzapine). In 2010, DH was referred into the CRHT to support compliance and assist with recovery. At the point of assessment by the ATS practitioner, DH declined to take prescribed medications, and this was included as part of the rationale for not accepting DH into mental health services.

- Inaccurate scoring of 'no current risk of harm towards others' despite the referral from the GP and disclosure from DH 'in angry/determined manner' that *"all I do know is if I don't get help I'll kill myself/take some people with me".* Neither the GP or the assessing practitioner explored this further with DH. The current risk of harm to others would therefore have been unknown without robust assessment and accurate information pertaining to DH's forensic risk history.

- The assessment included that DH was presenting with symptoms consistent with relapse, and in keeping with previously recorded risk assessments in 2010. The ATS assessment included that DH asked if he could record his assessment on his mobile phone and, *'…after many minutes of jumbled tirade of memories that had paranoid, thought disordered flavour…but he didn't elaborate stating "the Mullah (Romany language for the devil) has always been after me". He then recalled events from the past when he has seen the Mullah…He appeared preoccupied with past events... his stream of consciousness was often on random subjects and tangential, making an assessment very difficult…'.* Furthermore, the overview of the assessment included DH's belief that he reported feeling "*used by people…getting in my head"*. The information provided by the assessment overview appears to include symptoms that could be consistent with emerging psychosis and/or mental illness. Historically DH had met the criteria for CRHT and community mental health services (CMHT) with a similar mental health presentation where DH's religious views were understood as interlinked with his delusional beliefs. In 2010, DH's housing needs were considered as a destabilising factor towards his deterioration in metal health and at the time of the ATS assessment, DH was facing eviction from his council property and had 'fallen out with the pastor' who he had known for a period of twenty years . This detail reinforces consideration that there may have been a missed opportunity for protracted assessment or acceptance into mental health services when DH was assessed by the ATS service in 2017.

- The referral to the ATS service described DH as having a history of severe depression and psychosis and that DH was subject to a psychiatric admission in 1999 due to experiencing a drug induced psychosis episode (the drug identified was cannabis). At the point of the ATS assessment, DH described using a 'legal high', similar to cannabis, six months previously and that he had felt 'weird' after this. There is no supporting information that this was explored further with DH. This could be considered as a missed opportunity to refer him to a specialist drug service for greater exploration and support, strengthened further by DH's positive drug screening result for cannabis, post incident.

- Both the GP referral and ATS assessment referred to DH expressing suicidality and/or '*I'm going to take someone with me'*. DH had expressed a need for help at both appointments, although was unable to quantify or express what this would mean for him when asked directly, "*put a bullet in my head*". The ATS assessment described DH

as ‘low in mood, due to his circumstances at the time of assessment; he presented as paranoid and occasionally thought disordered’. They also documented that DH’s ‘major preoccupation at the time and the reason for attending the assessment was the threat of homelessness and probably what he wanted ‘help’ with but was unable to clearly state what support he needed’. The ATS practitioner texted DH with the number for the Housing Options Team for DH to receive support with his housing needs and he was discharged back to the care of his GP. DH may have interpreted not being accepted into mental health services as not receiving the perceived help he had sought by attending the initial GP appointment and subsequent ATS assessment. This may have exacerbated any feelings of hopelessness associated with low mood and/or confidence in mental health services to provide support and promote recovery.

AC’s risk assessment and care provision at the time of the incident:

4.20 We did not review the clinical care records for AC but have noted some aspects of his care and treatment that we believe should have been explored further by the internal investigation.

4.21 AC was referred into Sussex mental health services in 2014. Prior to this he resided in Oldham, had experienced a ‘number of overdoses’ and had been detained as a psychiatric inpatient subject to Section 3 of the Mental Health Act (1983). AC appeared to have chronic long-standing needs in the context of alcohol abuse, often precipitating incidents of verbal aggression including;

- Threats to kill acquaintances in London (2014)
- Shouting and banging on doors (2015)
- Threatening a vet (2016)
- Harassment without violence (2016)
- A neighbour contacting the police as AC was observed to be hanging out of his window, with a high-powered air rifle (2016)

4.22 Over this period, there were occasions where alcohol use was discussed and identified as an unmet need either following face to face assessment or telephone consultation. These contacts detailed mental health services providing contact details for alcohol support services and advising AC to complete a self-referral.

4.23 Given AC’s long history of maladaptive coping by using alcohol, it is reasonable to consider that there were missed opportunities to extend support to AC by completing referrals to specialist alcohol services on his behalf. Given that AC’s clinical history evidences that he had not acted on this advice historically, the likelihood that AC would complete a self-referral and address this unmet need without increased support, was reduced. It is unclear if this would have had any bearing on the outcome of the incident, but

it does highlight areas for learning specifically how services offer/extend support to those service users with alcohol and substance misuse needs.

4.24 In our view there were also some safeguarding concerns in relation to AC. He was described as living alone in a two-bedroom bungalow following the death of his wife in 2014. AC had been under the specialist care of a neurologist attributed to his significant alcohol use and recorded non-compliance with epilepsy medication. The investigation report includes that he was reluctant to leave the house without the supervision of his wife due to fears that he may experience an epileptic fit in the community. To some extent, AC could be considered as vulnerable both in relation to his physical and mental health and at risk from others associated with confrontational/challenging behaviour whilst intoxicated by alcohol.

4.25 In 2015 AC was arrested by the police for the use of threatening behaviour. They expressed concern in relation to self-neglect both in personal presentation and his property, describing AC as *'covered in cat faeces'*. The police removed AC's clothes due to these being perceived as a 'hazard'. Seven months later AC's GP referred him into mental health services for assessment and the police attended AC's property again in relation to an incident involving a high-powered rifle. The police recorded that his property was *'filthy dirty…in an incredibly poor state…the floor was covered in cat faeces...'*. When ACMHS attended on 14 December 2016 to complete their assessment, the house was described as *'…heating up high…pungent odour of urine….he was dressed inappropriately for the temperature….he insisted in showing staff his feet which were blackened by dirt…'.*

4.26 AC appeared to be heavily intoxicated by alcohol and the practitioner was unable to complete the assessment. Following this visit, the service discharged AC back to the care of his GP, without rearranging a visit to complete a biological-psychological and social needs assessment.

4.27 Given the safeguarding concerns raised by the police and referenced in AC's clinical history, there was a missed opportunity to fully assess AC's health and social care needs and risk of self-neglect. Although it is unclear if this would have had any bearing on the outcome of the incident, a more assertive approach could have been employed by the service. This could have enabled the completion of a comprehensive assessment of AC's needs and robust review of any safeguarding needs and/or risks.

Clinical Commissioning Group oversight of the internal report

4.28 The internal investigation report was submitted to the CCG via the Sussex-wide Patient Safety Team on 5 July 2017. This was reviewed by the Patient Safety Manager who commented that the timeline contained excessive amounts of information spanning several years and asked if this could be reduced to relevant information only.

4.29 The author of the report re-iterated that this was a panel review for a homicide (of an ex-service user by an ex-service user) and felt it imperative to demonstrate the review was full, open and did not miss any patterns or previous instances of similar behaviour. The investigator also wanted to show

that staff worked collaboratively and in tandem with other statutory services/agencies. Accepting that the report may appear lengthy the author confirmed that it was likely to go through an external review process and therefore the review of the input both service users received over a number of years would be able to inform/assist with this process; many entries had already been précised.

4.30 The CCG Scrutiny Group reviewed the report and formally closed the incident on 21 September 2017. They added that 'this is subject to other investigation processes.' There was an expectation that an independent external investigation would be commissioned given this was a homicide.

4.31 We have been told that it was unusual for SPFT not to identify any care and service delivery problems particularly for an incident of this nature. However, in our view, if a CCG accepts a reduced threshold for closing locally led homicide investigations on StEIS, (attributed to the expectation that an independent investigation team will complete a more robust review and subsequent action plan) there is a risk that any immediate learning and safeguarding measures would not be implemented in a timely manner. Therefore, assurance that all areas of learning have been addressed to reduce the likelihood of reoccurrence is significantly impaired.

Recommendation 5: The CCG must ensure that incidents are only closed once full assurance has been gained that an appropriate investigation has been undertaken.

4.32 We have not been provided with any evidence of a CCG SI closure checklist having been completed for this homicide. However, the document that is currently in use is in line with good practice and would have tested some of the shortfalls in the internal investigation that we have identified in our report such as:

- did the core investigation team consist of more than one person;
- were interviews conducted;
- were good practice guidance and protocols referenced to determine what should have happened; and
- is there evidence that the most fundamental issues or root causes have been considered.

4.34 Since this event there have been other significant governance changes in relation to oversight of the SPFT contract by the CCG. In 2018, the CCG coordinating responsibility for this moved from Coastal West Sussex CCG to High Weald Lewes Havens CCG. Monthly Clinical Quality and Performance Group meetings have been established (commencing in November 2018) with serious incidents as a standing agenda item and specifically the implementation of learning and action plans from resultant investigations.

4.35 In line with good practice, these monthly contractual meetings have covered a range of thematic issues including, for example: risk assessment completion; the Active Engagement Policy; involving families in risk assessments, falls

SIs; and a thematic review of homicide SIs. The CCG is also starting to review information within SPFT reports to determine whether there are gaps in terms of a multi-agency response for a cohort of complex and high-risk patients.

4.36 SPFT additionally submit quarterly quality reports to the CCG with information on all open and closed actions from SI investigations. This report is reviewed at contractual meetings with actions agreed for any remaining assurance gaps. The CCG Quality team then provide bi-monthly SI Reports to their Quality and Safety Committee, which is a Tier 1 committee of the Governing Body. These reports include thematic updates on SPFT's SIs, reviews which have been undertaken at the CCG Scrutiny Group, and evidence of learning from incidents which have been closed (also items at risk and for escalation).

5 Trust Action Plan

5.1 The Trust was not required to develop an action plan given that there were no recommendations or points of learning arising from the internal investigation report. There is evidence of service, Clinical Director and Deputy Chief Nurse review but an absence of further executive approval prior to submission to the CCG.

5.2 We have, however, reviewed current processes in order to determine how the Trust currently maintains oversight of the investigation process, quality and outcomes.

5.3 The Incident and Serious Incident Policy in use at the time of the homicide was ratified in October 2015. The policy has since been revised (May/June 2017) and now includes the requirement for an Initial Management Review (IMR) within two days for all serious incidents (this was previously omitted). Serious Incident Grading workshops are held which allow discussion of the incidents as they present and agreement of the level of investigation required.

5.4 The template for these investigations has also been updated in line with the revised policy. This is a more comprehensive document which is aligned to the SIF, although in our view additional instruction is required in the terms of reference section in order to prompt investigators to consider an expanded scope which is reflective of the IMR and complexity of the review to be undertaken where appropriate. There is also a new Homicide Investigation template which is good practice.

5.5 Monitoring SI Action Plan Review and Closure guidance is available, and the Trust is endeavouring to ensure greater oversight and monitoring of actions through the following process:

- on submission of the SI Report and action plan to the CCG, the action plan is uploaded to the risk register;
- the services are responsible for each action; however, this is held centrally so that progress can be tracked;

- a monthly report is sent to the services detailing the number of outstanding actions and evidence to support implementation of the actions is requested prior to closure;

- once the CCG (and NHS England if appropriate) have agreed closure, the final SI Report is disseminated to the services for sharing and implementing learning; and

- the Head of Incident Management and the Associate Director of Nursing Standards and Safety revisit a percentage of closed actions after approximately 6-12 months to review the evidence submitted and to ensure the learning has become embedded in practice.

5.6 The Trust has also initiated a range of mechanisms for collating and sharing learning from incidents including:

- a monthly Serious Incident Assurance Report which is presented to the Board and Quality Committee. This details the number and type of SIs in the previous month, contains the action plans and learning from SIs, and outlines the Trust's performance regarding the completion of Serious Incident Investigation Reports within mandated deadlines;

- a comprehensive quarterly Quality & Patient Safety Report which is circulated Trust-wide and includes: a dashboard of all deaths, incidents and concerns; National Reporting and Learning System reporting; themes of learning, changes to practice and patient safety improvements. All incidents are reported, reviewed and actions for learning identified in accordance with the SI framework and as specified within the Trust's incident reporting and management policy;

- monthly Patient Safety Matters newsletters which use patient stories to share learning from incidents and serious incidents occurring across the Trust; and

- Patient Safety Events 'Learning & Improving' interactive workshops which aim to share learning from incidents, reflect on practice, and consider the steps the Trust can take to improve patient safety.

5.7 Although not tested by this assurance review, these processes appear to be comprehensive, but the Trust will need continued assurance that learning from incidents is more robust than at the time of this homicide.

Recommendation 6: An annual audit programme is required which tests the effectiveness of the Trust's investigation processes against best practice and national guidance. This should include a review of the application of RCA methodology, the panel review process, and the quality assurance of the final report.

Appendix A – Terms of reference

Terms of Reference

1. Purpose of the Review

To independently assess the quality of the level 2 Trust RCA investigation into the care and treatment of DH, the subsequent action plan and the embedding of learning across the trust and identify any other areas of learning for the trust and/or CCG

The outcome of this review will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2. Terms of Reference

Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference.
- If the investigation was completed in a timely manner.
- If all root causes and potential lessons have been identified, actions and shared within the organisation.
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and root causes.
- Review whether the action plan reflects the identified contributory factors, root causes and recommendations, and those actions are comprehensive.
- 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 culture of trust services.
- Review whether the Trust Clinical Governance processes in managing the RCA were appropriate and robust.
- Review whether the CCG Governance/Assurance processes in managing the RCA were appropriate and robust.
- Make further recommendation for improvement to patient safety and/or governance processes as appropriate.

Review the trusts application of its Duty of Candour to the family of the perpetrator and the victim's family.

3. Timescale

The review process starts when the investigator receives the Trust documents, and the review should be completed within three months thereafter.

4. Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.

- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

5. Outputs

A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof-read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

Appendix B – Documents reviewed

Trust documents	
Clinical care records for DH	SI Final Report 5 July 2017
Police and Court Liaison and Diversion Service Operational Policy – Updated April 2018	Thematic review of Serious Incidents in West Sussex with DNA policy actions August-December 2018
Evaluation Charts for Clinical Risk Assessment Training January-June 2019	Thematic Review of Community SIs – Active Engagement /Did not Attend January2018-19
Incident and Serious Incident - Policy on a Page	Active Engagement/DNA Policy PowerPoint September 2019
Internal Serious Incident Scrutiny Panel terms of reference	Patient Safety Events, Fliers and Feedback (various)
Quality and Safety Reports (various)	DNA Checklist
Patient Safety Matters (various)	Incidents Dashboard August 2018-19
Implementation of Serious Incident Action Plans. Internal Audit April 2018	Serious Incident Grading Workshop September 2018
Incident and SI Governance Process	Open SI Actions Report February 2019
Monitoring SI Action Plan Review and Closure	Clinical Risk Training for Qualified staff 2019
Incident & Serious Incident Reporting Policy & Procedure 2015	Serious Incident Assurance Reports (various)
Incidents and Serious Incidents Policy and Procedure 2017	
CCG documents	
Scrutiny Group Meeting September 2017	SI Closure Checklist
Sussex and East Surrey CCG Serious Incidents Scrutiny Group Terms of Reference	

Appendix C – Terms of reference for the internal investigation

Purpose

1. To establish the facts
2. To establish any root causes to the incident
3. To provide a report recording the investigation process
4. To establish and record notable practice and any identifiable service/care delivery problems
5. To establish how risk of a recurrence may be reduced
6. To formulate recommendations
7. To provide a means of sharing learning from the incident
8. Answer appropriate questions raised by family/carers.

The review team

1. Lead Incident Reviewer – Operational Project Manager
2. Panel Chair – West Sussex Service Director

As part of the panel review process the Draft Review Report was fed back to the team by the Reviewer, Panel Chair and Clinical Director; necessary changes / additions made and learning points shared.

Level of review and scope

Level 2 single incident comprehensive root cause analysis.
Review of all health records for both victim and suspected perpetrator