An independent external quality assurance review following an internal investigation into the care and treatment of mental health service user A in Northumberland, Tyne and Wear NHS Foundation Trust

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Highly Confidential

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Our Report has been written in line with the terms of reference as set out in the Terms of Reference on the independent investigation into the care and treatment of service user A. This is a limited scope review and has been prepared 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Events which may occur outside of the timescale of this review will render our report out-of-date.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 EXECUTIVE SUMMARY

1.1 Northumberland, Tyne and Wear NHS Foundation Trust (the Trust – now known as Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) provides mental health and disability services across the north of England.

1.2 In September 2018, a 19-year-old male patient (referred to as service user A in the report), of the Trust South Tyneside Early Intervention in Psychosis (EIP) Service, attacked a 62-year-old woman. The victim, whom service user A did not know, later died in hospital as a result of the injuries she sustained.

1.3 Northumbria Police confirmed that service user A had no forensic history prior to this incident.

1.4 Service user A pleaded guilty to manslaughter by reason of diminished responsibility at Newcastle Crown Court. In March 2019 he was detained under Section 37/41 of the Mental Health Act (MHA)[1].

1.5 Service user A had first been referred to South Tyneside NHS Foundation Trust[2] Child & Adolescent Mental Health Services (CAMHS) as an eight-year-old child in 2007. He was reportedly participating in activities without consideration to risk, such as jumping off trees and crossing the road without looking and having once been hit by a car. He was diagnosed with attention deficit hyperactivity disorder (ADHD) and prescribed appropriate medication supervised by CAMHS.

1.6 His mother asked for help as service user A disclosed thoughts to harm someone and he was carrying weapons. He reported paranoid thoughts about neighbours interfering with his phone, watching him in his home through a window and he also reported seeing them shining a torch on him.

1.7 In June 2017 service user A was admitted to a Trust hospital ward. He was reported as having a history of cannabis use, with intermittent use of cocaine and amphetamines. It was thought he was suffering from a drug induced acute psychotic episode. He was detained under the MHA on Section 2[3].

1.8 Whilst an inpatient, service user A disclosed longstanding thoughts of wanting to hurt people (for one-and-a-half or two years beforehand) and disclosed suicidal intent in case he did hurt someone. His thoughts were initially directed to his mother's ex-partner, but later they became more generalised.

1.9 Following an MHA Tribunal[4] appeal in August 2017, service user A agreed to remain as an informal patient in hospital, and as a result the Responsible Clinician (RC) ended the formal detention of service user A.

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[1] *Powers of courts to order hospital admission, and restriction on discharge.* http://www.legislation.gov.uk/ukpga/1983/20/section/37
[2] *Now South Tyneside and Sunderland NHS Foundation Trust.*
[3] *Admission for assessment for up to 28 days* http://www.legislation.gov.uk/ukpga/1983/20/section/2
[4] https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health
The First-tier Tribunal (Mental Health) is responsible for handling applications for the discharge of patients detained in psychiatric hospitals.

1.10 Service user A was a patient in a child and adolescent unit at the time, but had turned 18 years of age, therefore it was considered that he should be discharged into the care of EIP. The plan at discharge was to:

- continue with antipsychotic medication;
- follow up with EIP service for extensive assessment;
- self-referral to drug services; and
- referral to adult forensic services for assessment.

1.11 He remained with the EIP until the time of his arrest under the provisions of the Care Programme Approach[5] (CPA). The last Functional Analysis of Care Environments (FACE)[6] risk assessment undertaken on 1 March 2018 detailed that the risk of violence or harm to others and risk of adult abuse was 'low apparent'.

1.12 Service user A's last face to face service contact prior to the incident was with his Care Coordinator (CCO) from the EIP service on 10 April 2018. His mother saw the CCO on 28 June 2018, but service user A was absent at the visit. His mother made telephone contact with the EIP service on 30 August 2018 to request an appointment for herself as she had concerns about his behaviour, however, she was not seen prior to the incident taking place.

1.13 On 6 September 2018 following the incident, a debriefing for staff who had been involved with service user A was held.

1.14 On 7 September 2018, a Trust initial serious incident (SI) report was completed. This report included a brief psychiatric history and did not indicate that any immediate remedial clinical or managerial actions were required. The report detailed that post incident attempts to contact service user A's mother several times had proved unsuccessful.

1.15 The Trust undertook an after-action review (AAR) on 14 November 2018 with the professionals (including the GP) involved in service user A's care. This review included a summary of the incident and an overview of service user A's needs and the core learning. There were no significant key actions identified. The AAR core learning included:

- *The importance of post discharge recommendations being completed or a rationale for them not being completed being documented.*
- *The recording and management on the electronic care record of patient disclosures and the subsequent escalation and/or handover of concerns within [name] Ward.*

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[5] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/ *The Care Programme Approach (CPA) is a package of care for people with complex mental health problems.*

[6] *FACE is an approved tool to record the outcome of the assessment of risk.* https://www.cntw.nhs.uk/content/uploads/2017/01/NTWC20-App4-ApprovedRiskTools-V05-Oct15.pdf

- *The engagement of service user A following a significant period of disengagement. He had not been seen for six months prior to the incident.*

- *Lack of contemporaneous storage of clinical information is an avoidable risk, in relation to having a full chronology of information available to inform care and treatment, in addition to ensuring full compliance to formal police disclosure requests.*

1.16 The internal independent investigation author was provided with confirmation to proceed with the investigation on 3 October 2018. The Trust initially requested the report to be completed by 24 January 2019, however, this was subsequently changed to 28 March 2019, the reason for which is not detailed in the Trust report. We discuss this further in the report, please refer to paragraph 3.9 for more information.

1.17 At the outset of the investigation, a brief telephone conversation was had with service user A's mother and a letter was subsequently written to offer her the opportunity to meet, to have the investigation process explained and to identify any questions she wanted to be considered as part of the process. Service user A's mother told us she wanted to meet, but did not feel in a fit state to do so at the time.

1.18 The purpose of the internal independent investigation was: to review the circumstances surrounding the health care provision and treatment of service user A; to identify whether there were any aspects of care which should have been delivered differently and any lessons that could be learnt, including improvements to services which could help prevent similar incidents occurring; and to highlight areas of good practice.

1.19 The internal independent investigation identified service user A's diagnosis and his lack of engagement with mental health services as the root causes of the incident and made eight recommendations.

1.20 In August 2019 NHS England North (NHSE) commissioned Niche Health & Social Care Consulting (Niche) to undertake an external quality assurance review, specifically to:

- undertake a desktop review to consider the internal independent investigation by the Trust into the care and treatment of service user A and assess the quality of the findings;

- review the implementation of the actions arising from the internal independent investigation; and

- review the Trust's quality assurance processes in relation to this incident with particular reference to the development of appropriate recommendations, the monitoring of resulting action plans and the embedding of learning across the Trust.

1.21 The external quality assurance review has focussed on the following key lines of enquiry:

- a desktop review of the care provided;

- assessment of the quality of the internal independent investigation;

- implementation of the internal independent investigation recommendations; and
- governance and systems for oversight.

1.22 The external quality assurance review commenced on receipt of the clinical records in October 2019 and was completed in March 2020. We used the Niche Investigation Assurance Framework (NIAF), to provide a well evidenced and rigorous assurance process. Publication of the review was delayed due to the Coronavirus pandemic in 2020.

1.23 In order to complete the review, we carried out a range of tasks including, reviewing clinical notes and the internal and independent investigations; staff interviews; reviewing policies and procedures, minutes of meetings and various reports.

1.24 We made three recommendations in response to our review of the internal investigation and action plan.

1.25 NHS England contacted service user A's RC, who deemed him to have capacity, and sent a letter to him about this assurance review offering a meeting with the investigators. Service user A's RC advised against further contact.

1.26 NHS England contacted service user A's mother who communicated her views. These included her feeling that the Trust independent investigation did not address her concerns or that the report allowed for sufficient anonymity, she lacked support following the incident, the Trust had not made enough effort to contact and engage her and had kept her waiting for a long time for answers as to why her son had been failed.

1.27 The Trust independent investigation notes that service user A's mother informed services her son was not taking his medication (see 3.33) which she disputes. She did not agree with the root causes to the incident as being his diagnosis (see 3.41- 3.42), or his lack of engagement, given her son was not contacted by the services for 148 days (see 3.34).

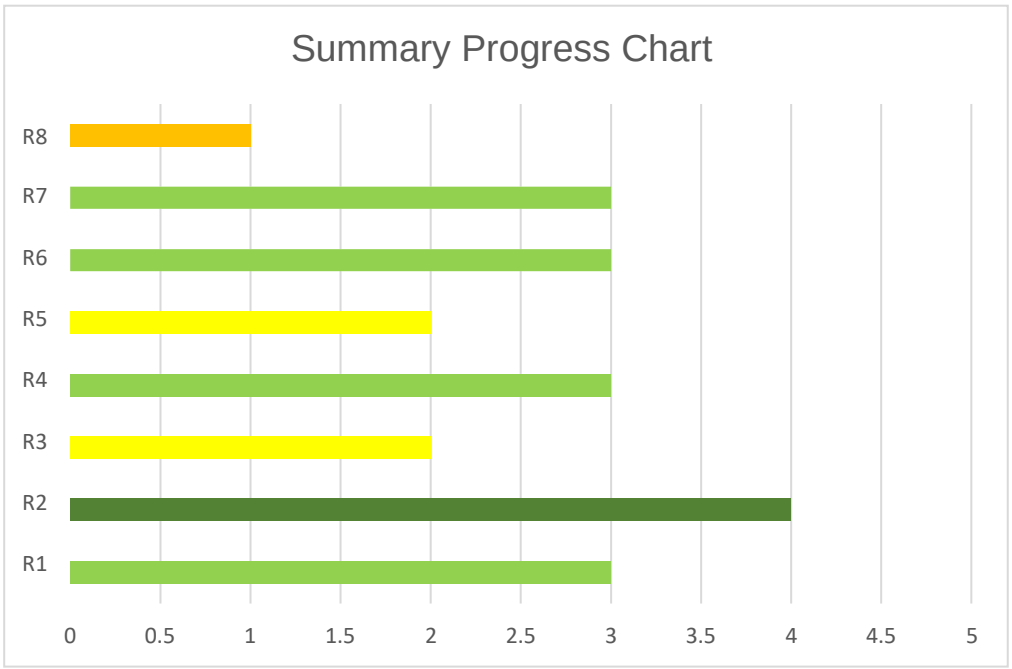
1.28 We kept service user A's mother updated on the external quality assurance review as it progressed, and on 9 March 2021 we shared the final review report and incorporated her feedback. Service user A's mother told us she would like to involved with the Trust in making changes to the services.

1.29 Service user A's biological father contacted the Trust to request a copy of the internal independent investigation, however, we were informed by the Trust that service user A has no relationship with him. Further contact was not attempted by Niche and he has not requested his involvement in this assurance review. Service user A has a brother, living with his aunt, and although mobile telephone contact details were made available to Niche, contact was not successful.

1.30 Niche contacted the victim's daughter to advise her about the independent investigation offering a meeting with the investigators. We subsequently spoke to the victim's son, who advised that his sister did not want to meet. We updated him on the investigation's progress, and he communicated their views.

Assurance summary

1.31 In relation to progression of actions which have been agreed from the eight recommendations made from the internal investigation report, we have rated the findings which are summarised below:



2 ASSURANCE REVIEW

Approach to the review

2.1 The external quality assurance review has focussed on the implementation of the Trust's internal investigation action plan to identify progress made, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

2.2 The external quality assurance review commenced in October 2019, was completed in March 2020, and was carried out by:

- Sue Denby, Senior Consultant, Investigations and Reviews, Niche.
- Kathryn Hyde-Bales, Associate Director, Niche.

2.3 Expert advice and peer review were provided by Dr Carol Rooney, Associate Director, Niche. The investigation team will subsequently be referred to in the first person in the report.

2.4 We provided monthly updates to NHSE, as per the terms of reference.

2.5 This external review was comprised of a review of documentary evidence supplemented by an interview with the Trust investigation report author.

2.6 We have graded our findings using the following criteria:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

2.7 The terms of reference for this external quality assurance review are given in full at Appendix A. Documents and policies reviewed are referenced at Appendix B. Appendix C provides details of the credibility, thoroughness and impact checklist and Appendix D provides a summary of the assurance scores. Appendix E lists the abbreviations in the report.

2.8 The draft report was shared with NHS England and the Trust. This provided opportunities for those organisations that contributed significant pieces of information to review and comment upon the content.

3 KEY LINES OF ENQUIRY

Review of the care provided and quality of the internal independent investigation

3.1 We reviewed whether the internal independent investigation was robust, appropriate, and complied with best practice and policy. We also reviewed the Trust quality governance assurance processes and considered it in relation to its investigation management.

3.2 With regards to quality governance assurance processes we note the Trust Annual Report and Quality Account 2018-2019 states that the Trust undertook an external review of its governance arrangements using the Well Led Framework during 2015/16; this was supported by Deloitte and in line with NHS Improvement's recommendations to all foundation Trusts. No material governance concerns were identified.

3.3 As part of the comprehensive inspection from the CQC in 2018 the governance of the Trust was reviewed through the Well Led Domain, gaining an 'Outstanding' outcome in this area. It was also rated as 'Outstanding' overall in both 2016 and 2018 following the CQC Well Led review and comprehensive review of services.

3.4 The Trust Annual Report and Quality Account 2018-2019 also provides information on the core standards they are required to meet including the rate of patient safety incidents reported, and the number and percentage of such patient safety incidents that resulted in severe harm or death. The Trust was below the national average for number of patient safety incidents reported for the first three quarters of 2018/19 (i.e. had less incidents).

3.5 The Trust investigate incidents through the application of the Serious Incident Framework (2015) which forms the basis of the Trust's Incident Policy.

3.6 The Trust Board of Directors has a system of performance reporting, which includes analysis against the full range of performance and compliance standards, regular review of the Assurance Framework and Corporate Risk Register, ongoing assessment of clinical risk through review of complaints, serious incidents, and lessons learned.

3.7 We assessed the internal independent investigation report against the Niche 'credibility, thoroughness and impact' framework to objectively quantify (and score) how the investigation complied with best practice guidance (see Appendix C).

3.8 We found that the terms of reference for the internal independent investigation were clear about what was to be investigated, and set the scope, and type of the investigation. The report was to be presented to the Trust Incident Panel.

3.9 The internal independent investigation author was provided with confirmation to proceed with the investigation on 3 October 2018. The Trust initially requested the report to be completed by 24 January 2019, however, this was subsequently changed to 28 March 2019. The Trust informed us that an

extension was granted due to a delay in the availability of a key clinical member of staff and factors associated with finding a suitable time to meet with the mother of service user A. The Trust believed these were important factors and it was therefore reasonable to allow for an extension.

3.10 We therefore found that the 60-day timescale for the completion of the internal independent investigation was not met due to the complexity of the case and the need to interview the care coordinator (CCO) who was on sick leave for a substantial amount of time during the process. Our view is that these issues were balanced appropriately in order to produce a comprehensive report.

3.11 According to the terms of reference, the independent investigation also referred to NMC professional standards for nursing with regards to record keeping[7], NICE guidance for ADHD[8] and psychosis in children and young people[9] and the Department of Health Risk Assessment Guidance[10] (2007). This is in keeping with the National Patient Safety Agency (NPSA) and NHS England (NHSE) good practice.

3.12 We explored whether the people involved with and caring for service user A were adequately supported and were informed by the Trust investigator that a discussion with all staff involved found they felt supported.

3.13 It was reported in the independent investigation that the author was not able to meet with the mother of service user A who, although declined the opportunity to meet, agreed to a brief telephone conversation. Service user A's mother told us she wanted to meet, but did not feel in a fit state to do so at the time.

3.14 The author stated he subsequently wrote to the mother to explain the investigation process and identify any questions she wanted to be considered, however, she did not respond. A specific Trust recommendation was made in respect of this to ensure further correspondence with the mother to offer feedback on the internal independent investigation.

3.15 The victim's family were not approached with regards to involvement in the internal independent investigation process. A specific Trust recommendation was made in respect of this, with a view to ensuring sensitive engagement with the victim's family in the future, with support from NHS England.

3.16 We found the internal independent investigation appropriately referred to Trust policies for serious incidents, CPA, promoting engagement with service users, records management, clinical supervision, Department of Health (2006) records management: NHS code of practice, NHS England (2016) implementing the Early Intervention in Psychosis access and waiting time standards.

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7 https://www.nmc.org.uk/standards/code/record-keeping/
8 https://www.nice.org.uk/guidance/cg72
9 National Institute for Health and Care Excellence, 2016, Psychosis and Schizophrenia in Children and Young People: recognition and management, CG155.
10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

Chronology

3.17 The internal independent investigation chronology commences August 2007 and encompasses the duration of service user A's care within the Trust's services until 5 September 2018 in accordance with the terms of reference for the investigation.

3.18 The internal independent investigation chronology is detailed, provided in narrative form, and includes key dates and events. The chronology commences with service user A's referral to South Tyneside NHS Foundation Trust Child & Adolescent Mental Health Services (CAMHS) followed by an ADHD assessment by a consultant in neuro-disability, and ends 5 September 2018 detailing the notification of service user A's arrest for suspicion of murder.

3.19 We developed a high-level chronology based on a review of the clinical records and information contained within the internal independent investigation. We found that the internal independent investigation chronology was accurate, comprehensive, and met the terms of reference. Commentary was provided as further narrative.

3.20 We found that the level of internal independent investigation commissioned was appropriate to the incident with clear terms of reference. The person leading the investigation had the required skills, experience and training in investigations and was supported by a consultant psychiatrist and a senior nurse, both with experience in EIP services, however, not from the service where the incident occurred. This independence from the service was good practice.

3.21 The internal independent investigation provided a summary of the incident including the outcome and severity, included the terms of reference, and identified that the information was analysed with reference to NPSA Root Cause Analysis (RCA) Guidance.[11]

Methodology

3.22 The internal independent investigation states that RCA methodology was utilised to enable a clear rationale for the recommendations to support learning from this incident.

3.23 We found the findings detailed whether they were an incidental finding (a gap or occurrence that did not contribute to the overall outcome), a root cause (an underlying or initiating cause of a causal chain which led to the outcome), or a statement of fact in relation to the incident.

3.24 We found that these findings included the human factors associated with the incident through examination of the CCO's caseload capacity, access to and quality of clinical supervision, internal, primary care and interagency communication, organisational systems, and processes.

[11] https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

3.25 However, apart from the timeline and chronology, we did not find explicit evidence of the use of RCA methodology incorporated into the report, for example, use of RCA tools such as a fishbone diagram, the contributory factor framework to identify contributory factors, or the five 'whys'.

3.26 Our view is that the use of RCA tools would have assisted in the analysis to help understand the fundamental systems issues associated with the findings and therefore identify outcome focussed recommendations to address these.

3.27 In addition, our view is that the clarity and flow of the report would have been improved by clearly outlining the findings as contributory factors.

Care and service delivery problems

3.28 We found that the internal independent investigation addressed the issues raised through the chronology and identified 28 findings under four overarching themes:

- Assessment and management of risk.
- Care and treatment including diagnosis, medication, and engagement.
- Standards of record keeping and communication.
- Organisational systems and processes.

3.29 We found that the internal independent investigation reviewed the findings relating to these themes in detail, however, lacked analysis as to the systems issues associated with them. Additionally, our view is that determining whether the findings were specific care and service delivery problems, would have improved the clarity and flow of the report.

Root cause

3.30 The internal independent investigation determined the root causes to the incident as being service user A's 'diagnostic position' and his lack of engagement.

3.31 With reference to the first root cause of service user A's diagnostic position, we found that the internal independent investigation identified that service user A's diagnosis prior to the incident was mental and behavioural disorders due to cannabinoids-psychotic disorder.

3.32 In February 2018 service user A was assessed to be symptom free and his antipsychotic medication was reduced. Although prescribed medication followed NICE recommendations, there was no care plan relating to the monitoring of this change.

3.33 Post April 2018, service user A's concordance could not be accurately monitored, and it was reported in the independent investigation that there was an indication from his mother that he had stopped taking his medication in the week leading up to the incident. However, service user A's mother fed back to us that she did not provide this information.

3.34 The internal independent investigation identifies the second root cause as being service user A's lack of engagement and found that he began to disengage after 10 April 2018. He was not seen for a period of 148 days before the incident, despite the need for a more assertive approach identified in June 2018, and as a result there was no contemporary

understanding of his mental health status.

3.35 The internal independent investigation states that the effort to re-engage service user A utilising an assertive approach was weak, not timely or responsive to his mother's concerns.

3.36 We found that in relation to this, the internal independent investigation identified that both clinical and management supervision arrangements were operational and there was evidence of supervision being utilised with regards to service user A's case.

3.37 However, there were two occasions when, despite service user A's non-engagement, the possibility of discharge was discussed in supervision and was not informed by contemporary assessment of risk.

3.38 The internal independent investigation concluded that the supervision process did not provide a challenge to these discussions and the need therefore to establish an assertive approach to engagement with service user A was not effective. Additionally, student nurse involvement and care record entries were not always validated by a registered practitioner.

3.39 We found an absence of analysis in that the internal independent investigation does not provide information to assist in understanding why the discussions in supervision were not in line with the agreed plan of a more assertive approach, linked to an assessment of risk, or why student nurse entries were not validated.

3.40 Our understanding of a root cause[12] is that this is a fundamental, underlying, system-related reason why an incident occurred. Identifying the root cause allows action to be taken to improve patient safety and prevent recurrence.

3.41 Our view is that the clarity and flow of the report would have been improved by more clearly stating the identified fundamental systems issues, rather than the patient related issues of service user A's diagnosis and non-engagement, as root causes which we do not believe are appropriate. The essence of RCA is to focus on learning and avoid apportioning blame.

3.42 For clarity, our view is that the root cause in patient safety investigations should be the earliest point at which a system intervention should have prevented the error and cannot be the patient.

Internal report recommendations

3.43 The internal independent investigation provides eight recommendations. We found these were written in full and could be read alone but were lengthy and lacked clarity.

3.44 We found that the internal independent investigation agreed recommendations to be taken forward into an action plan were transactional, lacked detail about how the actions would be monitored and did not provide associated outcome measures. The recommendations were not SMART (specific, measurable, achievable, relevant, and time-specific).

[12] https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

3.45 We did not find a specific recommendation to address the identified root cause of service user A's diagnostic position, the lack of a care plan relating to the monitoring of a change in his medication or his concordance.

3.46 However, we found recommendation seven detailed that the process of care coordination was influenced by the perceived wellness of service user A and the approach to the ongoing assessment, care and treatment pathway was therefore limited as a result.

3.47 To address this, recommendation seven states that the EIP team should hold a learning event to ensure that the lessons learnt are discussed, integrated into the care coordination process and that individual team members have the opportunity to reflect on their contribution to the care process through both clinical and management supervision.

3.48 Our view is that this recommendation is not outcome focussed or specific enough to address the lack of a care plan relating to the monitoring of a change in his medication or his concordance. Equally, the recommendation should seek to implement improvements for all services users rather than service user A only.

3.49 We found specific recommendations to address the identified root cause in respect of service user A's disengagement.

3.50 Recommendation one states that the EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users' Policy.

3.51 Recommendation two states that the EIP service should ensure with immediate effect that changes of risk warrant the creation of a new or updated risk assessment.

3.52 We also note recommendation six in respect of supervision to ensure that student nurses' clinical record entries are validated by registered nurses.

3.53 Our view is that these recommendations are transactional, not outcome focussed and do not address systems issues.

Implementation of the internal recommendations

3.54 We reviewed evidence provided by the Trust to assess whether the recommendations had been implemented, embedded, and tested. We considered whether the implemented actions had led to positive changes within the Trust, and, whether there were areas where further work was required.

3.55 We found that the Trust has taken extensive steps to share the learning and findings of the internal investigation with its community teams. There is evidence of it being discussed in numerous meetings and that it was considered as part of a wider clinical review.

3.56 However, whilst the Trust was able to evidence varying progress with each of the eight recommendations, we have not been provided with sufficient

evidence to indicate each recommendation has been successfully implemented and embedded, despite all being listed as complete in the Trust action plan. In particular, there were gaps in the Trust's evidence in relation to its implementation of recommendation eight.

3.57 Consequently, though we do not consider further recommendations are warranted in relation to the Trust action plan, the Trust must assure itself within the three months of receipt of this report that it can evidence that each recommendation has been successfully implemented.

4 GOVERNANCE AND SYSTEMS FOR OVERSIGHT

4.1 The Trust has a process in place for the oversight and management of its serious incident investigations and resultant action plans. The Trust has an Incident Policy which includes the management of serious incidents. The policy refers to the NHS England Serious Incident Framework (2015) for incident classification and thresholds.

4.2 The Policy (2016) is underpinned by Practice Guidance Notes (PGNs) which include:

- Incident Policy.
- Incident reporting and management.
- How to investigate an incident.
- Serious incident review panel.
- How an After-Action Review is carried out.
- Learning lessons from incidents and near misses.
- Supporting staff involved in an incident.

4.3 The PGNs provide detail on roles, responsibilities, and tasks to be undertaken.

4.4 Trust investigations are signed off by the Head of Clinical Risk and Investigation, then submitted to the Associate Director of the Clinical Business Unit (CBU) where the incident occurred for approval. Reports are then presented at a multi-disciplinary review panel for final sign off. The SI panel is not formally minuted, but handwritten notes are made, and an electronic copy scanned and attached to the Trust's electronic records pertaining to each case. Attendance at the SI panel varies according to involvement in the SI, but staff only attend if they have been involved with the review.

4.5 The Trust provided a copy of the SI review panel agenda for 28 March 2019 at which this incident was discussed. The meeting was attended by the Associate Nurse Director, investigating officer, lead clinicians, clinical manager, pathway manager and two medical staff. We were provided with the handwritten notes for the meeting. The notes use abbreviations to identify staff. A list of attendees is not included, rather the reader has to refer to the agenda to cross reference who was present at the meeting.

4.6 The notes serve as a good record of the meeting but contain a number of questions, illustrating the detailed nature of the discussion, as opposed to evidence that the panel signed off the report. The notes do not include any statements to the effect that the panel agreed the report should be signed off; but we note the cover of the final report says it was signed off at panel on 28 March 2019. It would be helpful if the Trust formally recorded panel decisions in relation to report sign off.

4.7 However, we were informed that an aide memoire is completed during the SI review panel meeting, whilst members are present, rather than a full set of formal minutes. This includes areas of discussion, the agreed final outcome and actions. Reports are signed off at the panel, with no further stage in the internal governance process to sign off the report.

4.8 Action plans are signed off by the Quality Standards Group where the incident occurred. The Group terms of reference (2018) say the purpose of the meeting is to *"oversee effective management of risk, safety, quality and performance across the Locality… ensure lessons learnt, innovation and best practice identified and shared across the Locality (and wider where relevant)".*

4.9 The action plan for the Trust investigation was signed off at the South Locality Care Group[13] Quality Standards meeting on 24 September 2019. The meeting was chaired by the Group Nurse Director for the South Locality Care group. The Associate Nurse Director for the South Community CBU and Neurological Services and Specialist Services CBU told the meeting the EIP had *'significantly changed some of their practice, have carried out some good work and have reflected on their approach'*.

4.10 However, our review of the Trust action plan identified gaps in assurance. The minutes for the Locality Care Group on 24 September 2019 do not detail whether there was testing of the action plan evidence, but we consider that there were at least three recommendations for which further evidence is required before they can be considered fully implemented. The Trust did not provide consistent evidence of monitoring and testing of the recommendations and we do not consider any of the recommendations are embedded to a level that demonstrates sustainable improvement.

4.11 In summary, the Trust has a system in place for the management and sign off of its SI reports. The Trust can demonstrate that the SI report was subject to oversight and review at senior level, but we recommend it maintains formal records of panel discussion and sign off, to provide substantive evidence of governance.

4.12 Similarly, the Trust has a system in place for the review of action plans, but further evidence is required to demonstrate robust testing of evidence in advance of sign off.

Recommendation 1:
Trust SI panel meetings should be formally recorded.

Recommendation 2:
The Trust should ensure that SI action plan evidence is rigorously tested and recorded in advance of action plan sign off.

[13] *Which covers Sunderland and South Tyneside*

5 ACTION PLAN PROGRESS

Recommendation 1: The EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back learning to CBU/South Quality Standards Group.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Incident discussed at the EIP Strategy meeting on 11/01/19. The Trust told us that there was a detailed discussion at the meeting with particular reference to promoting engagement. • EIP Clinical Business meeting 24/04/19, under Any Other Business, the Associate Nurse Director for the south locality and Modern Matron attended the meeting to discuss the actions arising from the SI and to facilitate a team discussion about the lessons learned. We were told the Promoting Engagement with Service Users Policy was part of this discussion. • EIP Clinical Business meeting 21/05/19, under Any Other Business, the Promoting Engagement with Service Users Policy was discussed. • South Community CBU Lessons Learned meeting minutes 3/06/19 detail a discussion about the policy, that it should be read, and its profile raised with all teams. • Email from Trust-wide lead for EIP to Operational Support Manager (South Locality Care Group) on 6 June 2019 saying the case had been discussed at the EIP strategy group [11/01/19 – minutes provided] and it was agreed to highlight at all team meetings. • Incident discussed at South Locality Quality Standards Group meeting 24/09/19. • Blank clinical supervision template includes a discussion point for 'clinical contact time'. • We were told the EIP receives monthly reports from the IT department detailing each service users last face to face contact.	• The EIP Strategy meeting minutes (11/01/19) have a SUI/lessons learned section. There is reference to a homicide, but there are no identifiers to confirm reference to service user A. The minutes do not reference requirements on staff to comply with the Promoting Engagement with Service Users Policy. The minutes describe the homicide as '*a very unique situation'*. • There was good attendance at the EIP Clinical Business meetings (few apologies). • Several disciplines/teams were represented at the South Community CBU Lessons Learned meeting in June 2019 (e.g. EIP, CYPS, Community Treatment Teams, Improving Access to Psychological Therapies and the Memory Protection Service). The meeting discussion highlighted core learning and key actions from Trust investigation. • 17 members – over half of the South Locality Quality Standards Group did not attend the meeting on 24/09/19. A further 15 apologies were received, though the Trust advised the meeting was quorate, in line with the Group terms of reference. • The incident was discussed in the context of signing off the action plan. We did not see evidence of a broader discussion around specific learning/actions. • The Associate Nurse Director, South Community CBU and Neurological Services and Specialist Services CBU told the Group "*… the EIP Team have significantly changed some of their practices, have carried out some good work and have reflected on their approach*".

• Open SI action plans processes flow chart (undated). • The Trust told us the Quality Standards Group received assurance the action plan had been discussed in local meetings that included the Clinical Management Team meetings, Lessons Learned Forum and South of Tyne Adult Leadership meeting. • EIP caseload audit (April 2020). Criteria includes 'evidence of promoting engagement policy'. • A monthly report, detailing a patient's last appointment, is available to team managers. Any gaps are picked up via supervision.	• EIP caseload audit (April 2020) demonstrates awareness/application of promoting engagement policy.
NIAF rating: The Trust has provided evidence that steps were taken to raise the profile of the Promoting Engagement with Service Users Policy and it has been shared across the community teams. April 2020 audit results evidence staff are aware of the Policy, though further audits are required to demonstrate embedding of practice. **Overall rating for this recommendation: 3**	

Recommendation 2: The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based FACE risk assessment tool at points where changes of risk warrant this using supervision and the IT audit report.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• All service users have a FACE risk assessment which is reviewed during staff supervision. • Internal CAS safety alert re FACE FAQs emailed to community staff on 28/03/19. • FACE - FAQ handout dated March 2019. • EIP Clinical Business meeting minutes (24/04/19, 21/05/19 and 03/10/19). • EIP Clinical Business meeting 24/04/19, under Any Other Business, the Associate Nurse Director and Modern Matron attended the meeting to discuss the actions arising from the SI and to facilitate a team discussion about the lessons learned. • South Community CBU Lessons Learned meeting 03/06/19. • Email from Trust-wide lead for EIP to Operational Support Manager (South Locality Care Group) on 06/06/19 saying	• The EIP Business meeting minutes do not make explicit reference to the FACE risk assessment tool. Discussion may have taken place, particularly as part of risk formulation training on 03/10/19, but it is not documented. • There is evidence the incident has been reviewed at meetings, but the notes of these discussions do not extend to the use of supervision. • EIP caseload audit (April 2020) evidences clinical risk and assessment was consistently at Trust expected standard.

the case had been discussed at the EIP strategy group [11/01/19 – minutes provided] and it was agreed to highlight at all team meetings. • EIP Clinical Pathway meeting minutes 28/08/19, 11/09/2019, and 18/09/19 under Any Other Business, staff reminded to complete FACE risk assessment pertaining to current and historical risk. • EIP Clinical Business meeting 03/10/19, risk formulation training delivered. • Trust Quality and Performance dashboard (dated 21/02/20) showed 98% of CPA service users had a risk assessment undertaken/reviewed in the last 12 months. • Performance dashboards are used to monitor that service users on CPA have a FACE risk assessment and supervision notes will reflect the risk formulation section of the assessment is reviewed in clinical supervision. • Sunderland & South Tyneside EIP Clinical Documentation audit template includes questions about the use of FACE risk assessment. • EIP caseload audit (April 2020) criteria includes 'is the clinical risk and formulation at Trust standard'. • The Trust told us the findings from the incident will be shared at the Trust-wide Learning event in June 2020 and the EIP Steering Group in August 2020 to ensure learning is shared across the Trust.	
NIAF rating: The Trust has taken steps to promote the use of the FACE risk assessment and provided evidence of monitoring via performance dashboards. Further evidence is required to demonstrate practice has become fully embedded. **Overall rating for this recommendation**: **4**	

Recommendation 3: The EIP service should review within three months, how to ensure that a carers needs assessment is offered and facilitated and include an audit of the Getting to Know You documentation.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• EIP Clinical Business meeting 24/04/19, under Any Other Business, the Associate Nurse Director and Modern Matron attended the meeting to discuss the actions arising from the SI and to facilitate a team discussion about the lessons learned. • Sunderland and South Tyneside EIP audit data: Getting to Know You. Nine cases are recorded as having 'Getting to Know You' documentation completed between July and September 2019. • EIP Clinical Pathway meeting minutes 28/08/19, 11/09/2019, and 18/09/19, under Any Other Business, staff are reminded of the SUI action plan and the need to complete Getting to Know You and family/carer contact details. • EIP caseload audit (April 2020) includes the criteria 'Getting to Know You/carers documentation or evidence completed'. • The Trust told us it intended to undertake a further caseload review to test that 'Getting to Know You' processes have become fully embedded in clinical practice and that carers are being signposted for carers assessments. Leading from this, the audit findings will be shared across the team, CBU and locality meetings. The Trust told us the findings will also be shared across other localities via the EIP Steering Group by August 2020.	• The Business meeting minutes do not make explicit reference to offering a carer's needs assessment. • We have not seen details of an EIP review of carers' needs assessments. • The Sunderland and South Tyneside EIP audit data is undated and has no explanatory note. • EIP caseload audit (April 2020) demonstrates 'Getting to Know You/carers documentation' is applied in assessments.
NIAF rating: The Trust has provided evidence that the incident has been discussed with staff, but it has provided limited evidence of whether it has reviewed how carers assessments are offered and facilitated. **Overall rating for this recommendation: 2**	

Recommendation 4: The revised arrangements for transition between CAMHS and adult ADHD Services should be audited within three months to ensure they are timely and effective.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The Trust told us it undertook a Trust-wide audit in 2018 (we have not seen the results). The South locality discussed in team meetings and during supervision, that when a patient reaches 17.5yrs, discussions must start about transition to adult services. The locality has implemented: - A tracker within CYPS and a monthly Clinical Nurse Manager meeting which takes place between LD Adults and CYPS. - Monthly emails are sent to the CYPS team notifying them if any of their patients are 17.5yrs old and that the case will be added to the tracker and discussed at the monthly Clinical Nurse Manager meeting. - The Clinical Nurse Manager meetings are tasked with ensuring any issues identified are resolved and that joint meetings take place between CYPS and adult services. - CYPS uses a 'My moving on plan' with young people to support their transition to adult services. • Case record audit of young people who transitioned out of CYPS MHS during Q3 and Q4 completed by Modern Matron (reported in May 2019). 180 records of which two were excluded. 81 young people transitioned to adult/other commissioned services (of which there was evidence of transition planning in 35% of cases 6-12 months before discharge. • The Trust told us that, in response to the (May 2019) audit results that 65% of transitioning patients did not have a transition planning meeting, the South community locality had set up pathway meetings between LD CYPS and Adult services to ensure every young person has a transition meeting.	• The 2019 audit results are good in terms of the old and new service agreeing the transition plan (97% and 94% respectively), but further work is needed in some aspects of joint working: the key worker and new worker were present in 65% of cases, contact details had been shared in 70%, and family carers were involved in 84% of cases.

NIAF rating: The Trust provided details of revised transition arrangements and completed an audit of the revised arrangements. However, the audit results indicate that there are still gaps in practice, which the Trust has advised it is taking steps to address, but we note further testing and evidence is required to achieve full assurance.
Overall rating for this recommendation: 3

Recommendation 5: Referral between forensic CAMHS and adult forensic services needs to be streamlined. To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17.04.19	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Discussed at BDG on 29/3/19 – agreed Group Nurse Directors from the South and Central localities would take forward the work to address referral pathway issues. • Quality improvement meeting scheduled for 17/04/19. • The Trust told us that an output of this meeting was that the Forensic Community Mental Health Team (FCMHT) Manager made appointments with the CMHT leads and reviewed the process and services available to the team. This led to the development of the Forensic Community Team North East and Cumbria (FCT) referral flowchart. • Reported at Central Locality Quality Standards Group (13/08/19) that an algorithm had been circulated and a meeting was taking place with team leads. 'A plan is now in place'. • The Trust told us the FCMHT scaffolds teams and has supported numerous complex patients.	• The BDG meeting minutes were sent in email format on 29/03/19. They say a brief summary of the SI panel findings were shared and actions listed. The minutes do not reference the CAMHS/adult forensic services referral pathway. • We asked to see the minutes of the Quality Improvement meeting scheduled to take place 17/04/19 but the Trust told us this was not a formal, minuted meeting, rather it was a discussion between two Group Nurse Directors who agreed to further develop the understanding of access to Forensic Community Services. • We asked for detail of any subsequent agreement in relation to streamlining referrals between CAMHS and Adult Forensic Services, but beyond the FCT referral flowchart, we did not receive further evidence.
NIAF rating: The Trust has not provided evidence of its review of the referral process between Forensic and CAMHS services but has developed a flowchart designed to improve the referral process. However, testing is required to assess the effectiveness of the revised process. **Overall rating for this recommendation: 2**	

<table>
<tr><th colspan="2">Recommendation 6: [Name] Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.</th></tr>
<tr><th>Trust response and evidence submitted</th><th>Niche comments and gaps in assurance</th></tr>
<tr><td>[Name] Ward Educational Audit completed on 25/04/19 by Practice Placement Manager. The audit referenced a specific need to ensure all clinical note entries by student nurses are validated by an appropriate Registered Nurse.
A reminder was sent to all mentors to discharge their professional duty regarding signing off clinical notes.
Students reminded of their responsibility regarding validation of notes in student induction programme.
Northumbria University Student Nurse Induction (November 2019) includes, under Practicalities, ‘RiO Training - Ensure entries are validated by your mentor’.
A screen shot of a slide which we were told is included in a mentor presentation which was updated in May 2019. It says: “All registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student”.
Mentorship practice assessor/supervisor update 2020 also includes the above statement.</td><td>The Trust provided an EIP Clinical Team Review of Serious Incidents (completed on 09/01/19) of which the incident was one of five taken into consideration. All findings and comments were provided generically therefore it is not possible to attribute actions identified as being taken in response to this SI or the other four reviewed.
A documentation audit tool has been developed as a supervision tool, but we have not seen evidence of implementation or testing.</td></tr>
<tr><td colspan="2">NIAF rating: The Trust has taken steps to ensure clinical notes are appropriately validated and has communicated this message to students and their mentors. We have not been provided with evidence of ongoing monitoring of student nurse entries in clinical notes and whether this has led to improved practice.
Overall rating for this recommendation: 3</td></tr>
</table>

Recommendation 7: The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the Care Coordination process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. Update required on the Trust wide implementation of the Trust supervision process and policy.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The incident was discussed at the EIP Strategy meeting on 11/01/19. The meeting was attended by every member of the EIP clinical team. • The Trust told us a full and in-depth discussion took place about the incident during this meeting. • EIP Clinical Business meeting 24/04/19, under Any Other Business, the Associate Nurse Director and Modern Matron attended the meeting to discuss the actions arising from the SI and to facilitate a team discussion about the lessons learned. • South Community CBU Lessons Learned meeting 03/06/19. • Email from Trust-wide lead for EIP to Operational Support Manager (South Locality Care Group) on 6 June 2019 saying the case had been discussed at the EIP strategy group [11/01/19 – minutes provided] and it was agreed to highlight at all team meetings. • The Trust has developed a clinical audit tool to facilitate supervision. • Clinical Supervision Policy (February 2020). • The Trust told us the above policy has been ratified and is available on the Trust intranet. • The Trust told us that South Community services have developed a supervision proforma that has been embedded into all community services to ensure a consistent standard of caseload and supervision. The Trust advised that this process would be subject to regular audit.	• The Strategy meeting minutes (11/01/19) have a Serious Untoward Incident (SUI)/lessons learned section. There is reference to a homicide, but there are no identifiers to confirm reference to service user A. The minutes describe the homicide as ‘a very unique situation’. • We asked the Trust to provide an update on the Trust-wide implementation of the supervision process and policy (e.g. May 2019 adherence to policy audit results, action plan, implementation of new clinical system). At the time of report submission, we had not received this. • We have not seen evidence of auditing the supervision proforma.

NIAF rating: The Trust provided evidence that the internal investigation report and resultant learning was shared at team meetings and a Lessons Learned event. The Trust did not provide an update on implementation of the Trust supervision process or detail any resultant impact from the shared learning.
Overall rating for this recommendation: 3

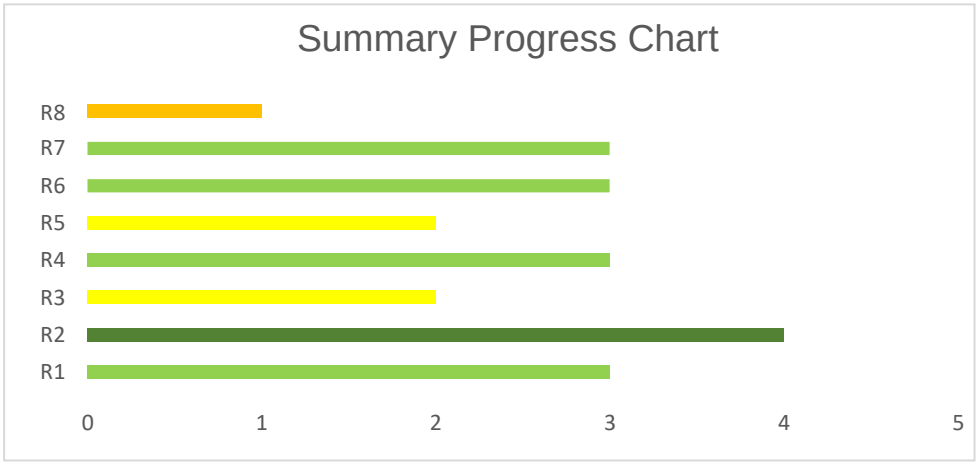
Recommendation 8: Senior Trust officers should discuss and agree future Trust Policy in relation to involvement/information sharing with the family of a victim, when the victim is not known to mental health services in these circumstances. In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family. A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting. The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from service user A's RC regarding any feedback or otherwise to the patient regarding the review of his care and treatment.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Reported at the Incident Management Group on 15/05/19 that the Trust had tried to contact the [victim's] family but no response had been received. • A representative for the victim's family contacted the investigating officer on 10/06/19 to advise the family would like to see the SI report. • [Victim's] Family to be advised that requests for the report should be submitted to the Coroner. • The Trust provided a copy of the letter it sent to the perpetrator's mother on 2 May 2019. The Trust provided an email from the Group Nurse Director dated 01/05/19 which confirmed the letter had been approved and would be sent by the Chief Executive Officer. • The Trust advised that the report was shared with service user A's solicitor on 5 December 2019, with a view to it being shared with service user A and his mother. The action plan was shared on 22 April 2020.	• We have not seen evidence of the correspondence to the victim's family or service user A's solicitor. • The Trust letter to service user A's mother (2 May 2019) does say she is welcome to contact the Trust if she would like to meet or speak to the Chief Executive Officer, but the letter does not specifically offer a meeting to receive feedback about the Trust investigation report findings. • The Trust did not provide evidence of its progress in developing Trust Policy about involvement/information sharing with families of victims when the victim is unknown to the Trust. The Trust did not provide the revised copy of PGN6 Being Open.

• The Head of Information Governance and Medico Legal emailed those involved[14] in the SI on 10/12/19 to advise she had received a request from service user A via his solicitor to see the SI report. She asked which clinicians should review and consider the disclosure in view of the impact it could have on the clinical team. • Service user A's mother tried to contact the Nursing and Chief Operating Officer on 06/12/19, asking for a copy of the SI report. The Chief Nursing Officer sent an email on 10/12/19 to individuals involved in the SI flagging concerns that the perpetrator's mother said she had tried to contact her a number of times, but this was the first she had learnt of this. It was unclear who from the Trust has been speaking to the perpetrator's mother. • The Trust follows Duty of Candour (DOC) PGN, which forms part of the incident policy, when the victim is unknown to the Trust. The perpetrator has not given consent to share the report. • The report has since been shared with the Coroner who is now responsible for deciding whether the report can be shared with the victim's family. • Policy and PGN's are currently under review to ensure each case is treated on an individual basis. • Legal advice was sought in relation to sharing the Trust investigation with the victim's family. • The Trust advised that senior Trust officers were to discuss and agree the policy in relation to involving and sharing information with families, and, that a section would be added to PGN6 Being Open with specific reference to homicides and sharing information with families.	
NIAF rating: The Trust has not provided evidence that it has developed/reviewed its policy for sharing reports with families, that the report was shared with the victim's family, or if a meeting was offered to service user A's mother to discuss the report findings. **Overall rating for this recommendation: 1**	

[14] Group Director (South Locality Care Group), Head of Clinical Risk and investigations, Group Nurse Director, and a fourth person (JR – role unknown).

6 SUMMARY

6.1 We have summarised the Niche scores as follows:



6.2 The Trust has provided extensive evidence that the incident was discussed with community teams, and considered as part of a wider clinical review, the learning for which was shared with teams.

6.3 However, we note that there are areas in which further evidence of assurance and testing is required, particularly in relation to recommendation 8.

6.4 The Trust has demonstrated varying progress with all the recommendations. It should now take steps to assure itself that changes in practice have been successfully implemented, embedded, and where possible, can demonstrate improvements in practice.

6.5 For example, the Trust provide evidence that it has taken steps to raise awareness of the 'Promoting Engagement with Service Users Policy' (recommendation 1) but did not provide evidence that it had tested adherence to the policy and improved practice, e.g., through regular audit.

6.6 Similarly, in relation to recommendation 7, the Trust was able to demonstrate it had shared the learning from the internal investigation with staff but did not provide evidence of whether it has tested that the learning had been integrated into the care coordination process.

6.7 We do not consider residual recommendations are warranted in relation to the Trust's action plan, though have identified during our review that the Trust does not formally record its SI panel which we recommend it review. We have also recommended that the Trust seek to assure itself that action plan evidence is subject to robust testing in advance of sign off.

Recommendation 3:
The Trust should assure itself within three months of receipt of the final report that it can evidence the implementation and completion of each recommendation, all of which were signed off at the South Locality Quality Standards Group meeting in September 2019.

APPENDIX A – Terms of reference

Purpose of the review

To undertake a desktop review to consider the internal independent investigation commissioned by the Trust into the care and treatment of service user A. The review will examine the terms of reference and key lines of enquiry identified within the internal independent investigation to ensure they have been adequately considered and explored. The review should also identify any potential gaps or omissions that may require further examination.

An assurance review of the implementation of the recommendations from the internal independent investigation will be undertaken including the identification of any gaps or omissions based on the report's findings.

This review is to ensure that effective learning has taken place and identify any additional improvement actions.

Involvement of affected family members and the perpetrator

Ensure that all affected families are informed of the review, the review process and are offered the opportunity to contribute including development of the terms of reference.

Ensure that updates on progress are communicated to family members in the format and timescales they request.

Offer a minimum of two meetings; one to explain the process and contribute as appropriate and a second to receive the report findings.

Scope of the desktop and assurance review

The desktop review will consider the internal investigation commissioned by the Trust and will include:

- A review of the internal investigation to ensure that the terms of reference were met and that the key lines of enquiry were appropriate. This should include compliance with local policies, national guidance and where relevant statutory obligations.
- The sourcing and review of relevant documents to develop a comprehensive chronology of events by which to review the investigations findings against.
- Identify any gaps or omissions in the key lines of enquiry into the care and treatment within the investigation commissioned by the Trust.
- To identify any additional key lines of enquiry that require further investigation.

Undertake a multi-agency assurance review

- Consider the original recommendations ensuring they adequately address the internal investigation findings. If any gaps or omissions are identified develop additional recommendations or propose changes to strengthen the original recommendation.

- Assess the associated action plan to establish progress made against the implementation of the recommendations from the internal investigation.
- Consider any partially implemented actions and identify possible organisational barriers to full implementation, propose remedial recommendations or actions as appropriate.
- Conduct interviews with key personnel, where necessary, to provide additional information, clarity or assurance as to how actions have been embedded.
- Identify any notable areas of good practice or any new developments in services as a result of the investigation[15].

Output

- Provide a written report to NHS England identifying the key findings and providing outcome focused recommendations. The report should follow both the NHS England style and accessible information standards guide.
- The report should highlight any areas that require additional investigation and be submitted alongside an additional proposal for consideration by NHS England.
- Provide a concise case summary to enable wider sharing of learning.
- Provide NHS England with a monthly update, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.
- Support an action planning and/or learning event to promote learning opportunities for the Trust, CCG and wider stakeholders.
- Within 12 months conduct a further assurance review on the implementation of any new or outstanding actions in conjunction with the CGG and Trust. Provide a brief written report to NHS England, which may be published.

[15] *The original terms of reference also contained: Review and assess the CCG's assurance processes and oversight of Serious Incident management (to be confirmed by NHS England - Cumbria and North East). However following discussions between the CCG and NHSE, NHSE agreed to remove this from review.*

APPENDIX B – Documents reviewed

	Document	Date
1	Initial report	7 September 2018
2	ToR Quality Standards Group	March 2018
3	After action review	21 November 2018
4	Clinical records	August 2007 – 5 September 2018
5	Blank supervision template	N/A
6	Screenshots	N/A
7	EIP Clinical Team review of serious incidents	9 January 2019
8	EIP Strategy Group minutes	11 January 2019
9	Internal independent investigation	28 March 2019
10	Serious Incident Review Panel agenda	28 March 2019
11	314829 – Aide Memoir	Undated [28 March 2019]
12	Internal CAS Safety alert – FACE FAQs	29 March 2019
13	FACE FAQ handout	March 2019
14	Community South CBU CMT minutes	12 April 2019 18 April 2019 13 September 2019
15	Quality Standards Group ToR V4	April 2019
16	[Ward name] CYPS Ferndene Audit	25 April 2019
17	Letter of apology from CEO	2 May 2019
18	EIP Incident Management Group minutes	15 May 2019
19	South Community CBU Lessons Learned minutes	3 June 2019 5 August 2019
20	Trust action plan	23 August 2019
21	EIP clinical pathway meeting minutes	28 August 2019 11 September 2019 18 September 2019
22	South Locality Quality Standards agenda	24 September 2019
23	South Locality Quality Standards minutes	24 September 2019
24	Lessons learned from incidents and near misses, incident policy practice guidance note	October 2019
25	Northumbria University Student Nurse Induction	November 2019
26	Review of the Sunderland and South Tyneside Early Intervention in Psychosis service	13 November 2019
27	Trust governance structures V2.7	December 2019
28	Serious Incident Thematic review action plan	Undated
29	Incident Policy V4	February 2020
30	The Trust 31 Policy with attachments	February 2020
31	EIP caseload audit	April 2020
32	Flowchart of SI processes	May 2020
33	Sunderland & South Tyneside EIP audit data – Getting to Know You and Consent Screen	Undated
34	Practice Guidance Notes	Various
35	Mentorship practice assessor/supervisor update	2020
36	FCT referral flow chart	Undated
37	Internal email updates	Various

APPENDIX C – Credibility, Thoroughness, and Impact checklist

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
Theme 1: Credibility				
1.1 The level of investigation is appropriate to the incident.	NPSA	No.	Not applicable.	Yes. Level 2.
1.2 The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	NPSA	No.	Not applicable.	Yes.
1.3 The person leading the investigation has skills and training in investigations.	NPSA; NHSE-SIF	The report does not contain the details to make this clear.	The appointed independent investigator and the Clinical Lead held the review.	Yes, it is clear in the report. The author has a clinical background as a mental health nurse having qualified over 40 years ago and was an Executive Director 10 years ago. He was approached to do this internal level 2 investigation as he does similar work elsewhere and has previously worked for the Trust The author undertook RCA training in Cumbria some time ago, and in addition he has an MSc in total quality management. RCA is one of the tools and techniques involved in this and as a result he informed us that he looks at a case from a systems and process point of view.
1.4 The investigations were completed within 60 working days.	NHSE-SIF	The report was completed 7 September 2018 – 2 days after the incident occurred.	Not applicable.	This independent review was commissioned on 2 January 2019 by the Deputy Director of Nursing and Governance with a final and absolute

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
				submission date for the report to the Trust of 25 January 2019. The report details that it was to be presented to the Trust Incident Panel on 24 January 2019 (this date was subsequently changed to 28 March 2019). The 60-day timescale was not met due to complexity and the CCO being on sick leave. The author had to have regard for the CCO's health status and the occupational health advice. The author informed us that the criminal justice process did not interfere with the investigation process.
1.5 The report is a description of the investigation, written in plain English (without any typographical errors).	NPSA	The report details the incident very briefly, followed by a brief psychiatric history and community follow up. Immediate remedial action headings do not contain the appropriate information.	Yes.	Yes.
1.6 Staff have been supported following the incident.	NPSA	There is no detail in the report to provide this assurance.	The review notes that a timely debriefing for staff involved was held on 6 September 2018. Those	Yes, the author informed us that he had a joined-up discussion with all staff involved and one of the questions he asks is about support. This case was very traumatic for

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
			attending the After-Action Review (AAR) meeting indicated an appropriate level of post incident support has been provided by the Trust.	those involved, however, they said they felt supported. The CCO was later off work on sick leave. The author spoke to the CCO who said he felt supported in this context.
Theme 2: Thoroughness				
2.1 A summary of the incident is included that details the outcome and severity of the incident.	NPSA	Yes, but very briefly.	Yes.	Yes.
2.2 The terms of reference for the investigation should be included.	NHSE	No.	Not applicable.	Yes.
2.3 The methodology for the investigation is described. This includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	NPSA	No.	Not applicable.	The report details that the investigation involved the gathering and mapping of a wide range of evidence and that once all of the evidence had been assimilated the information was analysed with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis (RCA) Guidance. However, the use of RCA methodology and tools apart from the chronology is not evident in the report.
2.4 Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	NPSA, NQB	The report details that contact was attempted several times with his mother unsuccessfully.	The review notes that following initial engagement with Consultant post incident the mother requested no further contact from the	The perpetrators mother did not want to engage until after the report was produced so the family's input into the terms of reference was not possible. The investigator subsequently spoke to the perpetrators mother at length on two

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
			service (a position that has been respected by clinical services). Following the incident, the Trust made assertive daily attempts to contact the mother to offer support and discharge Duty of Candour responsibilities. The mother initially engaged; however, she subsequently communicated that she did not want further contact. She was made aware of the investigation by the investigation author on 17 October 2018. She was reluctant to speak therefore a letter was forwarded on 18 October to explain the process and offering an opportunity to provide her views in addition to influencing the terms of reference. As of July 2020, no contact has been received.	occasions. The perpetrator was asked by his mother if he wished to contribute to the review and his response was that he did not at this time. In terms of the victim's family, the investigator was not made aware of these details until contacted by NHS England in January 2019 when a joint approach was suggested. An advocate became involved following which the family declined the opportunity to give feedback at that point.

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
2.5 Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	NPSA, NQB	As above. No further detail provided.	As above.	As above.
2.6 A summary of the patient's relevant history and the process of care should be included.	NPSA	The patient's history is briefly outlined.	Yes.	Yes.
2.7 A chronology or tabular timeline of the event is included.	NPSA	No.	Yes.	Yes.
2.8 The report describes how RCA tools have been used to arrive at the findings.	NPSA	No.	Not applicable.	The report indicates that RCA methodology was used, however, the report does not explicitly refer to RCA tools.
2.9 Care and Service Delivery problems are identified (including whether what were identified were actually Care Delivery Problems (CDPs) or Service Delivery Problems (SDPs).	NPSA	No.	The review identifies key learning points rather than SDPs or CDPs.	The report sets out findings under themed headings rather than identifying SDPs or CDPs.
2.10 Contributory factors are identified (including whether they were contributory factors,	NPSA	No.	No.	No, however, the report findings would appear to be contributory factors. Use of the classification index is not apparent.

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
use of classification frameworks, examination of human factors).				
2.11 Root cause or root causes are described.	NPSA	No.	No.	Yes, diagnosis and engagement. No medication issues: however, these are patient related root causes rather than systems issues and we do not believe these are appropriate.
2.12 Lessons learned are described.	NPSA	No.	The review contains a section on core learning which details: the importance of post discharge recommendations being completed or a rationale for them not being completed being documented; the recording and management on electronic records of patient disclosure (drawing) and the subsequent escalation and handover of concerns within [name] ward; the engagement of service user A following a significant period of disengagement (he had	Lessons learned are described as gaps identified in a recommendations table. The report contains a section on arrangements for shared learning and lessons from the first internal investigation.

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
			not been seen for six months prior to the incident); lack of contemporaneous storage of clinical information is an avoidable risk in relation to having a full chronology of information available to inform care and treatment in addition to ensuring full compliance to formal police disclosure requests. No significant key actions were identified by those attending the AAR. Any additional key actions will be identified post AAR following completion of the root cause analysis exercise by the investigation team.	
2.13 There should be no obvious areas of incongruence.	NPSA	The report is not detailed enough to assess this.	No.	No.
2.14 The way the terms of reference have been met is described, including any areas	NPSA	The terms of reference are not specified.	Not applicable.	The terms of reference have not been met in terms of specifically identifying contributory factors, care and service delivery problems and producing

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
that have not been explored.				recommendations that are outcome focussed.
Theme 3: Lead to a change in practice - impact				
3.1 The terms of reference covered the right issues.	NHSE SIF	The terms of reference are not specified.	Not applicable.	Yes.
3.2 The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	NPSA, NHSE-SIF, NQB	No.	The review examined core learning and key actions.	Yes.
3.3 Recommendations relate to the findings and those that led to a change in practice are set out.	NPSA	There are no recommendations.	There are no recommendations.	There are 28 findings detailed in the report which are then themed into four areas of risk: care and treatment, record keeping and communication, organisational systems and processes. However, they are not outcome focussed.
3.4 Recommendations are written in full, so they can be read alone.	NPSA	Not applicable.	Not applicable.	Recommendations are expressed as a description of the issue followed by actions identified. They can be read alone; however, they are not outcome focussed.
3.5 Recommendations are measurable, and outcome focussed.	NPSA	Not applicable.	Not applicable.	The recommendations do not all include measures or outcomes, however, the report indicates the recommendations are to be carried forward into an action plan.

APPENDIX D – Summary of Niche scores

The summary of the internal and independent investigations identified gaps, Trust actions and Niche scores are as follows:

Number	Internal independent investigation findings	Internal independent investigation recommendations	Niche Score
1	The patient disengaged from service contact and as a result was not seen for a period of 148 days before the incident. As a result, there was no contemporary understanding of his mental health status.	The EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back the learning to the Clinical Business Unit and the South Quality Standards Group.	3
2	There are occasions, such as when non-engagement became apparent, where changes of risk warranted the creation of a new or updated FACE risk assessment and this did not occur.	The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based FACE risk assessment tool at points where changes of risk warrant this using supervision and the IT audit report.	4
3	The needs of the mother had been considered within service contact, however there was no evidence that she had been offered a carers assessment.	The EIP service should review within three months, how to ensure that a carers needs assessment is offered and facilitated and include in audit of the Getting to Know You documentation.	2
4	Transition between CAMHS and Adult ADHD Services was not timely or effective. In instances where a child with a diagnosis of ADHD is in hospital for reasons other than their ADHD and they are being transferred to Adult services, ADHD care and treatment should be integrated into the overall approach to transition with immediate effect.	The revised arrangements for transition between CAMHS and adult ADHD Services should be audited within three months to ensure they are timely and effective.	3
5	Referral between forensic CAMHS and adult forensic services needs to be streamlined.	To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17 April 2019	1

6	Student nurse entries in the clinical record were not always validated, therefore there was no evidence demonstrating appropriate accountability by registered practitioners.	[name] Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.	2
7	The process of Care Coordination was influenced by the perceived wellness of the patient. An approach to the ongoing assessment, care and treatment pathway was therefore limited.	The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the CC [care coordination] process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. An update is required on the Trust wide implementation of the Trust supervision process and policy.	3
8	The victim was a random member of the public unknown to the patient. There is limited guidance on the approach towards involvement and information sharing with the victim's family.	Senior Trust officers should discuss and agree future Trust Policy in relation to involvement/information sharing with the family of a victim when the victim is not known to mental health services in these circumstances. In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family. A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting. The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from the service user A's RC regarding any feedback or otherwise to the patient regarding the review of his care and treatment.	1

APPENDIX E – List of abbreviations used in the report

'A'	Service user referred to 'A' in this report
ADHD	Attention Deficit Disorder
AAR	After Action Review
BDG	Business Delivery Group
CAMHS	Child & Adolescent Mental Health Services
CBU	Clinical Business Unit
CCO	Care coordinator
CCG	Clinical Commissioning Group
CDP	Care Delivery Problem
CQC	Care Quality Commission
CPA	Care Programme Approach
CYPS	Children and Young People's Services
DoC	Duty of Candour
EIP	Early Intervention in Psychosis
FACE	Functional Analysis of Care Environment
FCMHT	Forensic Community Mental Health Team
FCT	Forensic Community Team
LD	Learning Disabilities
MHA	Mental Health Act
NHSE	National Health Service England
NIAF	Niche Assurance Review Framework
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NQB	National Quality Board
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
PGN	Practice Guidance Note
RC	Responsible Clinician
RCA	Root Cause Analysis
SDP	Service Delivery Problems
SI	Serious Incident
SIU	Serious Untoward Incident
SIF	Serious Incident Framework
SMART	Specific, Measurable, Achievable, Relevant, and Time-specific