Stage 1 Report

into

Southern Health NHS Foundation Trust

by Nigel Pascoe QC

Published February 2020

INVESTIGATION REPORT

Introduction

1. I have been invited to consider the circumstances of the deaths of five people between October 2011 and November 2015. The background to that decision is set out in the 'Background' below and my full terms of reference are set out as Appendix A.

2. In essence, I am asked to consider the internal and external investigations of those deaths and the steps recommended or taken to prevent their re-occurrence. Critically implicit in that undertaking is to be alert at all times to the deep feelings and criticisms of the immediate families concerned in these tragedies. In plain terms, there has been considerable dissatisfaction and indeed real anger in the care given prior to deaths, the circumstances leading to deaths and also some of their investigations and the time taken to conduct them. I have met relatives of all the persons who have lost their lives. They all have my profound sympathy for what has occurred and the devastation that they have experienced. I shall not hesitate to express a view where I consider that their complaints and concerns are well founded.

3. For nothing can alleviate fully the untimely death of a close family member. No parent can say comfortably that they have come to terms with such a loss where there appears to have been oversight, error or a failure to take steps to prevent future tragedies and other grieving families.

4. At the same time, I bear in mind as a matter of common humanity, that the great majority of those caring professionally for those who have died are not themselves immune from deep feelings of concern. They also can be plainly affected by what has occurred and as

individuals, will welcome reforms to prevent repetition of errors. Those errors may, at different times, include professional insensitivity to the continuing trauma of grieving relatives and a closing of ranks when serious errors come to light. But in a well-run organisation, there will be an unequivocal desire to prevent recurrence, mitigate harm and a hunger to learn from mistakes of care or treatment.

Method of Investigation

5. I have decided to adopt the following approach:

    1) In each case I have set out an **All Purpose Working Chronology,** which acts to summarise key evidence and, crucially, which tells its own story. This is not intended to be a dry or indeed inscrutable document and I have highlighted passages deliberately which seem to me to be particularly important**. It is a selective document and I want to *stress* that it does not seek to contain every relevant chronological detail in these comprehensive papers.** Nor does it include precise details of prescribed medication. But it goes well beyond a bare summary of dates. It contains significant notes and comment and is intended to inform the conclusions which ultimately I have reached. Indeed it has been prepared to bring clarity to very detailed and traumatic events.

    2) I have reached conclusions on the in-house, quasi-independent and fully independent reports into what has happened. I have not hesitated to criticise failure. At the same time, I have endorsed good investigations which have demonstrated detached clinical analysis and robust recommendations. However, where there are clear differences on the facts which I cannot resolve on a paper review, I have made that clear.

    3) A summary of relevant parts of the Investigation Reports appears either in the All Purpose Chronologies or in the body of this Report.

    4) Where there are recommendations from any investigation which appear to me to have particular merit, I have highlighted them.

However, inevitably there are a number of recommendations, attractive on paper, which frankly cannot be assessed on a paper review. In some cases I have recommended their further examination.

5) Following my terms of reference, I have reviewed the evidence and set out my own views on the progress or otherwise of steps taken. I have also considered changes of policy since the dates of each death.

6) In my view, a limited number of issues arise, both in terms of responsibility and recommendations, which merit a fuller Stage 2 Public Investigation. I have identified these in my Conclusions in each case. Stage 2 should take place as soon as arrangements have been made, but should not be delayed.

7) I have set out my **Recommendations** and **Conclusions** in each case and then **final Recommendations** and **Overall Conclusions.**

8) In the above process, I have commented on a number of specific complaints, where the evidence permits me to do so, but I have not sought to adjudicate as if acting as an appeal forum.

9) There is one other important caveat to this Report. My terms of reference do not require me to adjudicate, resolve or seek to comment on every past or continuing issue or criticism. That would be a sterile exercise, particularly where the only fair course would be a public hearing with appropriate questioning. In one case, Edward Hartley, I have concluded that it is necessary, on the facts, for that process to take place. But as will be plain, I have made selective findings or recommendations, where it seems to me absolutely essential to do justice between all concerned. For this Investigation *cannot* be elephantine or all-embracing if it is to keep its focus. I have sought to explain that to all.

6. I would like to thank James Cullen, Briony Cooper and Tom Wood for their considerable help throughout this Investigation and all others

who have assisted me. I am particularly grateful for the outstanding research and dedicated work of Alice Scott in my chambers.

January 2020 **Nigel Pascoe QC.**

Background

This Report considers in the order of their deaths:

1. Robert Small, who died on September 17, 2012
2. David West, who died on October 21, 2013
3. Edward Hartley, who died on May 28, 2014
4. Marion Munns, who died on November 12, 2015

This Independent Report was commissioned by NHS Improvement to review the deaths set out above, after Southern Health NHS Foundation Trust ('the Trust') had requested their assistance. The declared purpose of the Trust had been to support the families who had lost the family members named above. The approach to NHS Improvement followed a period of approximately eighteen-months of engagement by the Trust with the family members. That had included senior staff members, chosen by the families, to work with them one-to-one, and a number of group meetings with the families were facilitated.

Unfortunately, the combined efforts to resolve outstanding issues did not allay all of the family's concerns, notwithstanding the desire and potential for progress. Feelings were still running high and the minutes of some meetings give an indication of a number of the issues which remained in contention. That was the point at which the Trust sought help from NHS Improvement and this Report was commissioned.

The care and treatment of all who died falls to be considered primarily under the responsibilities of the Trust. The contract for the provision of Adult Mental Health Services and learning difficulties is managed by the lead commissioner, West Hampshire Clinical Commissioning Groups ('CCG'), with other associated commissioners.
From the beginning, NHS Improvement have stipulated and understood the need for the Report to be totally independent.

1. ROBERT SMALL

1. All purpose Chronology

November 8, 1983	Birth of Robert Small. Note. Robert Small had a history of poly substance abuse and alcohol excess. He had been taking amphetamines for weight reduction. There was a history of depression. He was said to have considerable debt before his death. Note. Mrs Small believes his debts were about £1000, which she does not think amounts to “considerable debt” (£1350 in one record). Note. Mrs Small described during our meeting some mental health and other family background issues including hospital admissions (some details are provided in mental health assessments). Mrs Small described Robert drinking alcohol and smoking marijuana since the age of 14 and that problems with drinking permeated Robert’s life. Robert Small had four siblings who were older than him and one who was 18 months younger. Robert Small’s parents separated in 2011.

August 10, 2012	Robert Small cut his wrists when very depressed. At Southampton General Hospital he was seen by a medical doctor (i.e. without being referred for a mental health assessment, which then would have been written up in his notes). Thereafter he went to live with his mother. A letter was sent by the Emergency Department regarding the injuries to Robert Small's wrists to the incorrect GP practice. The result was that his GP did not know about this serious incident. Note. Mrs Small stated that a neighbour found him, because Robert had left him a note. Mrs Small described Robert as being "devastated" that he was still alive. Four weeks later, Robert Small wished to return to his flat. His mother sought help from the Osborn Centre to dissuade him, but was told that he would be "ok". This request was not passed on or acted on, to the continuing concern of Mrs Small. He returned to his flat and is said by Mrs Small to have been without support from the Osborn Centre or from any local GP. He remained an "open" referral to the Osborn Centre with numbers to call if he required and a follow-up appointment was arranged. Mrs Small reports that he had anti-depressants which he did not take, with no one to encourage him to do so. The flat was dark, with noise easily heard from argumentative neighbours. Note. Mrs Small feels that if she had had more support from the mental health authorities, Robert might have agreed to return to his family and friends in Porchester and **such a move might have prevented his death.**

	The period from cutting his wrists to his death on September 17 was **38 days**. In that period he received one and a half hours of appointments. The Trust record the following: face-to-face appointments on August 13, 15 and 29 and September 12; and telephone contact on August 16 and 23. Note. Mrs Small is concerned about some of the inaccuracies in the paperwork at this stage, with obvious mistakes which should not be repeated. Mrs Small is also concerned as to the degree of communication in place at the time between the Access and Assessment Team in Southampton and the East Hampshire Access and Assessment Team, as both considered Robert Small.
August 12, 2012	Robert Small removed his own stitches in his wrists, a significant detail which was not subsequently recorded in his clinical records.
August 13, 2012	A home assessment took place by an Approved Mental Health Professional and a Social Worker from the Southampton Access and Assessment Team. Robert Small's mother was present. It was described in a later Report as a comprehensive initial assessment, including family history, psychosocial factors and other mental state examination. The clinician noted a history of disordered eating of binging, using amphetamines, alcohol and illicit substances.

August 14, 2012	A discussion took place between Consultant 3, a Consultant Psychiatrist and an Approved Mental Health Professional. An appointment was booked for the following day with a trainee psychiatrist, a second-year trainee psychiatrist operating under supervision of Consultant 3 at the Osborn Centre. That was in view of the urgency of the position and based on the level of Robert Small's depression and the ongoing risk to him.
August 15, 2012	Robert Small came to the Osborn Centre with his mother and was seen by the trainee psychiatrist. The trainee psychiatrist had joined the East Hampshire Access and Assessment Team on August 3, 2012. Robert Small was given a diagnosis of moderate depression. In the notes there is a reference to family psychiatric history. The trainee psychiatrist believes this appointment would have been at least one-hour long. In reaching a diagnosis of Robert Small and assessing risk, the trainee psychiatrist would have had the opportunity to review the notes of matters recorded in the initial assessment on August 13, 2012. Following this appointment, later that day, the trainee psychiatrist discussed Robert Small's assessment and management plan with Consultant 3, her supervisor.
August 16, 2012	The trainee psychiatrist discussed the case of Robert Small at a multi-disciplinary meeting. A Plan was put in place for Robert to be seen during the trainee psychiatrist's absence. But "Hospital at Home" was not deemed necessary, notwithstanding the level of his depression, a suicide attempt and other known risks.

August 23, 2012	The trainee psychiatrist discovered on a return from leave that Robert Small had **not** been reviewed or contacted at all by the Access and Assessment Team or reviewed in the clinic by another psychiatrist. That is notwithstanding what had been agreed on August 16, 2012 where the trainee psychiatrist had indicated what needed to be done. Note. That failure by another clinician to see her son during the absence of the trainee psychiatrist remains a deep concern of Mrs Small; asking understandably, why did this not happen? It raises the issue of what provisions were in place at the time to provide proper cover when clinicians were on leave. Later an experienced nurse practitioner from the Access and Assessment Team spoke to Robert Small by telephone. He reported 'feeling more positive now' and did not feel he needed additional contact until his next scheduled appointment with the trainee psychiatrist on August 29, 2012. Note. Mrs Small has questioned this as she says Robert did not have a mobile phone at the time, having destroyed it to prevent people contacting him, and in her view, he wouldn't have answered the landline at her flat.
August 29, 2012	Robert Small was seen by the trainee psychiatrist in an Outpatients Clinic. He presented with an improved mental health state and he was considering returning to work. He expressed no suicidal ideation. Note. Mrs Small disputes the accuracy of the assessment of Robert's presentation. The trainee psychiatrist has indicated that she was not aware at that stage that Mrs Small had concerns about the mental health state of her son.

September 5, 2012	Mrs Small, the mother of Robert Small, concerned and very distressed, attended the Osborn Centre after her son had decided to return home to his bedsit. Note. Mrs Small confirmed this and said that a member of staff in the Access and Assessment Team dismissed her without further enquiries or steps, such as looking at the notes of Robert Small. However her visit was recorded by a Registered Mental Health Nurse, who made a note setting out the distress and concern of Mrs Small. **But this information was not bought to the notice of the team and the trainee psychiatrist only became aware five days afterwards on September 10, 2012.**
September 10, 2012	The trainee psychiatrist documented in the clinical notes that she was aware of the concerns of Mrs Small following her son's decision to return to his bedsit. After discussion, it was decided that the trainee psychiatrist could review the position at the imminent appointment on September 12, 2012.
September 12, 2012	Robert Small attended his appointment with the trainee psychiatrist in an Outpatients Clinic. He reported that his mood had improved and he had attempted to return to work. Although he boarded a train, he did not feel able to face colleagues and so returned home. He had retained contact with a supportive boss. He still appeared anxious, despite improvements to his mood. Another appointment was arranged in two weeks. Later, Dr Deshpande, in a Report in 2018 reviewing the care of Robert Small as part of family pairing arrangements, indicated that the trainee psychiatrist had

	recognised that, **despite outward progress, Robert Small remained unwell.** Note. Mrs Small describes him as looking “wonderful”. However she attributes this as being for her benefit, although Robert had not known that she was going to attend the appointment. Mrs Small believes her son had decided already to take his own life at this point. Note. The Access and Assessment Team missed the opportunity to engage with Robert Small when he returned to his bedsit. That is not withstanding the fact they knew that his mother had been “an important protective factor”. It is clear from the later Report of Dr Deshpande that the team missed several opportunities to engage with Robert Small and offer him additional support at home.
September 17, 2012	***Death of Robert Small, aged 28.*** Robert Small was killed instantaneously after he went on to a railway line. He walked across one set of tracks and stood on the next track, awaiting an oncoming goods train. The driver of an approaching train sounded his horn. Subsequently the train struck him. Note. These specific details were provided by Mrs Small, who wishes them to be known in support of her own belief that the death of her son Robert was pre-meditated and not a spontaneous decision made by him. Mrs Small told the Access and Assessment Team of his death.
September 18, 2012	An **Initial Management Review** was conducted.

September 21, 2012	The trainee psychiatrist wrote a letter to Mrs Small, offering her the chance to meet with Consultant 3 and sending her condolences.
September 24, 2012	The trainee psychiatrist wrote to the GP of Robert Small in order that his death might be linked to the GP record of Mrs Small, putting the GP on notice of what had occurred.
October 8, 2012	Interview with a Social Worker for the Critical Incident Review.
October 10, 2012	Interview with an Access and Assessment Team practitioner nurse for the Critical Incident Review.
October 10, 2012	Interview with the trainee psychiatrist for the Critical Incident Review. On reflection, the trainee psychiatrist felt that the learning which arose was for there to be greater involvement of relatives at appointment consultations.
October 10, 2012	Interview with Consultant 3 for the Critical Incident Review. There had been no indication of a suicide risk at his last appointment. Thus this was described as a tragic **unpredictable event.** Note. That description is strongly disputed by Mrs Small.
October 23, 2012	Jane Thomson, Chair of the Critical Incident Review, met Mrs Small at her home. Mrs Small has no recollection of this meeting.
October 24, 2012	Jane Thomson, Chair of the Critical Incident Review met the trainee psychiatrist and Consultant 3 at the Osborn Clinic.

October 26, 2012	The trainee psychiatrist and Consultant 3 and Mrs Small met at Osborn House.
November 29, 2012	Date of approval of the **Critical Incident Review Report**.
July 21, 2014	Telephone **Complaint** by Mrs Small. Note. Mrs Small says she asked for an apology soon after her son died, but was told to make a complaint, which she did. Then she was told to make a written complaint, which she did.
August 20, 2014	Mrs Small met Doctor 1, a Consultant Psychiatrist and the Clinical Services Director. Note. Mrs Small expressed concern of the perception of independence: Doctor 1 and Consultant 3 worked in the same private clinic. This report draws no adverse conclusions on that issue.
August 27, 2014	**Mrs Small expressed her concern with the lack of care for her son in the Osborn Centre, Fareham in a Complaint letter**. An apology was sought and a need for change for the better.
October 28, 2014	Doctor 1 completed an Investigation and subsequent Report as the Investigating Officer. The Complaint was not upheld.
November 20, 2014	Letter from Katrina Percy, Chief Executive of the Trust, to Mrs Small following her verbal Complaint on July 21, 2014 and subsequent letter on August 27, 2014. A copy of the Critical Incident Review Report was attached. Doctor 1 concluded that **the degree of help and support**

	could have been greater. Furthermore there was **no evidence to show that Mrs Small had been offered a Carer's Assessment.** Accordingly Katrina Percy was **extremely sorry that the level of support Mrs Small received fell below what should have been offered by the Service.**
June 29, 2015	Mrs Small met Doctor 1 together with the Business Manager. Mrs Small said how very important it was to receive an apology on behalf of Adult Mental Health Services.
July 20, 2015	Letter to Mrs Small from Katrina Percy, Chief Executive of the Trust, regarding the circumstances surrounding her son's suicide. It said that the Trust had looked at the services they had offered and had already highlighted and made changes where it was identified that improvements could be made. This particularly related to the assessment and inclusion of families and carers and their involvement in the care of the patient.
August 4, 2015	A consultant and a Trust representative met with Mrs Small at her home. Mrs Small was very unhappy that the written apology which she had received had not been signed by Doctor 1 and that hitherto, excuses had been made. It was agreed that there would be a Review commissioned of the care and treatment provided to Robert Small.
November 2015	**The Trust's Review Report** by Dr Gil-Rios, Consultant Psychiatrist and Jane Druce, Head of Quality &

	Organisational Learning. Recommendations and Conclusions set out in the body of this Report.
December 3, 2015	Letter to Mrs Small from Jane Druce, Head of Quality and Organisational Learning, with a copy of the Trust's Report.
February 29, 2016	Letter of Complaint sent to Katrina Percy, Chief Executive of the Trust by Suella Fernandez MP, on behalf of Mrs Small.
April 25, 2016	Meeting between Mrs Small, Doctor 1 and an Operational Manager. Note. Mrs Small said this meeting took place at her home. Mrs Small was very unhappy that the apology from Doctor 1 had not been signed by him. Mrs Small felt that excuses were being made. Subsequent to that request, Mrs Small received a hand written apology on a card dated May 19, 2016.
May 20, 2016	Response from the Trust's Complaints and Patient Advice and Liaison Service ('PALS') to a letter from Suella Fernandez MP with an update on the meeting held and next steps.

June 2016	Mrs Small was invited to Westminster by Suella Braverman MP, with other families, to meet a Government Minister, Alistair Burt MP ahead of a debate. Subsequently Mrs Small again met Alistair Burt MP in Winchester with the interim Chair of Southern Health Trust. However it should be noted that Parliamentary issues are beyond the scope of this Report.
September 26, 2016	Handwritten note sent to Mrs Small from Julie Dawes, acting Chief Executive of the Trust, apologising for the loss of her son, extending that to Robert Small. Julie Dawes **accepted that the service failed to spend enough time with Robert or Mrs Small** and also wrote that they have learned from Robert's death' and response services have changed a great deal' and accepting there is still 'a great deal to do'.
January 27, 2017	Local Resolution Meeting requested by Mrs Small on November 25, 2016, so that she can 'forgive' those involved. Those attending from the Trust included Julie Dawes (acting Chief Executive of the Trust), Doctor 1 and Consultant 3.
2017 - 2018	Over the period of 2017 and 2018 there have been a number of meetings held with families as a group, with varying attendance and different strategic topics and areas of discussion. Those have included some follow-up meetings.
May 2018	First meeting of Dr Deshpande and Mrs Small as part of the "Trust Pairing" established with the families.

June 2018	Second meeting of Dr Deshpande and Mrs Small.
July 2018	Further meeting of Dr Deshpande and Mrs Small.
September 17, 2018	**Report of Dr Deshpande into the Review of Care of Robert Small**, and responding to specific questions of concern from Mrs Small. Part of her chronology of events is incorporated above.
September 24, 2018	Letter from Dr Nick Broughton, Chief Executive of the Trust, to Mrs Small. "The care provided to your son by the organisation I am now responsible for fell below the standard we would expect in a number of important respects…I would like to again **apologise to you for these failures** and for those associated with the subsequent investigation carried out by the trust".
September 29, 2018	Dr Nick Broughton, Chief Executive of the Trust, met Mrs Small and Dr Deshpande.
April 24, 2019	Second Letter from Dr Nick Broughton, Chief Executive of the Trust, to Mrs Small with a comprehensive and sensitive apology.
August 6, 2019	Meeting with Mrs Small for the purposes of this Investigation Report. Details provided of the affect of the investigations and complaints on family members are set out below.
November 4, 2019	Telephone call with Mrs Small for the purposes of this Investigation Report.

2. Complaints and Investigations

Critical Incident Review, by Jane Thomson, dated November 2, 2012

This Report was compiled before the outcome of the Inquest was known and toxicology reports had been conducted.

Findings

1. The findings were,
    - A Carer's Assessment was not offered.
    - The treatment delivered by Adult Mental Health Services was appropriate and timely.
    - The Risk Assessment and Care Plan were current and in date.
    - Detailed letters from outpatient consultations were sent to Robert Small and the GP.
    - Robert Small and his mother were included in the initial assessment.
    - Consideration was given to providing continuity to Robert Small when he moved back to his own accommodation.

Recommendations

2. There was shared learning to come out of this: the executive summary should be shared with the Coroner, families and other stakeholders.

Lessons learned

3. The Trust should consider a Carer's ongoing input into a treatment plan to maximise the information about a service user's presentation.

My Conclusions on the Report

4. The Investigator met with Robert Small's mother, so that she was engaged in the process of producing this report. However I note and fully understand Mrs Small's distress that she did not receive this report until two years after Robert's death. Notwithstanding representations to the contrary, I am of the view that that is an **unacceptable delay.**

5. Robert Small appears to have had contact and care from the Trust for a very short period of time before his death – a period of just over four weeks – and he didn't remain in the locality during that time.

6. The Report is very brief and provides an overview only. However, I acknowledge it was prepared at a time when not all of the test results were known and Robert Small's engagement with the service was short-lived. I also recognise that this Report finds that the incident was a "**tragic but unpredictable event".** That is an important conclusion in considering if any Public Investigation on the facts is required.

7. The Report does not address or acknowledge Mrs Small's reports that her son had cut his wrists on August 10, 2012.

8. In the main, I endorse the limited findings. But I find that the lessons learned and recommendations are not specific or far-reaching in

terms of improving the service so as to ensure that adequate Risk Assessments are in place. For example, the Report does not identify how the professionals involved decided that Robert Small was not a suicide risk.

Investigation by the Clinical Services Director, Doctor 1, dated November 20, 2014

1. Doctor 1 carried out an Investigation, following a Complaint by Mrs Small on July 21, 2014 and a subsequent meeting on August 27, 2014.

2. In order to carry out his investigations, Doctor 1 interviewed Consultant 3, reviewed Robert Small's medical records and met with Mrs Small.

Findings

3. The findings were,

    - Mrs Small was present at the initial assessment and risk assessment and was given support by the service; she was contacted several times and follow-up advice was specifically arranged on at least one occasion.
    - Mrs Small was not given sufficient support as Robert Small's Carer, such as a Carer's Assessment.
    - The letter written by the trainee psychiatrist on August 15, 2012 refers to 'family psychiatric history'.
    - The clinicians involved in Robert Small's care reflected on his presentation at individual and group supervision.
    - The service has instituted training in awareness of Carers' support.

- The clinicians are confident they offered Robert Small appropriate support and advice.
- There is clear evidence that Mrs Small was actively involved in Robert Small's care and she gave him all the support she was able to, to give him the best possible chance of recovery.

My Conclusions on Doctor 1's investigations

4. Katrina Percy, Chief Executive of the Trust, wrote a letter reporting on Doctor 1's findings. It would have been beneficial for Mrs Small to have received this information from Doctor 1 first-hand and/or a copy of his Report.

5. Furthermore, I find it regrettable that this Investigation does not set out any further recommendations or details as to the changes that have been implemented in the service. Once again, the tone and approach adopted by the Trust appears defensive.

6. This Investigation is brief and I find that it goes no further to addressing Mrs Small's complaint than the Critical Incident Review Report. It is also the view of Mrs Small that it contains some inaccuracies, which, given the lapse in time, would be difficult now to remedy.

Report review by the Trust (draft), by Dr Gil-Rios, Consultant Psychiatrist and Jane Druce, Head of Quality & Organisational Learning, dated November 2015

Findings

1. The Report states that the system for assessment and services in place at the time of Robert Small's death have been replaced, so that service users are now referred directly to the Community Mental Health Team in the first instance.

2. It found that there were no grounds available to have prevented Robert Small from returning to his flat, but he would have received more intensive support under the new care system.

3. It found missed opportunities for the Team to have obtained further information from Mrs Small and to work more closely with her to provide her with more support and know that her concerns were considered.

4. It recommended that after Robert Small's death, the team could have been more proactive in contacting Mrs Small, by telephone and then by a meeting.

5. It further found that practical written information was not readily available to support Mrs Small.

6. The investigations met the standards required at the time. But there were missed opportunities: lack of understanding of the investigation requirements, insufficient divisional and corporate oversight to secure

the root causes and to identify effective improvements in systems of care, both for service users and their families.

Lessons learned

7. The Report identifies lessons learnt by the previous investigations and reports and lists the following changes that have been implemented since Robert Small's death,

    - Referral and assessment within 24 hours by the Community Mental Health Team, with the Psychiatric Liaison Team available at weekends and evenings.
    - Assessment by an experienced practitioner, doctor (with psychiatric supervision) or both.
    - His needs would have been discussed in a multi-disciplinary setting.
    - He would have been allocated a Care Coordinator.
    - He would have been considered for the Shared Care List, where the whole team would be aware of his needs and they would be discussed every morning by the team with a weekly plan put in place. The Carer Support Worker is present at the meetings "to ensure family input is now taken into account". Time spent on the List is for a definite period.
    - If a user requires a hospital admission, a referral to the Acute Mental Health Team can be made; they work with the service and families to maintain health (the Report notes that this Team are unlikely to have been involved in Robert Small's care).
    - The Area Substance Misuse Keyworker is invited to the Community Mental Health Team's weekly multi-disciplinary meetings to discuss, feedback and offer joint appointments and assessments.
    - Carers are (still) welcome to attend the service user's appointment.

- All Carers are now offered a Carer's Assessment by a Carer's Support Worker and in the weekly multidisciplinary team meeting one of the slots is dedicated to discuss a Carer's needs.
- Carers are given a named person to contact, usually the Care Coordinator.
- An information booklet for Carers, 'Help at Hand' is in place for clinical teams to give to families to support them (sourced in 2013).
- The initial review and decision making has been strengthened for the Serious Incident investigations.
- The Trust has strengthened the Serious Incident investigations standards by establishing a *"dedicated central specialist pool of senior Investigating officers who have undergone intensive and comprehensive investigation training".*
- The Trust has put in place senior Serious Incident Corporate Assurance Review Panels, chaired by an Executive Clinical Director.

8. At a meeting with the Trust on November 4, 2015, Mrs Small identified 'when engagement could have been improved',
    - Acting early: wider general Community engagement early in school education, and pro-actively identifying problems and signposting on how to access help, through GP surgery opportunities for the wider Community.
    - Acute crises: Family knowledge and understanding - how best to recognise that family engagement could be vital in supporting service users such as Robert Small, with acute mental ill-health, particularly in recognising key priorities, information, and discrepancies in clinical presentation that may have a bearing on care decision making.
    - Aftermath: how failure to offer support to Mrs Small herself in the initial aftermath of Robert's death had impacted on her ability to deal with the situation in practical terms, and to find a way through the grieving process over time.

9. The Trust recognises today that in the absence of its own formal bereavement service, Mrs Small should have been helped to find local services. Today The new Trust role of Family Liaison Officer could facilitate such an important referral. I welcome that step. I also consider it should encourage a formal bereavement service in the Trust in the future.

Recommendations

10. The Report recommended,

- The use of Mrs Small‘s ‘Cars on the Motorway’ analogy to be transformed into posters in Community areas.
- The Trust leadership course to be refreshed to include service users and families to share their experiences directly to help staff learn.
- A series of service user and family video stories, additionally to be used for wider staff engagement.
- Articles by Carers and patients in the Trust journals.
- Stories to be used to prompt clinical reflection in formal practice supervision sessions.

My Conclusions on the Report

11. I note that a meeting took place with Robert Small’s mother in preparation for this Review. Mrs Small was thus engaged in the process: “Mrs Small’s own experience as she told it to us, has been pivotal in understanding what would be most valuable to consider in this review to ensure positive change results from the tragic events in 2012”.

1. The Review itself notes that “changes in the service since 2012 have occurred and it concludes that immediate recommendations made following the first investigation into this tragic event have largely been implemented”.

2. The changes it says the Trust has implemented are wide-ranging and appropriate in addressing Mrs Small’s concerns and Complaint. I have recommended that some of these changes must be tested in a Public Investigation. For example, the Care Coordinators and the Serious Incident Review Investigation process. Having met with Mrs Small, it is my understanding that these key issues remain very important to her to make sure that mistakes are not repeated.

3. As part of this Investigation, I have had sight of the ‘Help at Hand’ booklet and can see how it would have been a beneficial document for Mrs Small to have access to at an earlier stage. I have also received evidence in support of the contention that a multi-disciplinary approach has been adopted within the Trust and I am satisfied that this is now happening. But for the avoidance of doubt, I make it clear that I would not recommend that this is a topic for a Public Investigation.

4. It is regrettable that the Report, helpful, detailed and fair as it is, does not set out an Action Plan for the implementation of the further recommendations that were made by Mrs Small. It is very important to know the extent to which these have been implemented and for that to be made crystal clear. More to the point, it would help Mrs Small. So I repeat that Mrs Small must be provided with such an update, if this has not already happened.

Report into the Review of the Care of Mr Robert Small, by Dr Deshpande with Mrs Small, dated September 17, 2018

1. This Report was prepared as part of the 'Trust Pairing' scheme that was borne out of the meetings held between the families and senior members of the Trust in 2018. The context was the ongoing exploratory review of unexpected deaths.

2. Dr Deshpande carried out a review of Robert Small's patient records, and the Critical Incident Review Report and its review. Keith Dickinson's role was to address Mrs Small's questions regarding the Trust's governance and oversight processes. There were then meetings held with Mrs Small to discuss the findings and next steps.

3. This review focused on Mrs Small's outstanding questions regarding the care and treatment provided to Robert Small in 2012.

Findings

4. Dr Deshpande's findings were,

   - Assessments of risk were completed and discussed in the Access and Assessment Team.
   - Robert Small's family history of depressive disorders was adequately taken into account in the Risk Assessment.
   - While Robert Small was severely depressed he was unlikely to have the motivation and energy to engage in therapy at this stage.
   - The trainee designated as the lead professional for Robert Small's care and treatment was adequately supervised and supported.
   - There was a **missed opportunity** to engage with Mrs Small and take her views into account. But, there is **now an increased**

emphasis on involvement of families in assessment, treatment and risk management.

- The Access and Assessment Team **missed opportunities to engage more assertively with Robert Small** to offer him support at home. There is no evidence that the enabling therapies, described in the Standard Operating Procedure for the Access and Assessment Team dated December 2012, were considered or provided to Robert Small.
- The scope of the Access and Assessment Team model was limited, as it only allowed **limited input and engagement** to be offered.
- Between 2012 and 2014, as a result of the learning emerging from a range of sources including Robert Small's death, **secondary mental health services were changed.** The Access and Assessment Team was dissolved and direct referrals were made to the Acute Mental Health Team which allowed early relationship development and it was made simpler for individuals and their families.

Dr Deshpande's Conclusions

5. Dr Deshpande found **"that the main gaps in the care and treatment of Mr Small are systemic in nature".**

6. Further she found that **"had the Access and Assessment Team provided Mr Small with enabling therapies, essentially more support and engagement at home, the longer-term outcome for him may have been different".**

7. Dr Deshpande set out in the Report the ways in which the Acute Mental Health Team and Community Mental Health Team have

changed and the new procedures that are in place now compared to 2012.

8. Dr Deshpande also commented that “there is a much more **robust system** in place since 2016 for investigating adverse incidents”.

My Conclusions on this Report

9. This Review had specific and focused terms of reference – the questions posed by Mrs Small. Dr Deshpande had viewed Robert Small’s medical records in some detail to produce the chronology. Further, Dr Deshpande gives an important summary of some of the changes that have been made in regard to mental health services. Overall, I find that this is a clear and comprehensive Review.

10. Mrs Small should take comfort from her finding that some of those changes are attributable to the issues she has raised following Robert Small’s death. For example, the reformed approach to crisis care arrangements and a shared care approach between the Acute Mental Health Team and Community Mental Health Team. This specifically addresses Mrs Small’s desire for a multi-disciplinary approach. Thus there is some evidence of the changes she has worked so hard to advocate for, have in fact been made. Mrs Small may be able to see them as part of her son Robert’s, legacy.

11. However, I have been informed that staff members involved in providing care and treatment to Robert Small were not interviewed for this Review; therefore they have not had the opportunity to contribute to the final findings. But I appreciate that this Review was dedicated to answering Mrs Small’s outstanding questions.

12. I consider there are three matters in Dr Deshpande's review which merit further comment.

13. First, it is absolutely plain from the chronology that the Access and Assessment Team **missed several opportunities to help Robert Small** after his serious attempted suicide.

14. Second, I would not myself seek to lay any blame whatsoever arising out of the trainee psychiatrist's lack of experience. That is because plainly the trainee psychiatrist was acting under the supervision of an experienced Consultant. There is no suggestion that the trainee psychiatrist made a wrong diagnosis.

15. But I am extremely concerned by Dr Deshpande's findings that the gaps in Robert Small's care were "**systemic**" and could have had a **direct impact on the length of his life.** That is a stark and sober assessment which cries out for further examination. For it is fundamental that these "systemic" failings have been eliminated, so far as that is possible. Accordingly some of the policy and procedure changes now need to be examined by way of a Public Investigation, for example **Risk Assessments** and the role and care provided by **Care Coordinators**. The blunt question is – are the changes good enough for purpose?

3. Views of Mrs Small

1. I met with Mrs Small and she gave a comprehensive account of her son's life and the experience she has had since his death. That is so as to secure a legacy for Robert and providing a driving force for change. I was deeply impressed and moved by her profound devotion and her plain desire for practical constructive change.

2. Mrs Small provided details of the events during the short period of 38 days from when Robert was first seen by Mental Health Services to his death, which I have incorporated into the All-Purpose Chronology section of this Report.

3. Mrs Small was clear during our meeting and a further telephone call, that she wanted "the truth to come out" and I have set out immediately below an overview of the key areas that I understand Mrs Small believes still need to be investigated. However I think it is also important to note the heartfelt view expressed by Mrs Small that she wants this to be the "end of the process".

    - Evidence of whether the improvements and recommendations following the Investigations and Reports into Robert's death have been implemented and whether *"lessons have been learnt".* For example, Mrs Small spoke about her suggestion of a book for young doctors and psychiatrists as a reference point of how 'not to do it'. Her reason for this echoes her concerns for Robert's legacy to live on.
    - Mrs Small's desire for there to be ***"a robust independent investigation team that looks at every death"*** was palpable. This reiterated Mrs Small's views in her letter titled 'What I Want From Southern Health'.

4. Mrs Small shared the affects that Robert's death has had on his entire family and many friends. She said the ripples of his death have been felt far and wide. Mrs Small said "it was never simple the way the NHS and Trust dealt with his death and it has been seven-years since he died". She described, "revisiting it every day". That distress has increased during the distressing process of this report and I am deeply sorry that has occurred.

4. Recommendations

1. I do not think that a Public Investigation on the facts of the death of Robert Small is necessary in this case. But specific changes which are said to have occurred do require public scrutiny.

2. **I am absolutely sure that Mrs Small and other family members are right in their desire for a new and transparently fair Investigation process. Mrs Small explained that to me in compelling terms and it forms a fundamental conclusion of this Report.**

3. I recommend the Trust provide Mrs Small with an **update** on the implementation of the different recommendations made in the reports.

4. I would recommend an ex gratia payment in the order of £2000. That is following the Ombudsman Guidance on Ex Gratia payments at level 4.

5. Conclusions

1. I endorse the findings of the Investigations and recommendations in the Reports in this case. I find that they have acknowledged finally, and ultimately sought to respond to, the bulk of the Complaints and concerns of Mrs Small. That, at times, has been done with sensitivity. But not always so. Mistakes and insensitive misplaced comments have been made and the wounds are still raw.

2. **The process of investigation has been far too long** and in that period, real and continuing distress has been caused to Mrs Small. That is completely unacceptable.

3. The changes that have been implemented by the Trust should be commended. Insofar as they have sought to address the concerns of Mrs Small, they are to be welcomed.

4. I accept also that significant wider changes in the systems and processes for mental health patients have occurred since Robert Small's death. This has been put to me as a continuing process: I cannot predict the likely success. But some policies of this Trust plainly require further public examination. They must be explained, evidenced, scrutinised and justified as a direct consequence of the historic failures that I have been examining.

5. I recommend the Trust provide Mrs Small with an update on the implementation of the different recommendations made in the reports, if this has not already been done.

6. I warmly endorse the excellent specific suggestion made to me by Mrs Small that **a complete new and transparent Independent Investigation process must be put in place by the Trust.** Mrs Small has expressed to me her desire for this to ensure that 'investigations are done correctly from the beginning', to remove the need for multiple complaints.

7. I acknowledge the fact that Mrs Small has not lodged a complaint with the Ombudsman Service. Upon meeting Mrs Small and reviewing the Reports and letters from the Trust, I have been able to understand the affect of the Complaint Handling and Investigatory Process on her: this is the injustice she has suffered.

8. My findings are that the injustice has been caused by the Trust's failings to deal with her Complaint at the first opportunity, forcing Mrs Small to make a second Complaint, and their communications with her being, at times, insensitive and inappropriate. The Trust also failed to keep Mrs Small abreast of the working implementation of the recommendations and Action Plans. Mrs Small has had to wait seven years for answers. This is simply far too long and over that prolonged period there have been too many administrative failings.

9. My reasoned recommendation for an ex gratia payment falls within Level 4 of the 'Injustice Scale' in the Ombudsman's Ex Gratia Guidelines.

10. In considering the level of injustice, I have considered the severity and impact on Mrs Small and her family. There have been physical health implications and continuing trauma caused by the injustices in this case. Mrs Small has had to make two Complaints and has waited seven years for justice for her son's death. Further, this is ongoing until she has been provided with updates on the implementation of the different recommendations made in the Reports. However, I have also found that some of Mrs Small's main Complaints have now been addressed or efforts have been made to do so.

11. In terms of the wording of the Guidelines, I have not found there to be any relevant external factors impacting on Mrs Small.

12. I have considered the severity in this case with reference to the 'typology category' in the Guidelines. This falls within 'material' and there is evidence of 'exceptionally poor complaint handling', given that there has been a delay of over seven years and 'qualitative failures such as provision of incomplete response'.

13. The affect has been significant distress, worry and inconvenience suffered by Mrs Small which has lasted for a prolonged period of time (seven years). I have no doubt it has, at times, taken over her life. For example, I understand that she has found the meetings and travelling enormously distressing and upsetting, but she has persisted to ensure Robert has a legacy. Mrs Small should be warmly commended for that.

14. Finally, whilst it may never be possible to recover fully from the death of a child, I hope Mrs Small will be helped further once she has received the updates that I have recommended. That is fitting, not least in the light of her own practical and valuable suggestions to the Trust.

15. In that connection, I was very pleased to learn that a very poignant poster given by Mrs Small to Dr Nick Broughton now hangs outside the Trust Headquarters Conference room, seen by many on a daily basis and included in the bibliography to this Report.

2. DAVID WEST

1. All Purpose Chronology

Note. *For the avoidance of doubt, I have read and considered a large number of letters and emails in personal files which are* ***not*** *set out in this Chronology. The reason is to seek to capture its specific focus without undue elaboration. That applies similarly to other working Chronologies.*

August 24, 1985	Date of birth of David West. Note. Mr Richard West, the father of David West, has described a difficult and premature birth. Mr West believes that his son sustained a brain injury at the time of birth. His son was diagnosed with ADHD and had issues socialising, but joined MENSA at 9 years-old with an IQ in the top 1% of the population. 1997: drug abuse alleged. 1999: alcohol abuse alleged. 2003: first contact with Mental Health Services in Swindon with a diagnosis of bipolar affective disorder. Thereafter it is suggested that there was a plain lack of liaison between the Community Mental Health Team and other Mental Health Services, which it is crucial to understand in the context of the later death of David West.
February, 2007	David West moved to Fareham to be near his father. He had been financially abused and physically assaulted by neighbours. He had had numerous admissions under the Mental Health Act.

	<u>General Note over period up to death in October 2013:</u> David West periodically discharged himself from Mental Health Services and on occasions, stopped taking his medication. He was described as having a history of alcohol and substance use, which exacerbated his complex mental health problems. He continued to receive differential mental health diagnoses, including bipolar affective disorder. This contrasts with a later view expressed by letter to Mr West that his son had no mental health issues.
August 2007	David West was seen by Mental Health Services.
May 2011	David West was seen by a Consultant Psychiatrist, after his GP had referred him again to Mental Health Services. It was recommended that he be allocated a Care Coordinator. Note. Mr West said David West was subsequently taken off the waiting list for a Care Coordinator. **Diagnosis:** David West was said to have a complex diagnosis, which included bipolar affective disorder in the past, attention deficit disorder in childhood and poly substance misuse. There was also a possible diagnosis of emotionally unstable personality disorder.
July 7, 2011	David West was admitted as an inpatient to The Meadows, Southampton.

July 2011	David West was allocated a Care Coordinator. Subsequently it was reported he did not then engage or keep appointments, except on his own terms.
August 23, 2011	David West was put back on the waiting list for a Care Coordinator.
November 9, 2011	A decision was taken to remove David West from the waiting list for a Care Coordinator again.
February 1, 2012	David West seen in Outpatients and appeared well.
February 2012	The Community Mental Health Team received a Vulnerable Adult Notification form from Hampshire Constabulary. David West was at risk of physical, psychological abuse and criminal neglect and acts of omission from his immediate neighbours and associates. **But no action was taken**. Note. Mr West said David had associations with local travellers who made him “work off his debt” by becoming a drug mule. When he refused, they “made his life unpleasant”.
February 18, 2012	David West was detained under Section 136 of the Mental Health Act 1983. On the arrival of the Police, he was brandishing two knives and had cut himself across the stomach. He agreed to an informal admission to hospital.
February 22, 2012	David West was discharged to his father’s house.

March 22, 2012	David West was detained under Section 136 after self-harming himself with a razor blade. His overwhelming problems may be seen to be to do with an emotionally unstable personality disorder and substance misuse.
May 10, 2012	David West saw a Consultant Psychiatrist.
July 16, 2012	David West's GP contacted Fareham and Gosport Community Treatment Teams (Hewat Centre) requesting he be seen that day. An appointment was made at the Hewat Centre. But the GP felt it should be at the Osborn Centre as David West could not get to Gosport: there were no staff available to seen him there. David West attended the Hewat Centre requesting hospital admission. He was told he would need to be assessed by "Hospital at Home". He returned home. There were reports from David West that there was a drug dealer living in his flat, who he found threatening and who was bullying him and would not leave.
July 17, 2012	David West was detained under Section 136, following a report to the Police by neighbours and was assessed. He reported feeling low and having thoughts of ending his life and paranoia. He was admitted informally for a short period at Antelope House in Southampton.
July 31, 2012	David West was discharged from Antelope House to his own flat. It was said that there was no follow-up from Mental Health Services of liaison with Substantive Misuse Services.

August 1-2, 2012	The Hospital at Home team have stated that they visited David West twice. They felt he had been discharged without a full care package and that he needed to be seen concerning his methadone prescription. **They took a unilateral decision to discharge him** and suggested the local substance misuse service supported him.
November 16, 2012	Police intervention. David West threatened to kill himself with a knife. He was overpowered and handcuffed.
November-December 2012	David West made frequent contact with Mental health Services, requesting benzodiazepines. He also presented as threatening self-harm and raising issues about housing. Note. Mr West said David would spend 3 - 4 days per week at The Meadows and he would then be discharged back into the Community, where his neighbours were prolific drug users.
November 28, 2012	David West was discharged from Mental Health Services, which was said to be due to his poor engagement. He had also missed a planned appointment for a CPA review. Note. Mr West said David's phone would frequently have no credit or he would trade it in.
February 21, 2013	David West was admitted to the Elmleigh Unit, Havant, under Section 2 of the Mental Health Act 1983 after a drug overdose.

February 21 – April 30, 2013	At Elmleigh his behaviour was very disturbed, necessitating psychiatric intensive care because of his aggression. But this was said *not* to be the product of a psychosis.
February 25, 2013	Multidisciplinary Team ('MDT') review concluded that David West was suffering "manic and paranoid" symptoms in the context of "poly substance misuse".
March 4, 2013	**Safeguarding procedures were not thought to be necessary**. Note. Mr West strongly disagrees with this assessment.
March 15, 2013	A recommendation was made for the detention of David West under Section 3 of the Mental Health Act 1983. Note. Mr West criticises the decisions not to carry out a Section 117 review (provision of aftercare services upon discharge after detention under section 3) and later to discharge him without the required support and safeguarding assessments in place.
April 15, 2013	The Multi-Disciplinary Team concluded that David West no longer had "active psychotic symptoms" and was "accountable for his behaviours." On a ward round, David West requested a Care Coordinator. But after consulting the Community Treatment Team, it was felt that there was little point because of his history of not engaging with the service.

April 16, 2013	David West was discharged from hospital under Section 3, again without section 117 aftercare provisions. He was told to return to his flat in Fareham and a meeting with a member of the Community Treatment Team was arranged for April 17, 2013. Note 1. The detailed records of David West in Elmleigh set out disturbed and very varied behaviour, with some physical damage alleged to a seclusion room door and window. The records also show considerable variations in his mood and the way he reacted with staff and patients. Note 2. The Team formed a view on April 15 that David West was not presenting with active psychotic symptoms and was insightful. Thus he did not then need to be detained under Section 3. Note 3. The decision of Consultant 4 to take David West off Section 3 detention was communicated to him on April 16, 2013. That resulted in a **Complaint** by Richard West and remains a strong issue for him, as does the consequential discharge of his son to the care of the Community Treatment Team on the same day. Note 4. Richard West maintains that Consultant 4 failed to consider his obligations under Section 117 of the Mental Health Act 1983 and his responsibilities under Safeguarding procedures, in the light of the full information which was in his son's notes. One entry indicated that David West had said he would be stabbed if he returned to Fareham.

April 17, 2013	David West did not attend the Community Treatment Team appointment. It was suggested that thereafter he could attend if he wished.
April 24, 2013	David West attended an A&E in East London expressing suicidal ideas. Mr West believes this was the first time his son made a serious attempt at suicide.
May 29, 2013	David West was assessed at Whittington Mental Health Adult Services. Note 1. The Assessment Form records feedback from Consultant 4 at Elmleigh Hospital - 'patient well known to services in Hampshire, with history of mood instability, polysubstance misuse, pseudo hallucination and self-harm…' Further 'has significant drug debts in Hampshire, forcing him to move to London. He is homeless staying with friends or on the street' [assessment on May 31, 2013]. Note 2. Mr West points to this as another example of the knowledge that Consultant 4 had, when he made the decision to discharge David West in April 2013. Note 3. David West's notes prior to a Mental Health Review Hearing contain other information known by Consultant 4 prior to the release of David West on April 16, 2013 without any Section 117 Review.
June 17 - June 20, 2013	David West came to the attention of a Homeless Charity in London saying that he needed medication. He then came home to his father and made contact with a Response Officer in the Community Treatment Team in Fareham, asking for medication support.

June 26, 2013	David West failed to keep an appointment with **Dr Bruce Adam**, then a Consultant Psychiatrist. Note. Mr West said David was living three miles from Fareham at the time and his appointment was in Gosport, eight miles away. David West had no means of transport, money or the ability to travel on public transport, which is why he did not attend that appointment. Note. Dr Adam had described David's conduct as **'toxic'** in his medical notes. Later Dr Adam was roundly criticised during investigations for using that term and subsequently apologised. That criticism was specifically endorsed by the Trust - letter of October 20, 2014 below. **Note by Mr West, summarised below, concerning Dr Adam and containing specific criticism and comment.**
June 27, 2013	David West contacted the Hewat Centre and was told he had been discharged. Note. Mr West said David had "no access to a GP, medication or medical services for a ten-week period".
June 28, 2013	**David West was shown as discharged from the Community Treatment Team at the Hewat Centre by Dr Adam after missing one appointment.** A letter was not sent to his GP to inform him of the discharge from the Community Treatment Team.
August 24, 2013	Birthday of David West. He was taken out for a meal by his family. He was described as being paranoid that evening. Thereafter he went to live with his father for

	seven weeks, as he had nowhere else to live.
September 6, 2013	David West finally gained a referral from the GP to the Mental Health Services and, according to his father, began to engage with them again.
September 13, 2013	A referral was made by the GP of David West to the Access and Assessment Team, after David West explained that he had returned to the Fareham area after a period in London. But he had declined to see one Doctor and had requested an appointment to see Consultant 3.
October 4, 2013	Contact between David West, his father Mr West and the Team Leader. Consultant 3 agreed to see him.
October 7, 2013	David West had an appointment with Consultant 3, presenting in a pleasant manner. Consultant 3 later said that he presented as a delightful, charismatic man, haunted by an intractable need for substances. He did not evince any suicidal intent. He had been taking heroin in bulk three days before. He wanted to change his thought patterns and be able to see his house without a sense of impending doom and mood swings. He wanted benzodiazepines and was told this was not an option. He became tearful. He was advised to engage with substance abuse services as he was using cocaine and heroin. A review was arranged for two weeks' time.
October 17, 2013	Telephone call from David West to the Access and Assessment Team.

October 18, 2013	David West telephoned the Access and Assessment Team to ask where his medication was. He sounded positive and said he wanted to turn his life around.
October 18 or 19, 2013	David West visited his father, saying his flat-mate was causing him huge amounts of distress. He was unsteady on his feet, consistent with taking drugs. Note. Mr West said David knew in particular two of his neighbours, one of whom was older and had health problems, for which he took medication. Mr West received reports from neighbours that David had been with this neighbour the night before his death, collecting drugs.
October 20, 2013	***Death of David West*** *aged 28.* He was found dead by Mr West's 'older neighbour', lying on the sofa in the flat where he was staying. Mr West also went to the scene.
October 25, 2013	A letter was sent to Mr West from the Trust, signed by a Team Leader and an Advanced Practitioner. It expressed condolences and stated that a detailed investigation had to be carried out and they would welcome his involvement.
October 26, 2013	David West had been due to have an outpatient appointment with the Community Treatment Team at the Hewat Centre.
October 30, 2013	Consultant 3 contacted Mr West offering her condolences. Note. Consultant 3 prepared a detailed Report for the

	Coroner – see February 4, 2014.
November 4, 2013	Funeral of David West. Mr West requested to meet with Consultant 3 and the Team Leader.
November 6, 2013	Summary in the letter of his GP, of the engagement of David West with the practice in 2013 up to his death. Details include his presentation on visiting the surgery and the medication prescribed. Investigation interview with the Team Leader.
November 14, 2013	**Investigation Interview with Dr Adam.**
November 21, 2013	Telephone call to a Housing Resettlement support worker at the Hewat Centre.
November 28, 2013	**Critical Incident Review Report** presented to the Critical Incident Review Panel.
January 7, 2014	Meeting between Mr West, the Team Leader and another.
January 8, 2014	Comments made by Mr West to the Trust regarding the care and treatment David West received from the date he was released from Elmleigh until his death. Note. His concerns remain, together with specific unanswered questions.
February 4, 2014	Final **Critical Incident Review Report** – approved by Doctor 3, Director of Mental Health and Learning Disabilities.

	That followed also a Root Cause Analysis, which found that David was not receiving regular follow-up despite repeated contacts with the Service.
February 4, 2014	Report of Consultant 3 for the Coroner.
March 13, 2014	Mr West's response and Complaint to the Critical Incident Review.
March 25, 2014	Mr West met with Doctor 1 and a colleague to discuss the care and treatment of his son, David.
April 2014	Verbal **Complaint** of Mr West following the Critical Incident Review Report. Note. Mr West complained to the Trust's Complaints Patient Advice and Liaison Service ('PALS') about the Trust. Mr West states that he was told to make a complaint to the General Medical Council ('GMC') if necessary.
May 9, 2014	Capsticks were proposed by the Trust to carry out an Independent Investigation. Mr West raised his concerns about the independence of Capsticks by email.
July 2, 2014	Mr West sent a further letter to the Trust and every Non-Executive Director, setting out his serious concerns about the investigations in his son's case and others. **He did not receive a response.**

August 20, 2014	A letter sent by the Chief Quality Officer of Hampshire and Gosport South Eastern Hampshire Clinical Commissioning Group ('CCG') to Mr West. The CCG was unable to process his concerns, as there was a simultaneous investigation by the Trust.
August 26, 2014	Letter from Mr West to the Chief Quality Officer of the CCG: he has made a Complaint about the Chief Executive of the Trust and had been interviewed by an investigator working for the HR Advisory Service, part of Capsticks LLP. He also reported **communication problems** with the Trust.
September 2014	**Capsticks Investigation** The Conclusions and Recommendations were the subject of comment and criticism by Mr West. Note. Mr West is of the view that Capsticks were not independent and should not have conducted the investigation. Secondly, he does not feel that the Investigator had sufficient experience to conduct the work. I make it plain that I make no adverse findings against the Investigator's own independence or experience. Following this Report, Mr West made a **Complaint** to the Ombudsman.
September 2014	Mr West challenged the Chairman of the Trust after the Annual General Meeting regarding his failure to respond to his letter. The Chairman said this was an "oversight". Thereafter arrangements were made to meet with the Chairman and Doctor 3 as Director of Mental Health and

	Learning Disabilities.
September 10, 2014	Letter from the CCG to Mr West responding to the problems of communication he had had with the Trust.
October 20, 2014	Letter of Katrina Percy, Chief Executive of the Trust, to Mr West **apologising for the distress** caused and attaching an **Action Plan** which had been implemented as a result of the Critical Incident Review and complaints Investigation. Katrina Percy agreed with the Capsticks' Report finding that David's difficulties related primarily to substance misuse and not serious mental illness. Note. The letter summarises the **deep regret of Dr Adam** with regard to unprofessional and derogatory comments made on David West's notes. The Trust indicated that comment was **"totally inappropriate".**
October 23, 2014	**Inquest into the death of David West** The Trust were represented by solicitors, in response to Dr Adam's decision to instruct solicitors to represent him at the Inquest, but Mr West was unrepresented. David West's death was determined by the Coroner to be due to dependent misuse of drugs as a consequence of life-long complex mental health problems. Email from an attendee speaking of the dignity of Mr West when giving evidence at the Inquest.

November 24, 2014	Mr West met the Chairman and the Medical Director. The meeting was not minuted and no response was sent afterwards.
May 29, 2015	Letter from the CCG to Mr West, responding in detail to his communication of May 19, 2015. It indicated that, “the CCG is fully cited on quality issues through our contract with the Trust and their performance is closely monitored through monthly clinical quality review meetings. It indicated that, the CCG had “genuinely listened to your concerns and looked into the issues you have raised in a thorough and diligent manner”.
April 20, 2016	Response of Katrina Percy, Chief Executive of the Trust, to Ombudsman Investigator, considering the draft Investigation Report into the Complaint of Mr West. It included “clearly while the trust has taken some actions following the investigation into David West’s death, there is **further learning from Mr West’s complaint that needs to be shared across our adult mental health service.”**
April 26, 2016	**Ombudsman Report.** This report partly upheld Mr West’s complaint, with specific findings of failings in the care provided to David West. The failings are summarised in paragraph 6: • failing to allocate a Care Coordinator • failing to refer to Assertive Outreach or for a forensic assessment • not following relevant national guidelines • not updating risk assessments and crisis, relapse and contingency plans • writing unprofessional comments within medical records

	• discharging from mental health services against the Trust's own policy on patients who do not engage or failed to attend appointments • discharging from the Community Treatment Team and not communicating this decision • failing to fully consider adult safeguarding policy • failing to assess the need for after-care under Section 117 of the Mental Health Act 1983 Note. Mr West is "very happy and content with the Report".
May 25, 2016	Letter from Doctor 1 to Mr West. This followed a meeting with Mr West and agreeing some actions arising from the Ombudsman Report.
May 27, 2016	Ex gratia payment of £2500 made to Mr West by the Trust on the recommendation of the Ombudsman.
June 2016	Handwritten letter from Katrina Percy, Chief Executive of the Trust to Mr West, expressing sympathy.
October 6, 2016	Meeting between the Trust's, Julie Dawes, and Mr West where the issue of the Independent Medical Examiner was discussed.
October 6, 2016	**Letter of apology to Mr West**, from Julie Dawes, acting Chief Executive of the Trust, *who accepted* ***that the decision to discharge David West from the Community Mental Health Team should not have been taken and that staff failed to explain this decision to David, or later his GP. It is also unacceptable that David was placed on the waiting list for a care coordinator and I accept the findings of the Ombudsman's professional adviser that***

	patients who need care coordination will generally have complex health needs and it is not appropriate for this group of patients to be on a waiting list. David should have been referred to the assertive outreach team… I accept the Trust did not do enough about David's discharge planning and the after-care he was entitled to under the Mental Health Act section 117." ***"… There are a number of areas where the Trust let David down and where the care provided was not of the standard that I would accept."***
November 8, 2016	Letter from the Trust to the Ombudsman updating them on the progress of implementing their recommendations.
November 22, 2016	Letter from Julie Dawes, Acting Chief Executive of the Trust, to Mr West addressing his concerns with the investigation of Serious Incidents.
January 16, 2017	Letter from Julie Dawes, Acting Chief Executive of the Trust, responding to questions raised by Mr West, who was invited to meet to discuss improvements in the investigation process.
April 13, 2018	Letter from Lynne Hunt, Chair of the Trust, to Mr West and Mr and Mrs Hartley (and another), in response to their paper including '17 should-be' points. It set out the Trust's plans for furthering their "vision" and their thoughts on the points raised. Note. One of these 'should-be' points is the ***'appointment of an independent medical examiner to review every death certification and that bereaved families be invited to be involved in the co-***

	investigation and co-production of unexpected death reports and action plans'.
December 2018	Mr West attended meetings in the House of Commons and his MP wrote to the Chair of the Trust, signed by five MPs. Note. Those Parliamentary contacts and discussions are beyond the immediate scope of this Investigation and Report.
December 14, 2018	**Trust Partnership Report** produced by Mr West and his chosen Trust Partner, Sara Courtney. Note. Mr West describes this initiative as having "good intentions" and Sara Courtney was "honest, engaged and professional". However, he was dissatisfied with the lack of detail in the conclusions and he was "frustrated" that as he saw it, the Investigation was being down-graded to a Review. In his opinion, that meant that it was not grasping the nettle in regard to the Governance issues he had raised. Note. The Trust indicated that there were four individual Trust Pairing meetings in 2018 with Mr West. Further, over the period of 2017 and 2018 there have been a number of meetings held with families as a group, with varying attendance and different strategic topics and areas of discussion. Those have included some follow- up meetings.
August 6, 2019	Meeting with Mr West for the purposes of this Investigation. Details were given of the affect on the family of these extended proceedings of investigation

	and complaint, which are set out below.
October 30, 2019	Second meeting with Mr West for the purposes of this Investigation.

2. Complaints and Investigations

Report to the Coroner by Consultant 3 and Doctor 1

1. This Report was compiled with the input of Mr West as David's father. His additions are highlighted and include David West's discharge by Dr Adam. This is clearly a key event in the chronology leading up to David West's death and it would have been inaccurate if it had been sent to the Coroner without this detail. However, it was added in, following a meeting with Mr West. On that basis, I find that it presents accurately the timeline of the involvement of David West with Mental Health Services. Thus this is not a case of any willful or accidental misleading of the Coroner. It is plain that information was put before the Coroner in good faith.

Report to the Coroner, by Dr Adam

1. This Report shows that Dr Adam was relying upon other professionals' notes in David West's medical records from 2012, in order to form an opinion as to his mental state and condition at the time of the scheduled appointment in June 2013. He bases his diagnosis on these notes: *"The core problem was his substance misuse".*

2. Dr Adam provides an explanation as to what informed his decision to discharge David West: "*I felt that on balance his long term interests would be better served if he was nudged towards the substance misuse services*". He says he did not write to David's GP: "*I was not in the position of being able to inform the GP as I did not know which GP he had after the last one took the opportunity to cross David off his books when he went to London. We had not been informed of any new GP prior to the appointment. This was clear on Rio in the notes prior to mine*".

3. Dr Adam has set out the nurse's record of calling David West on June 28, 2013 to inform him that he had been discharged from the Community Treatment Team the day after.

4. Dr Adam's Report concludes: "*I considered that Mr West needed to take responsibility for the states he got into and the behaviours he displayed to those around him".*

5. Those comments plainly may be considered to be clinically very inappropriate, as they are open to the criticism that Dr Adam was punishing David West for his previous actions by discharging him.

6. In conclusion, this report suggests that Dr Adam has accepted regret for his "toxic" comment, but his final comment suggests that his reasoning may have been flawed.

Capsticks Investigation and response of Mr West, father of David West

Findings

1. The findings were,

    - The medical consensus was that David West's difficulties were substance-related, rather than being a primary serious mental illness. Therefore decisions about his care were logical, based upon the premise that severe psychotic illness was not present.
    - Better communication would have helped.
    - A team discussion was required under the Trusts' Clinical Disengagement/Did Not Attend Policy, which was not adhered to here.
    - There was poor record keeping.
    - The comments made by Dr Adam were "regrettable".
    - There should have been more discussion with the Multidisciplinary Team at key points on the patient's Care Pathway.
    - There is a need across the Trust to review and update Risk Assessments in a robust and timely way.

Mr West's view: considering the implications and consequences for David West of Dr Adam's reactions on June 26, 2013.

2. Shortly following the death of his son, Mr West produced this letter which specifically criticised the actions of Dr Adam. He made five principal points, which remain valid today,

    - David was a prime candidate for at least a try with a referral to the Assertive Outreach Team, which did not happen.

- David was never given a Care Coordinator, despite numerous recommendations.
- David's 'Crisis, Relapse and Contingency Plan' and Risk Assessment were not reviewed and updated.
- Dr Adam did not send a letter to David's GP informing him of his discharge from the Community Treatment Team.
- The language and personal views expressed by Dr Adam were unprofessional.

My Conclusions on the Report

3. The Capsticks Report endorsed Dr Adam's recommendations, so that it followed logically that David West needed the substance misuse service. But it also acknowledged that the Trust's policy for patients who do not engage was not adhered to in his case. That could be seen as inconsistent or not easy to reconcile.

4. The findings in the Report on a number of the crucial points raised by Mr West and the Critical Incident Review are either omitted or covered briefly when considering the scope of the Report.

5. The finding in the Capsticks Report that David West's current difficulties were substance-related, rather than being an indication of underlying mental illness follows the view of Dr Adam. Accordingly it should not be criticised for its inclusion. But considering the wider medical history of David West, the question is whether that may be a simplification of a much more complex medical picture.

6. The Report does raise the issue of forensic assessment raised by Mr West, but, as indicated, no further steps were taken.

7. The Capsticks Report was commissioned by the Trust, engaging one of the firms used by the Trust to act as their legal advisors. That is in line with well-established practice, but in the circumstances which surrounded David West's death, it may be thought that *perception* was particularly important. This was a death where perceived independence was crucial. Viewed in that light, it is difficult for a family member or detached member of the public to see this as a wholly independent Report.

8. That perception is completely understandable. But it raises a key question: whether a different investigative process was and is required here and in similar serious future cases. In my view, perception was and remains really important in the case of David West and in other serious incidents or unexpected deaths.

9. That said, I do bear in mind that the Ombudsman concluded that Capsticks were sufficiently independent to carry out this report. Thus I must emphasise that my different view is based on my own view of the crucial importance of perception here.

10. However, in fairness, the Report does itself highlight the very strong need for a **new and Independent Investigative structure** in the future. **That is a very important conclusion with which I agree completely**. Such a new structure needs further examination and analysis. In cases involving an unexplained death, such a structure is needed without doubt to guarantee impartiality and objectivity.

11. In general terms, I find the criticisms made by Mr West to be reasonable, fair and evidenced-based. But that should not be taken as an unconditional dismissal of the Report or of its specific recommendations. That would not be a fair or proper approach to take.

Ombudsman Report, dated April 26, 2016

Findings

1. The Review found that the Trust had taken appropriate remedial action to address a number of the failings but that it had not acknowledged the full extent of the failings in relation to,
    - The inappropriate decision to discharge David West from the Community Treatment Team.
    - The failure to communicate the decision to discharge from the Community Treatment Team to David West or to his GP.
    - The failure to allocate a Care Coordinator.
    - The failure to refer David West to the Assertive Outreach Team.
    - The failure to assess David West in relation to section 117 aftercare.

Recommendations

2. The Recommendations were,
    - Within one-month of their Report, the Trust should write to Mr West to acknowledge the failings highlighted in the report and apologise.
    - The Trust should pay Mr West £2500 as an ex gratia payment.
    - Within three-months the Trust should produce an Action Plan, explaining what it has done and will do to prevent a recurrence of the failings identified and give an update on the actions in that Action Plan.
    - Further, the Trust should explain how improvements in its Mental Health Services and **Complaint Handling** have and will be monitored.

My Conclusions on the Ombudsman Report

3. The Report addresses the Complaint made and shows engagement with the family.

4. I endorse the findings of the Ombudsman.

5. I agree with the Ombudsman's finding that the Trust's reliance upon the Capsticks Report as their response to Mr West's Complaint demonstrates their failure to accept fully the failings in David West's care. That is particularly so in relation to the decision to discharge him; the failure to establish whether he had a GP who should be informed and the failure to inform David West personally.

6. The Ombudsman found that the Capsticks Report and response from the Trust failed to acknowledge fully the failure to provide David West with a Care Coordinator. This was not only one of Mr West's key concerns, but was also instrumental in establishing whether more could have been done to support David West. **Ultimately that may have prolonged his life**. It also would have helped to ensure a change in practices that could improve the service provided to other patients.

7. The Ombudsman Report is both clear and fair in giving credit to the Trust where there *is* evidence of acknowledgment of their failings and where remedial action *has* been taken. I do not share the Report's finding that Capsticks were sufficiently independent to carry out the investigation in this case. The issue is one of perception, which was and is key to the acceptance of conclusions and recommendations.

Response by the Trust

1. The Trust responded to the Ombudsman Report, first by a handwritten note from Katrina Percy to Mr West, which he felt was inappropriate. Subsequently a more formal letter was sent to Mr West from Julie Dawes.

2. **The Trust acknowledged and accepted the Ombudsman's findings that David West was let down by the Trust and the care provided was not of the standard expected. They apologised to Mr West for the impact on his family.**

My Conclusions on the Trust's response

3. Notwithstanding their apology, the Trust's response does not address all of the concerns raised by Mr West in his Complaint and does not show what needed to be demonstrated, namely to engage in critical analysis of the failures in the practices, processes and actions leading to David West's death.

4. The response of the Trust also omits to address the inconsistencies between some of the findings in the Critical Incident Review Report and the Capsticks Report.

5. But there is one encouraging feature. The Action Plan produced by the Trust and attached to their response has the potential to make far-reaching changes and improvements. However it is not wholly clear to me the extent to which they have been or crucially are being implemented. Although I have had some helpful representations from the Trust, which are summarised below, the key issue of implementation needs to be examined further. In my view, it should be included in a series of discrete topics in a limited and specifically

targeted Public Investigation. For example, Complaint Handling, which was specifically raised by the Ombudsman.

Partnership Report, co-authored by Mr West and Sara Courtney, dated December 14, 2018

1. This Report was commissioned by the 'Trust Pairing' initiative in 2018, as a response to numerous meetings between Trust members, staff and family members.

2. An individual approach was adopted for each Report; this one was focused on review, learning and recommendations to improve care for patients and families now and moving forward.

Findings and Recommendations

3. The Report made specific findings and corresponding recommendations,

    - It must be clarified how families and carers are involved in the 'Triangle of Care' when service users withhold consent.
    - There is a need to simplify and reduce radically, handovers between teams, professionals and services. This will avoid the lack of continuity experienced by David West.
    - The Adult Mental Health Care Pathway must be understood and mapped better.
    - The establishment of mechanisms to understand better the psycho-social impact of people in distress and their treatment over time.
    - There is a need to review Risk Assessments across Adult Mental Health Services and Screening, with results in a centralised, easily accessible system.

- The introduction of ‘non-clinical’ specialist roles to provide support would be beneficial at times of crisis.
- There needs to be a formal approval process for the selection of Independent Investigators and Independent Medical Examiners.
- The organisational structure should focus on multi-disciplinary integrated teams to ensure clear accountability.
- The focus should be on prevention rather than crisis. Thus money should be focused on supporting people early on, and Community Mental Health services could assist with this.

My Conclusions on the Report

4. It is clear to me that both parties put significant time and effort into this collaborative piece of work, and that should be commended. It’s focus is on the future and it is respectful in the way it considers how the tragic death of David West can improve the lives of others going forward.

5. I note that there were ‘frustrations about Governance issues not being taken forward in a timely way, or at all’. Given that this Report was written fairly recently (2018), I find it of concern that these issues, which have permeated all of the investigations and complaints in these cases, still persist. Feedback and learning mechanisms must be set up to ensure recommendations are implemented promptly and effectively. That is to avoid the very real risk of further injustices occurring for patients and families. This must be examined as part of a Public Investigation, as outlined in my Overall Conclusions.

6. Further, some of the findings and recommendations identified in this review echo those that I have found as part of my Investigation and also acknowledged by the Trust in my meeting with them. For example, how families and carers can be involved where there are

issues surrounding the withholding of consent; the mapping of adult mental health Care Pathways and the involvement of families in this process; review of Risk Assessments and the need for Independent Investigators.

7. I acknowledge Mr West's contributions to the final conclusions in this Report and welcome the detail that he added.

8. But it is regrettable that the status of the Report changed over time and that this was not made clear to the families. In light of the 'Pairing' nature of this venture it is disappointing that this occurred. That said, I do not seek to criticise Sara Courtney at all, as it is a respectful and honest Report that highlights some of the key concerns I have found in this Investigation.

3. Views of relatives

1. I met with Mr West and have considered carefully the areas that, in his view, still need investigating, in addition to the specific criticisms made of Dr Adam. They include:
   - There needs to be scrutiny and reform of **the independence of the investigators** following a death.
   - There needs to be examination of the use and practice of conducting Section 117 Reviews.
   - There needs to be a **clear Care Pathway** or journey, in which family members play a clear and recognised part.
   - There needs to be a review of the allocation of **Care Coordinators**.

2. In addition, Mr West prepared a document listing **52 issues** he has had with the Trust in its dealings with his son. They include requests

to the Trust for further information and perfectly legitimate questions. For example, as to medication given and unacceptable delay in treatment and Community Care. Some are, understandably, rhetorical questions. They cannot all be answered or addressed in this Report, but I have sought to answer some of them at the end of this section. Further, Mr West should be reassured that I have considered all of the issues he has raised in deciding my own Recommendations and Conclusions.

3. In a further meeting with Mr West and written document, he made the following additions to his suggestions and criticisms set out above,

- Action Plans have not been followed as the same issues keep arising: **Risk Assessments** are lacking; **Care Plans** are non-existent and **engagement with families** is missing.
- The Trust is failing to measure outcomes of new initiatives and policies, such as the 'Triangle of Care'. This must be implemented to judge the effectiveness of treatments and care, assessed by families and service users.
- A new **Independent Investigative Process** should have **an Independent Medical Examiner,** a dedicated rapid response group to manage the in-patient scene and aftermath and investigation when a serious incident occurs.
- The 'Triangle of Care' should be mandated and audited.
- There needs to be a move towards a psycho-social model of care.
- There needs to be multi-disciplinary teams with a single line clinical management system, designed with input from relatives, carers and service users.
- There should be pilot studies to revolutionise the access to Community based services and treatment.
- There should be auditing and reviews of inpatients and **discharge plans.**

- Families and relatives should have legal support at an Inquest.

4. Mr West provided an account of the affect David's death has had on him. Since 2016, he has felt unable to accept and pursue work opportunities in Europe as he feels compelled to attend meetings, visit other families and try to make a positive impact to ensure the same mistakes that occurred in the lead-up to his son's death and the grave errors in the subsequent investigation process are not repeated. However he also explained graphically and clearly how, six years after his son's death, he is 'still here' and is seeing the same issues happening now. He has my deep sympathy. I would add that he would be in a very good position to give evidence in any further Public Investigation on specific suggestions that he has made.

Comment on Further Issues raised by Mr Richard West

1. As this Investigation Report does not extend to re-interviewing witnesses, I can only comment where the issue is plain on the existing information. But some of the concerns of Mr West are self-evidently legitimate and require further comment, even if I am unable to resolve them.

Non-engagement with Mr West and history of David West

2. There is evidence from Mr West that there was a lack of engagement with him as a parent, so as to be able to understand his son properly: his behaviours, lifestyle and difficulties. Additionally, there was no real history taken of the early years of David West.

3. Where that occurred, the Trust missed an essential resource to assist David West. Who else could have provided such a picture? Greater

parental input is absolutely **essential** in the future, which has been specifically recognised by the existing Trust Management.

Medication

4. Mr West has raised concerns, which are completely understandable, about the medication given, their risks, benefits and dangers and the question of informed consent. He has further asserted that there was no consideration of the Nice Guidelines.

5. In the absence of a differential Expert Report, those detailed clinical decisions can never be examined in a meaningful way. I do not recommend now that that should be done. Again I am of the view that such an exercise would not be cathartic or helpful, not least if a mixed professional picture emerged.

Section 117 reviews

6. Mr West has asked ‘why was there no Section 117 review when David West was discharged from Elmleigh in April 2013?’ In a further meeting he raised this important issue again. He is clear that he does not believe enough has been done to rectify the mistakes that occurred in his son’s case to ensure they are not repeated for other service users.

7. I am clear that the evidence supports the fact that such a review should have been carried out. It is deeply regrettable that it was not. However I do not consider that that specifically needs to be examined as a public issue, as it arises from the particular facts of this case.

Safeguarding issues

8. Mr West has raised concerns that there was a lack of consideration given to the documented safeguarding issues, before David West was released from Elmleigh in April 2013. I have been unable to find an answer in the papers to that fundamental question. The safeguarding issues in this case do not of themselves require examination at a Public Investigation, but the issues around Risk Assessments on discharge do merit such examination, as I have recommended in my Overall Conclusions.

Dr Adam's notes

9. I agree with Mr West's analysis that Dr Adam's notes made it virtually impossible for David West to be treated in the Community after he had been discharged.

10. On examining the Elmleigh records, it is plain that David West was, at times, a very challenging patient with a history of engaging and disengaging with Mental Health Services. That is no justification for the terms of the Consultant's notes, which caused such offence. Dr Adam accepted his error and he was roundly condemned by the Trust.

11. It seems to me that there was an inevitable link between the notes of Dr Adam, the decision to discharge and the subsequent inability of David West to have the Community support he needed. That should have been obvious at the time and understandably has caused his family deep concern and pain.

Incomplete questioning at the Inquest

12. Mr West believes that the questioning at the Inquest identified numerous mistakes but did not isolate personal responsibility. At a meeting with Mr West he further told me that he felt limited in regards to his questioning and troubled by the evidence given by some of the witnesses.

13. This is a difficult issue and I can only deal with it in general terms. It is rare to have direct evidence of professional personal fault in Inquest proceedings and limited questioning is not uncommon. Further, Coroners do not normally seek such evidence of their own volition. I understand entirely how that process may have appeared to Mr West at the time and even more so in hindsight. It fuels the concerns that individuals were being protected and reputations upheld at the expense of truth. But it does not lend itself to any easy solution, particularly because on the facts of death there cannot be a basis for a new Inquest here.

Legal support at an Inquest

14. As I have said in other cases, I agree with the principle that where a dispute arises after death, which requires family members to challenge those who have cared for their loved relatives, they should have the means to have proper professional representation. I repeat the suggestion I made in another case, which would be for an agreed arrangement with a reputable firm of local solicitors, who would be a first port of call. I would encourage the Trust to consider that suggestion.

The Capsticks Investigation

15. Mr West has raised significant concerns regarding the appointment of Capsticks to conduct the independent examination.

16. My view is that the perception of absolute independence is crucial. The Capsticks Investigation did produce a number of valuable recommendations. That needs to be recognised and accepted. But I am also of the view that in the future examination of deaths, an Investigator must not just be independent but must also be perceived to be so by all.

17. One way that may be achieved is by careful and constructive submissions as part of the Public Investigative Hearing that I recommend. For devastated family members in the future must have complete confidence in the processes used by this Trust to carry out independent investigations.

18. I have not sought to respond to all of the comments or concerns of Mr West. Some criticisms would require further evidence from named and unnamed individuals, which I am not in a position to obtain on a paper review. That includes the revalidation of Dr Adam.

4. Recommendations

1. In outline, I consider there are specific matters of practice and policy raised by Mr West, and other families, which require further careful review at a Public Investigation. I do not consider that should extend to the facts of David West's death.

2. In light of the ongoing injustices that I have found Mr West to have suffered and specifically since the first ex gratia payment in October 2016, three years ago, I would recommend a further payment of £1500.

5. Conclusions

1. I firmly recommend a Public Investigation to consider specific outstanding matters of policy. As will be seen, they include recommendations made by Mr West himself.

2. The central question is - what has been done now which would help to prevent a further tragic death? Only a focused Public Investigation on key policy issues can provide a reasoned and authoritative answer.

3. The fact that the Trust's Investigation was not upgraded to a Serious Incident Report Investigation, from a Critical Incident Review, remains a matter of real concern to Mr West. There are contrary Trust submissions and I am not minded to elevate the case-specific differences to a public investigative topic.

4. The actions and comments of Dr Adam speak for themselves and their failings have been recognised by the Trust and by himself. Dr Adam was struck-off and it seems to me reasonable to assume that there is no prospect at all of him giving evidence. I do not recommend that his role, in itself, now needs further examination at a Public Investigative Hearing. However, that does not diminish the need for and value of a Public investigation on the other specific issues I have identified in my Overall Conclusions.

5. I have reached the view that the controversial discharge of David West from Section 3 and the alleged failings of Consultant 4 are not matters for a Public Investigation and I make no specific other determinations.

6. In forming that view, I have had to consider the practical evidential position at this moment in time. That includes the availability of relevant psychiatric evidence and the inability in a public investigative hearing to compel any such witness to attend. I consider that then would make a public examination a matter partly of speculation rather than of decisive finding. I think that such an outcome would be wholly undesirable after the extended trauma Mr West has endured.

7. Similarly, the difficulty in forming any view on a paper review is that the notes of David West in Elmleigh raise real questions of professional judgment, but with no opportunity to test them by direct questioning. That is the essential limitation of a paper review.

8. Nevertheless I have formed the clear view on the evidence that the circumstances of the discharge of David West not long before his death are **a matter of very deep concern**. The notes record his disturbed, changeable and challenging behaviour, which demanded continuing close supervision in the Community. That did not happen and it left him vulnerable and at the mercy of his own demons. However, the fact of the discharge is not of itself a matter that calls out for analysis at a Public Investigation.

9. Upon meeting Mr West, I have been able to understand the affect of the significant omissions and failings in the way the Trust have dealt with his complaint and the implementation of specific recommendations by independent bodies: this is the injustice he has suffered. There have been multiple episodes of failings in this case. My recommendation for an ex gratia payment falls within Level 4 of the ‘Injustice Scale’ in the Ombudsman’s Ex Gratia Guidelines.

10. In considering the level of injustice, I have considered the severity and impact on Mr West's employment and mental health, given that he has been lodging complaints and asking questions, which have remained unanswered for six years. I have no doubt this has taken a significant toll on his emotional and mental wellbeing. There are no identifiable external factors impacting the effect or severity on Mr West.

11. I have considered the severity in this case with reference to the 'typology category' in the Guidelines. This falls within 'material' and I have found evidence of 'exceptionally poor complaint handling extending over several years', which falls within the category of the 'very worst complaint handling cases'. The affect has been suffering over a very prolonged period of time, six years, which goes beyond distress and inconvenience and I am satisfied that it has had a direct impact on David West's family's ability to find closure.

12. On the basis of my analysis of this case within the Guidelines, I would recommend a further payment to Mr West in the sum of £1500. I recommend such a further payment be made, given the ongoing distress, inconvenience and worry Mr West has suffered since the failure to resolve his Complaints over the past three years. I have also borne in mind the need to avoid obvious disparity between families, where the specific Guidelines of the Ombudsman places individuals in similar categories.

3. EDWARD HARTLEY

1. All purpose Chronology

August 23, 1995	Edward Hartley was born. Note: at six months Edward Hartley experienced his first seizure. Subsequently he had a diagnosis of Dravet Syndrome, a profound learning disability and limitations in movement particularly in his left arm. Then he was diagnosed as being on the autistic spectrum. During his life Edward Hartley received "consistent diagnostic inputs for his epilepsy from a range of national experts." By the time of his death at least ten separate NHS trusts and agencies had been involved. **1996 to 2014:** A comprehensive, but incomplete medical chronology is set out in the independent Health and Social Care Advisory Service ('HASCAS') Draft Report. That also includes specific details of placements and support. For the purpose of this working chronology, it is unnecessary to repeat all details of that information and the medical chronology is accepted as accurate. The entire record shows considerable specialist pediatric neurological input, with appropriate and varying medication depending on his changing presentation. However some of the selective dates and details set out below assist in considering the circumstances of his death in May 2014.

August 1997	Edward Hartley and his family moved to Singapore.
June 1998	Edward Hartley returned to England, with his mother and siblings, with his father following in January 1999.
March 2009	A Consultant Pediatric Neurologist wrote to the GP “he continues to have a lot of overnight seizures…”.
February 2010	Edward Hartley was reviewed by the Southampton Neurology Service. It was noted that he “still has early morning episodes of tonic-vibratory seizures first thing after waking up in the morning.”
June 2011	Edward Hartley was assessed by a Consultant Neurologist in Glasgow. It was noted that he typically had five tonic seizures each night, usually upon waking and lasting about a minute.
September 2011	Edward Hartley was reviewed by a Consultant Pediatrician; concerns about his seizures remained.
December 17, 2012	Date of a Risk Assessment by a Support Coordinator at TQtwentyone.
January 2013	Edward Hartley was referred to Tamerine TQtwentyone, a small Trust respite facility. The main risk was reported to be the management of his epilepsy, particularly at night. When he first attended, he was relaxed and settled in well. His general health was later described as good, as part of a healthy lifestyle. He also had non-epileptic seizures in the form of tensing and shaking, with no warning beforehand. A Risk Assessment was conducted, noting that he was

	at risk of sudden unexplained death in epilepsy and he needed to be monitored whilst at Tamerine TQtwentyone. *There would always be a need to have an up and awake member of staff on duty* and there would need to be a monitor in his room. If there was a cause for concern at night, then the staff member should knock on the door and enter the bedroom to check on his well-being. His seizures were to be monitored and recorded and if his health was of concern, a 999 call was to be made. Note. Mr and Mrs Hartley say they would not have stipulated that 'the staff member should knock on the door and enter the bedroom to check on his well-being' and it was contrary to their advice at the time.
January 12, 2013	Edward Hartley attended Tamerine TQtwentyone with his parents for the first time. Note. Daytime respite care was now being provided by TQtwentyone directly into the home of Edward Hartley.
January 14, 2013	The Osborne Community special school in Winchester, which Edward Hartley attended, completed a detailed day-to-day Care Plan which examined his risk and safety.
January 16, 2013	A profile of Edward Hartley was completed and his epileptic and non-epileptic seizures were identified.
February 16, 2013	A personal profile of Edward Hartley was developed, together with risk screenings and checklists.
February 21, 2013	First of eight recorded overnight stays at Tamerine TQtwentyone.

March 2013	A Care Quality Commission (‘CQC’) routine inspection was carried out at Tamerine TQtwentyone. It met all of the reviewed standards in full. The Risk Assessments and Care Plans were detailed and ‘person-centered’.
March 1 - 4, 2013	Edward Hartley stayed at Tamerine TQtwentyone. On March 1, he had two seizures at 04:00 and 05:15 and recovered well. On March 2, he had shaking shivering episodes and seizures from which he made a good recovery. On March 4, during the night he had several myoclonic seizures and after 05:00, tonic chronic seizures where his body and limbs went stiff.
March 20, 2013	A detailed continuing Healthcare Assessment was prepared by West Hampshire Clinical Commissioning Group (‘CCG’). Some challenging behaviour with members of his family were identified and the need for support for his mother in caring for him.
March 29 – April 1, 2013	Respite care was provided to Edward Hartley at Tamerine TQtwentyone March 31: several seizures during the night from which he recovered well.
April 10, 2013	Letter from his Consultant Pediatric Neurologist was sent to the GP: “He is stable at the moment although he does have night-time seizures…”.
April 17, 2013	Edward was interviewed by his Consultant Pediatric Neurologist and given a 24-hour EEG.

April 25 – April 29, 2013	Respite stay at Tamerine TQtwentyone and records of seizures kept.
May 10 – May 13, 2013	Respite stay at Tamerine TQtwentyone and details of seizures kept. May 12: seizures throughout the night during his stay at Tamerine TQtwentyone.
May 31 – June 3, 2013	Edward Hartley settled in well at Tamerine TQtwentyone. He had three seizures in the night, from which he recovered well.
June 21 – June 24, 2013	Records of seizures kept during a respite stay at Tamerine TQtwentyone.
July 1 – July 14, 2013	Records of seizures kept during a respite stay at Tamerine TQtwentyone. By way of example: July 2: several seizures during the night July 4: three seizures during the night July 5: after a day at school one seizure during the night July 6: several seizures during the night July 7: several seizures during the night July 8: a lot of seizures during the night and unable to settle July 11: noted that he had a very bad night July 13: several fits during the night July 14: one seizure during the night and incident form completed after an **injury** had been found. There was an unexplained serious injury: the loss of

	two front teeth. A Dentist's report indicated **serious trauma.**
August 21, 2013	Mrs Hartley made a **verbal Complaint** to the Trust about the teeth incident. The Locality Manager completed an Investigation.
August, 2013	Edward moved from Children's Social Services to Adult Social Services. It is suggested that an Adult Social Worker was provided. Note. Mr and Mrs Hartley indicate however that this move meant the end of support from Children's Social Services and that all 'information and continuity' was lost in that process. They described this as a "fault in the system".
Autumn 2013	Independent observations of Edward Hartley at Naomi House, Jack's Place and Young Epilepsy: he could experience up to 70 seizures at night. Note from Mrs Hartley: these would include movements falling short of actual seizures.
September 23, 2013	A Social Worker developed a Risk Assessment and Support Plan. No Safeguarding issues or concerns were identified.
October 11, 2013	The RiO notes (Leaning Disability) included: 'risk of seizure at night with potential for poor recovery' and 'risk of falling if Edward moves to get out of bed'.

October, 2013	Mr and Mrs Hartley's application for Continuing Healthcare funding for Edward was granted. It was done so on the basis of it being 24/7 care with the responsibility on the CCG to produce care plans, carry out Risk Assessments and commission the care.
November 6, 2013	Sue Harriman, Acting Chief Executive of the Trust, responded to Mrs Hartley's Complaint dated August 21, 2013 following an Investigation. *"Investigations did not provide any evidence to show that staff deviated from Edward's agreed care plans".* Note. A payment of £500 was offered to Mrs Hartley in 'full and final settlement' in respect of the injury to his teeth. Note. Mrs Hartley did not feel this response was satisfactory. Mrs Hartley was reimbursed finally with the full cost of the dental bills.
December 2013	TQtwentyone providing respite care directly into the home of Edward Hartley.
April 11, 2014	Letter from Katrina Percy, Chief Executive of the Trust, responding to Mrs Hartley's further Complaint about the response she received on November 6, 2013. "[The Locality Manager] has confirmed that **the recording of events that night fell short of what is expected by staff".**

April 16, 2014	A Risk Assessment and Support Plan for the morning routine were initially developed in December 2012 and completed on December 17, 2012 and were reviewed on this date in 2014 during a meeting between a Trust representative and Mrs Hartley.
May 27, 2014	**Details of the evening before the death of Edward Hartley** after his Carer had arrived for work at 19:00 hours. The Carer was due to provide 'Up and Awake' night support. After he fell asleep, his Carer went across to the small room allocated to the staff staying overnight, which had a small baby monitor, provided by his family, to monitor Edward Hartley in bed. Edward Hartley had a number of seizures from which he self recovered and two large seizures at approximately 00:00 and 01:00. After each, he settled back to sleep.
May 28, 2014	***Death of Edward Hartley***, aged 18. Between 05:40 and 07:00, the Carer looked on a number of occasions at the monitor. Between 07:00 and 08:00, the Carer was in the kitchen with Mrs Hartley. The timing and exact details of this were and are plainly disputed by Mrs Hartley. Edward Hartley was seen by the Carer at 08:00, just before his night shift finished, and when he had gone to say goodbye to Edward Hartley, who did not then appear to be in his normal state. He called for Mrs Hartley immediately and Paramedics were then summoned.

	0900: Edward Hartley was pronounced dead *Those bare facts need some amplification which nevertheless fall short of conclusive findings of fact.* Note 1. There appear to have been five epileptic seizures before death. In the HASCAS Report it was characterised as **sudden and unexpected death.** Note 2. The monitor used to observe Edward Hartley was a small baby monitor, the size of a mobile telephone providing a black-and-white view of his face and a remotely operated pan and zoom facility. But it was *not* a webcam. Note 3. The main focus of the overnight care was not to provide a skilled and expert response to Edward Hartley's epilepsy, "but to provide respite care ensuring that his mother was not disturbed in the night so she could sleep." Note 4. The Carer had not been told about Dravet's syndrome. The Carer had more experience of working with Edward Hartley during the day at a time when he did not have a fit. The Carer found the situation at night to be very different. Note 5. The instructions from Mrs Hartley, understandably, were that she did not want to be disturbed. The Carer was there to allow that to happen and to take responsibility at such a time. Note 6. In considering whether the death of Edward Hartley could have been prevented and whether anything had been done to save his life on the morning that he had died, the Pathologist gave a clinical view of

	what must have occurred: the fitting that he had experienced during the night would have caused his brain to swell. Each successive fit would cause swelling of the brain in an unstoppable sequence of events. The last major fit probably caused major swelling. Once the cerebellar coning occurred, nothing could have been done to save his life. Note 7. The Carer had not received basic life support training prior to the death of Edward Hartley. In practice, I understand from Mrs Hartley that he was not in a fit state to undertake that role.
May 29, 2014	**Post-Mortem concluded**. Severe cerebral oedema caused by cerebral hypoxia following an epileptic seizure, was given as the cause of death. Note. Comment in Critical Incident Review Report: individuals with Dravet's Syndrome face a higher incidence of sudden unexpected death in epilepsy.
June 10, 2014	Letter from Katrina Percy, Chief Executive of the Trust, to Mrs Hartley responding to a letter dated April 23, 2014 regarding the teeth incident in July 2013. The incident had been re-investigated by the TQtwentyone Locality Manager for West Hampshire.
June 11, 2014	Nicki Duffin, the Critical Incident Review Investigator held a meeting with the Support Manager of the Outreach service. Details of the support were provided, notably at night and when Edward Hartley was asleep.

June 12, 2014	Nicki Duffin, the Critical Incident Review Investigator held a meeting with the Acting Locality Manager, East Hants and Isle of Wight.
June 13, 2014	Nicki Duffin, the Critical Incident Review Investigator held a meeting with the Interim Locality Manager. Nicki Duffin, the Critical Incident Review held a meeting with the Carer working at night with Edward Hartley since April 2014. The Carer provided a statement, in which it was said that he had looked at the monitor between 05:40 and 07:00, but could not say how many times. At 07:00 he had told Mrs Hartley “he had not got Edward up as he had been unsettled during the night”. The monitor was left in the office from 07:00 as it did not work in the kitchen, where the Carer went. Finally the Carer said that when he was asked by the police if he had First Aid training he replied “No, it’s not usually required for the job I do”. Note. Mrs Hartley strongly disputes this account of the timings of the morning Edward died. She recalls entering the kitchen at 07:30. Mrs Hartley says the monitor did work in the kitchen if he was kept at one end – near the door.
July 9, 2014	**Serious Incident Panel Meeting**. Nicki Duffin, the Investigating Officer was not present. Note. The Chair informed the Panel that the date of the incident was during school half-term and that had it

	been a school day, Edward would have already been up and awake ready for school and says ‘it will remain unknown whether this would have made any difference to the tragic outcome’. Note. One statement indicates: ‘it is assumed that Mrs Hartley and the Carer then spoke for an hour in the kitchen’. That assertion should be examined in any review.
July 2014	**Critical Incident Review Report.**
August 2014	A **Corporate Scrutiny Panel** considered the Critical Incident Review Report with the Medical Director in the chair fifty days post incident.
August 22, 2014	A written Post-Mortem Report was sent independently to the Coroner by the Pathologist. The Coroner subsequently decided not to hold an Inquest. The cause of death had been given in the post-mortem as ‘epileptic seizure’.
September 2014	Edward Hartley would have taken up a residential placement at Young Epilepsy, which would have entitled a change of GP, environment and Neurologist.
September 2014	Final submissions made to the Strategic Executive Information System (StEIS) sixty days after the incident.
October 2014	After the parents of Edward Hartley had reviewed a final copy of the Critical Incident Review Report, they disagreed with some of the contents and raised serious concerns about its validity.

	Note. One issue arose over the **records** from the night leading up to Edward Hartley's death. These were not returned by the police until July 2015 and thus not initially available to the Investigator. Nor did the original Trust Investigation have the Post-Mortem Report. Mr and Mrs Hartley did not take part at that very sensitive and difficult time. These issues were discussed in a face-to-face meeting with the Divisional Director and it was agreed that the Investigation would be re-opened. This time the parents would be involved. Their concerns included questions from multiple agencies within their son's Pathway of Care. The CCG was approached to take ownership and commission a multi-agency Investigation. Following this, a HASCAS representative and Helen Ludford, a Trust employee, commenced an Investigation in Spring 2015.
May 1, 2015	The new Investigation Team met the parents of Edward Hartley.
July 2015	The Police returned the clinical records.
February 3, 2016	An Investigation Workshop took place
March 2016	**Draft Independent Investigative Report by HASCAS** into the care and treatment of Edward Hartley, which was never finalised. Note. The reasons for that are not central to this enquiry, but the fact that it was not finalised is a

	complicating factor in considering the significance of the draft Report. Note. This unfinalised report was not received by Edward' Hartley's family until August 7, 2016.
May 3, 2016	Mr and Mrs Hartley met the pathologist who undertook the post mortem of Edward Hartley, with the lead HASCAS Investigator present at the invitation of Mr and Mrs Hartley. No other investigating individual was present and the investigation was not discussed. Mr Hartley has indicated his absolute recall of what naturally was a very intense and difficult meeting Note This was *before* Mr and Mrs Hartley had been given the HASCAS Report ,which they were given in August 2016.
September 12, 2016	Julie Dawes, Acting Chief Executive of the Trust sent a letter to Mr and Mrs Hartley offering to meet with them.
November 13, 2017 – April 2019	There were a number of group meetings hosted by the Trust for some or all of the family members in the period 2018 to 2019, which Mr and Mrs Hartley attended. Those meetings were to discuss the 'Trust Pairing' Initiative and address unresolved issues.
January 1, 2018 – June 2019	There were a number of meetings that took place between Mr and Mrs Hartley and their Trust Pairing Investigator, Paula Anderson, for the purpose of undertaking a review of the Critical Incident Review Report and Panel minutes into the events surrounding Edward's death. There are five general points of note, • The night cover for Edward and what it was

	intended to achieve. • The absence of input from Mrs Hartley into the Critical Incident Review Report. • The **key** question as to why Edward's final seizure was not witnessed. • Mr Hartley was not referred to in the Critical Incident Review Report. • The failure of the Panel and CCG to pick up on the gaps in the Critical Incident Review Report. Note. Appendix B sets out specific points about the Critical Incident Review Report. Significantly, 'there was no change in night time seizure activity in this time' and 'the baby monitor was portable so it could have been taken into the kitchen'. Note. Mr and Mrs Hartley told me that this was the kind of investigation they wanted from the beginning and they were satisfied that Paula Anderson was diligent, conscientious and professional. Indeed records indicate plainly that was the case. However, they were disappointed with what they saw as 'the change in direction'.
April 13, 2018	Letter from Lynne Hunt, Chair of the Trust, to Mr and Mrs Hartley and Mr West, in response to their paper including '17 should-be' points. It set out the Trust's plans for furthering their "vision" and their thoughts on the points raised. Note. One of these 'should-be' points is the 'appointment of an **independent medical examiner** to review every death certification and that bereaved families be invited to be involved in the co-investigation and co-production of unexpected death reports and

	action plans'.
August 1, 2019	Meeting with Mr and Mrs Hartley for the purposes of this Investigation. Details were given of the affect on them of the prolonged process of investigation.
October 31, 2019	Second meeting with Mr and Mrs Hartley for the purposes of this Investigation.

2. Complaints and Investigations

The Trust's Critical Incident Review Report dated July 1, 2014

1. The Report focuses on the care and support provided by TQtwentyone Floating Support Team to Edward in the period immediately preceding and proceeding his death. In preparing the Report, the Investigator met with the managers and the Carer from TQtwentyone and reviewed their polices.

2. The Report was prepared at a time when the Police still had possession of TQtwentyone records from the night Edward Hartley died and the week prior to that. So they could not be reviewed. Further, this was at a time when the family could not have been expected to engage with any Investigation, even though they were invited to do so.

Learning outcomes

3. The learning outcomes recorded were,

- Edward's support file needed tidying up as the information was muddled due to it being in the process of being updated at the time of death.
- Edward's support plans needed updating as his needs had changed, which had come to light in a meeting with his mother on May 21, 2014.
- The fact that floating support is led by either the service user or their family, and delivered at home means that the policies in place are difficult to follow and staff reported feeling "vulnerable".

4. The Report records that Edward's family had instigated the use of a webcam (the family strongly disagree with it being called a 'webcam') in his bedroom and warns that *"an assumption could be made that the webcam was being used to monitor the seizures… however any equipment should not be relied upon and use of such technologies should be assessed on a case by case basis and include clear guidance for the use of the technology within individual support plans".*

5. The Report also notes that there have been requests for a process to ensure incident reports are shared with colleagues, including the Neurologist.

Recommendations

6. The recommendations were,
    - TQtwentyone policies for floating support should be reviewed.
    - TQtwentyone should not allow staff to work alone if they have not undertaken Basic Life Support training.

Steps taken

7. The Critical Incident Review Report sets out clear action points with deadlines to implement the changes. There is no follow-up to say whether these changes have in fact been implemented. The Report does note that TQtwentyone have amended their 'lone working policy' so that staff must have completed Basic Life Support training prior to lone working.

My Conclusions on the Critical Incident Review Report

8. The Critical Incident Review Report is valuable in providing an account of the weeks immediately preceding Edward's death and the evening and morning of his death by members of staff from TQtwentyone who were directly involved in his care over that period. Nevertheless, I do *not* consider that it should be regarded as all-embracing when considering the exact circumstances in which Edward Hartley died.

9. Specifically the Report does not include the comments of Edward's family due to the fact that it was prepared before Mrs Hartley felt able to engage in the Investigation and it does not include any views of Mr Hartley. The family were not made aware of any time constraints in providing their input, nor did they know of the Critical Incident Review process and the steps that would be taken. That said, I do also acknowledge the response that I have received of a sixty-day timeframe that applies to these investigations. But without the account of Mrs Hartley, whatever the reason, the Report cannot be seen as definitive.

10. Further the Investigator did not have the benefit of reviewing Edward's records with TQtwentyone, as they were still in the possession of the police. Objectively, these omissions are not a source of blame. But necessarily the picture that emerges from that Investigation is *incomplete.*

11. I note that these points were discussed between Mr and Mrs Hartley and their Pairing partner, Paula Anderson, during their meeting in February 2018. It is for these reasons that I am unable to endorse the Report in unconditional terms. It was not in a position to provide a complete picture of the circumstances of the death of Edward Hartley.

Draft Independent Investigation Report, by the Health and Social Care Advisory Service ('HASCAS') CEO and Helen Ludford, dated March 2016

1. This Report was commissioned by the CCG. It was never finalised beyond a draft version, which was shared with the family, and with me during this Investigation.

2. For reasons that are beyond the scope of this Report, the HASCAS Report was not completed. Mr and Mrs Hartley continue to be extremely concerned about the accuracy of this Report. On the other hand, I have had very detailed responses indicating the opinions of the then Investigator. That raises for this inquiry, in an acute form, the central dilemma of reaching conclusions without the ability to test witnesses in an investigatory capacity. That is the reason why I am not in a position and do not make specific adverse judgments on the Report. I have set out below where I consider it has merit and value. But I do recognise the continued deep concerns of Mr and Mrs Hartley arising directly from this draft report.

Findings

1. The Report findings were,

    - Edward received a robust and evidence-based treatment approach.

- Management Plans and General Care Pathway, although of a good standard, were not always shared or coordinated between all the services. Home and Community-based assessments were lacking.
- The Transition Process focused on funding and eligibility, managed by individuals who had only fleeting contact with Edward and his family and it was not clear how statutory service provision would continue beyond his placement at 'Young Epilepsy'.
- The funding system lacked coordination and leadership, which led to a weakness in the ownership of the care package, with safeguarding and processes omitted by the Clinical Commissioning Group ('CCG') and Local Authority. That led to Edward's mother arranging the care package alone. The Team found that ***"this lack of oversight made a significant contribution to the poor handover provided to TQtwentyone".***
- The adequacy of TQtwentyone Floating Support and Respite Care Assessment, management plans and standards of care delivery were of a good standard. However they were compromised by not having all of the information available from other providers and there was weak oversight and delays.
- The Team reported that they were told that the Support Worker had not received basic life support training prior to Edward Hartley's death. This meant that the CPR techniques deployed by both him and Mrs Hartley were not optimal".
- The care and treatment was always person-centered on Edward and his family. The fact that Edward Hartley was not provided with an advocate at aged 18 was an oversight.
- There is recognition of the lack of family engagement in the internal investigation process.

2. The Report concluded, based on the Post-Mortem Report and Pathologist's Opinion, that Edward's death could not have been prevented on that morning. Further there is no evidence to suggest that any act or omission on the part of the family, TQtwentyone or any

other service contributed to his death. That view remains extremely contentious for Mr and Mrs Hartley and merits a detached and very careful consideration.

Learning outcomes/practice

3. A need for a lead service and joined-up communication when there are multi-disciplinary services involved in a person's care.

4. There is **no fit for purpose Care Pathway** currently in place to manage it and this needs to be addressed as rapidly as possible for the wellbeing of future service users.

Recommendations

5. It was recommended that the CCG review and add to current Care Pathways to ensure multi-agency coordination and placement of the service user at the centre of the care and treatment provided.

6. The CCG should review and ensure all transition processes are fit for purpose and in keeping with National Guidelines.

7. The CCG should review the Continuing Healthcare process to identify management of coordination and oversight in relation to vulnerable adults; to make it clear how parents should be signposted and to bring early assessment to the attention of all concerned.

8. There should be a revision of Care Pathways and multi-agency protocols to ensure effective Communication takes place, with particular attention on vulnerable adults.

9. It was recommended that all TQtwentyone staff must be brought up-to-date with basic life support techniques with immediate effect. The Trust must conduct an audit to ensure compliance and ensure action is taken and monitored on an ongoing rolling basis.

10. It was recommended that Health and Social Care providers must ensure that assessment of carers is conducted in accordance with the Care Act 2014.

11. It was recommended that Best Interests and Capacity Assessment must be embedded into the transition Care Pathway and the appointment of independent advocates always considered.

12. It was suggested that where there is an unexpected death, the Trust must **work closely with families of the deceased** throughout the investigation process.

My Conclusions on the draft HASCAS Report

13. The draft HASCAS Report is balanced and very thorough. It acknowledges and seeks to address the concerns raised by the family of Edward Hartley. It is fair to recognise that its methodology - interviewing the range of service providers and witnesses and holding workshops with the relevant stakeholders - led to informed, sensible and detailed findings.

14. The recommendations, if implemented, could have made significant positive changes to service delivery, particularly where there is multi-agency involvement and a transition from Child to Adult Services. For example, the records from Naomi House and Jacks Place from July 2013 to early 2014 and the CHC Risk Assessment and epilepsy guidelines were not shared with the Floating Support Manager at TQtwentyone by the CCG Continuing Healthcare team.

15. However this is a *draft* Report. It is not clear if or how far the Trust or CCG implemented these recommendations or whether practices improved. I agree with Mr and Mrs Hartley that they should be challenged on this and the effectiveness of any changes.

16. Crucially, the reports from Naomi House and Jacks Place included concerns regarding Edward's night-time seizures and recorded that three members of staff were allocated to him and that he had equipment needs.

17. The HASCAS Report was compiled without consideration of the records from Great Ormond Street Hospital. Those records covered a two-year period, so that it is reasonable to ask why that did not happen. In that respect, there is a letter from Great Ormond Street Hospital dated July 29, 2016 which states that the records were provided to the CCG and thus in theory should have been made available to HASCAS.

18. However, I have received a detailed response explaining why those records were not considered by HASCAS and further, in their view, that it did not disadvantage the inquiry at all. Accordingly I do not consider that I should seek to draw definitive conclusions on that issue, which, in my view, is not ultimately a central issue for me to determine. It is fair to point out that Great Ormond Street Hospital reviewed the draft HASCAS Report when checking its factual accuracy and made no additions to it.

19. I note Mr and Mrs Hartley's extensive complaints about the HASCAS Report, specifically the independence of Helen Ludford, a Trust employee. In a statement, Helen Ludford states that she herself raised concerns as to whether there was a conflict of interest, considering who was employing her. But Helen Ludford indicated that she did not knowingly mislead Mr and Mrs Hartley to believe she was independent of the Trust.

20. As I have sought to emphasise throughout this Report, in cases where there has been a serious incident or death, the families must be able to have trust and confidence that the investigative systems and processes in place or adopted will be robust and independent and perceived to be so. I *stress* that I do not make *any* adverse finding concerning Helen Ludford. But this is another example of a complaint that Mr and Mrs Hartley should not have had to make, in circumstances which were already very tragic and distressing for them. I have no doubt this has added to their distrust and hesitancy in having confidence in the investigative processes, notwithstanding the integrity and professional experience of the Investigators and the scope of their conclusions. I do not overlook the problems which flowed from the fact that the report was never finalised, a complicating factor which limits definitive comment.

21. The key question now is whether there are unanswered questions which should be addressed if at all possible, notwithstanding the finding that the death of Edward Hartley could not have been prevented. My clear view is that there are questions which a sensitive investigation should address.

Hampshire County Council Learning Review of the response to a safeguarding incident, dated March 2016

1. The Review examines the work of Hampshire County Council (HCC) staff in response to an injury where Edward lost his two front teeth in July 2013 at the Tamerine TQtwentyone Residential Care Home, managed by the Trust. The Review also explores how HCC staff worked alongside staff from other agencies.

2. The Review forms part of the wider review undertaken by HASCAS.

Findings

3. The Review identifies missed opportunities and states that “if the case had been opened as a Section 47 investigation, more pressure would have been applied to ensure the health report was produced and shared in a more timely way”.

4. The Review reports that during a meeting with the Social Worker, Mr and Mrs Hartley raised a concern that the injury may have been caused by an assault. This was not recorded and was found to be a serious omission.

5. It also acknowledges that the Social Worker involved did not speak with the dentist. That was in contravention of normal practice which otherwise would have highlighted a clinical picture of serious trauma.

6. The Review reports that a referral should have been made to the Local Authority Designated Officer and information should have been shared with the Police. Thus an opportunity for the Local Authority Designation Officer to investigate whether safeguards were sufficient was missed. The Review concluded that a Section 47 Investigation should have been started at this point.

7. The Review found that the Local Authority Designation Officer made a reasonable decision that they had no role in the response to the incident based on the information available to them.

8. The Review suggests that in 2013 there may have been an under-use of child protection processes in at least one of the Children with Disabilities teams.

9. The Review found that there was some confusion held by the Team Manager and some team members about how the role of the Local Authority Designation Officer links with the broader section 47 Child Protection process.

Recommendations

10. It was recommended that the Children's Services Department should consider undertaking an audit of the current volume of Child Protection Investigations undertaken by Children with Disabilities Teams across Hampshire to ascertain if there is a broader pattern of underuse of procedures. Further, they should consider providing additional refresher opportunities for operational teams on the role of the Local Authority Designation Officer and their links with the broader section 47 Child Protection process.

11. It suggested the findings are shared with the Team Manager for Hampshire County Council as a learning exercise.

12. It was recommended that the Local Authority Designation Officer should record, retrospectively, the concerns related to the relevant members of staff on duty when the incident occurred, so that should any future concerns arise, it is acknowledged.

13. They recommended that the Head of Service write to Mr and Mrs Hartley to apologise on behalf of the Department for the way in which they responded to Edward Hartley's injury.

My Conclusions on the Report

14. It might be thought that this was a stand-alone incident, unrelated to the death of Edward Hartley. But I have decided to summarise this Report as it seems to me to be too serious to leave completely unexamined and it does assist me in a wider perspective. *At the same time, it would be absolutely wrong to attempt a paper adjudication on an issue only on the edge of my terms of reference and I do not do so.* Any observations must be seen in that light. Specifically I need to make it clear that I do not seek to comment **at**

all on any possible individual or wider responsibility of Hampshire County Council.

15. I note that the family was engaged with this Investigative process through meetings and their concerns were identified. However the initial decision that it was ‘reasonable’ not to start a Section 47 Investigation is in contrast to the Investigator’s findings regarding the opportunities that were missed. There was also a lack of information sharing between services caring for Edward.

16. There is a question arising from the Investigator’s conclusion that the Local Authority Designation Officer made a ‘reasonable decision based on the information available to them’. But that information was incomplete due to Tamerine TQtwentyone’s failings. But again that is not a question that I am in a position to decide and thus equally one which I should comment.

17. It is notable that Tamerine TQtwentyone had more experience with patients over 18 years-old and appears not to have known the processes to apply when a minor experienced an injury whilst in their care. The injury was obviously serious to anyone seeing it and the dentist’s expert conclusion is very disturbing.

18. I note that the Action Plan did not include a timeframe for implementing the recommendations or conducting the follow-up work.

19. The Review identifies serious and significant failings in Tamerine TQtwentyone’s practices and processes surrounding the serious and unexplained incident before Edward’s death.

20. In summary, whilst I am not required to and cannot resolve what exactly happened to Edward Hartley or make critical judgements on individuals, this serious and disturbing incident does have relevance in the wider context. By that, I meant the care and support received from services overall and whether opportunities to identify his needs were missed. Plainly they were.

3. Views of Relatives

1. In preparing this Report, I have met with Mr and Mrs Hartley on three occasions, gaining an understanding of their concerns and what they felt remained to be investigated. I do not intend to set out every detail of our discussions, but I want to reassure them that all of their comments were considered.
2. That includes their detailed documents setting out their specific concerns, provided after our meetings. I am very grateful for that. This summary is just that, but it seeks to be an accurate reflection of their major concerns about the Investigations, both at the time of Edward's death and today. I fully understand that their key objective remains "a desire to ensure that the failings that led to the death of Edward result in an honest and truthful appraisal of lessons to be learned, with subsequent demonstrable action to implement the necessary change and improvement."

3. I also recognise, as I do with all the families I have met, that Mr and Mrs Hartley have deep-rooted feelings as to the effectiveness of the Action Plans and Reports produced by the Trust. They made it clear to me that they do not believe the promises of change and the recommendations made by external bodies have been implemented, and if they have, they question their effectiveness. In summary, they believe mistakes are still being made on a frequent basis. In turn, this fuels their innate and continuing suspicion of the Trust. Nevertheless they have persisted with their quest to secure justice. They also want proper scrutiny of policy issues to avoid future harm to other families.

4. An overview of some of the key areas that Mr and Mrs Hartley believe still need to be investigated covers,

    - The unsatisfactory response to their Complaints about the incident on July 14, 2013 where Edward lost two front teeth whilst staying at Tamerine TQtwentyone.

- The commissioning of services and collaboration by the NHS to provide care and support following a successful application for CHC funding.
- The practice and procedures in place for **Care Plans and Risk Assessments**, particularly where there is a transition from Child to Adult Services and the involvement of clinicians in this process.
- **The unanswered questions concerning the role of the Carer** on the night/morning of Edward's death and the 'unwitnessed seizure'.
- The **independence and quality of the investigations** following Edward's death and the **communications with the family** during this process, including with the CCG.
- The fact that Mr and Mrs Hartley hold a strong belief that Edward's death was **not unavoidable**.

4. So far as *the unexplained incident on July 14*, Mr and Mrs Hartley agreed that this event is not strictly within my terms of reference, but they describe this as a "significant" incident and express their concerns regarding the response of the social workers, managers at Tamerine TQtwentyone and the Care Quality Commission. They do not feel it was accurately recorded or appropriately responded to and believe it was fundamental to understanding Edward's needs and the risks he posed at night.

Comments on issues raised by Mr and Mrs Hartley

Commissioning of services

5. Mr and Mrs Hartley are concerned about the operation of Continuing Healthcare by the NHS and the commissioning of service providers, in this case, TQtwentyone. They expressed that there were "*wholesale failures*" by the West Hampshire Clinical Commissioning

Group in developing Care Plans and Risk Assessments, once it was decided that Edward was eligible for 24/7 support.

6. In correspondence sent to me after our initial meeting and during a second meeting, Mr Hartley raised his interest and significant concerns regarding a Report conducted in 2016 into ‘Collaborative Commissioning’ (this relates to the collaboration of West Hampshire Clinical Commissioning Group and other Groups for the provision of Continuing Healthcare across Hampshire), which he believes was submitted to the public board meeting at West Hampshire Clinical Commissioning Group.

7. In his view, that Review in 2016 would have coincided with the Independent HASCAS Review into Edward’s death. He believes they were both produced by HASCAS. He expected it to show if the CCG imbedded lessons from Edward’s case into the commissioning of services by them.

8. As part of this Investigation I have received a Report dated February 16, 2016, co-produced by the CCG and Continuing Healthcare Service. The Report considers the outcomes of the ‘CHC Brokerage Pilot’. I do not consider this of direct significance to this Investigation and my Overall Conclusions.

9. Mr Hartley has also raised concerns with me and the CCG regarding the provision of further documents and correspondence which he believes are important for the purpose of this Investigation.

10. I have made it clear in my Overall Conclusions that at a Stage 2 Public Investigation, the CCG will be invited to give evidence of their past relationship with, and supervision of, the Trust. Those concerns may be an issue. On the present evidence, my main focus must be on the actions of the Trust.

Role of the Carer

11. Mr and Mrs Hartley expressed some reservations about the Carer's report writing and raised the fact that he was not CPR-trained. However, they have been clear that they do not blame him solely for Edward's death. As will be seen, I have formed the view that there are still unanswered questions which do need to be considered carefully which may throw further light on the death of Edward Hartley. That is what his parents seek.

12. Whilst on duty, the Carer had sight of a portable baby monitor with black-and-white night vision and a microphone. That monitor was to focus on Edward's face to allow him to see and hear Edward's movements and hear any seizures when the door was closed. Further, there is a line of sight from the 'station' to Edward's bed, estimated to be 20ft, which would have allowed him to see Edward when he was in his bed and when the door was open. His parents described how he would often appear to be purposely "bouncing on the bed" but in fact his seizures would cause his body to move significantly and uncontrollably whilst lying horizontally. They kindly provided me with a photograph of the layout of their home, including the location of Edward's bedroom and the carer 'station'. I note it is a small confined area.

13. Mr and Mrs Hartley informed me that at the time of Edward's death, it was the first school holiday where overnight support was to be provided in the home, so a routine had not been established for getting Edward up in the morning.

14. I also note the minutes of the meeting between Mr and Mrs Hartley and their Trust Pairing partner, Paula Anderson, in February 2018. In my view, there *are* outstanding questions to be answered as to the

arrangements, Risk Assessments and plans in place for the night cover that was provided to Edward Hartley on the night or early morning that he died.

Circumstances surrounding Edward's death

15. Upon receipt of advice from a Pathologist, Mr and Mrs Hartley believe that Edward suffered from a prolonged seizure or quick succession of seizures from which he did not die instantly or have the opportunity to recover. *But nobody heard or witnessed it.* I agree with the points raised in the minutes of the meeting between Mr and Mrs Hartley and Paula Anderson in February 2018. This is a key question which remains unanswered.

16. Mr and Mrs Hartley were dissatisfied with the response they received from the CCG and authors of the HASCAS Report, when they raised concerns with the Report - particularly when they expressed their view that Edward's death was *not unavoidable*. However I need to record a directly contrary position has been submitted to me, namely, that no one gave the authors themselves of the voided report sight of those concerns or the opportunity to respond. Again I do not think it is feasible or sensible to address that difference in critical terms. Rather, I have no doubt of the strength of view that Mr and Mrs Hartley have expressed to me as to the avoidabilty or otherwise of the death of their son. That is a potent reason to examine it at a Public Investigative hearing with such expert evidence as can be given to resolve it.

17. For that clear belief raises issues of fact which plainly cannot and should not be determined by a paper review. Crucial to this is when, on the available evidence, Edward Hartley is most likely to have died and why the fatal seizures were not overheard and or seen. I do not

consider those questions should remain unanswered if a careful sensitive public examination can address them, aided by expert evidence if available.

18. Mrs Hartley also expressed the view that she felt there might have been events included in the Investigation Reports for the sole purpose of avoiding legal action and to uphold Edward's right to privacy. That of course is a serious contention and I need to record that it has been denied to me in absolute terms. I do not wish to express any view at all and it would be wholly wrong to do so.

19. The concerns raised by Mr and Mrs Hartley during our meeting on August 1, 2019 echo those raised in their emails dated August 30 and August 11, 2016 in response to the HASCAS report.

Affect on the family

1. Mr and Mrs Hartley shared with me the affect that the death of Edward has had on the lives of his closest family members. Mr Hartley was a Chartered Chemical Engineer who had travelled around the world during his 32-year career. He took ten-months leave following Edward's death due to symptoms of anxiety and depression, which were diagnosed as Post Traumatic Stress Disorder and he was unable to return to work due to ill-health. He took early retirement and has not worked since that time.

2. Mrs Hartley wrote an incredibly moving email to me describing the affect of losing her son has had on her life. I thank her for that email and acknowledge that it must have been very difficult to write. Mrs Hartley provides a beautiful description of Edward during his life and the joy that he bought to her and to the rest of his family, is tangible. Her main role was as his carer and for many years she did that on her own.

3. Mrs Hartley also described to me in the most heartfelt way that looking after Edward was her life, but she never saw it as a burden. As Edward became an adult, it is clear and unsurprising that external help and support was required to provide him with 24/7 care and that it took an enormous degree of trust for Mrs Hartley to start to hand that responsibility over; but that she believed she was handing over to the professionals.

4. It is crystal clear to me that the unanswered questions Mrs Hartley still has following all the investigations that have been done in this case have prevented her from finding closure or a sense of justice.

5. The employment and educational prospects of other family members also suffered following his death and Mr and Mrs Hartley told me that their suffering is continuing.

3. Recommendations and Conclusions

1. The Reports raise a number of points which I consider require deeper examination at a Public Investigation, in order to address the issues in this case. Specifically they include the circumstances leading up to death.

2. Edward Hartley was liable to experience a large number of seizures at night and a small camera was in place which was angled so as to see him getting up but not to monitor seizures. That depended on hearing the sounds made. The question as to why the Carer did not hear the seizures which must have caused the death of Edward Hartley, sadly remains unanswered. That question of course includes the higher possibility of unexpected death with his condition.

3. **What is needed is a careful, sensitive, detached, forensic examination of the facts to consider exactly how Edward died. This should be done at a Public Investigative Hearing.**

4. Any assertion that death could not have been prevented is a critical issue to consider. It has been made absolutely clear to me by Mr and Mrs Hartley that **they do not accept that assertion**. Insofar as a careful Public Investigation may be able to throw light on that issue, it is, in my judgment, entirely appropriate to pursue it. Further, that is a process which may bring both understanding and help to Mr and Mrs Hartley.

5. Further questions arise potentially as to the training and experience of the Carer on the night in question. A further question arises as to his lack of training in life-saving techniques. That may need to be balanced with the Pathologist's view of the point of irreversible injury.

6. I have not ignored the family's compassionate views about the Carer. Nevertheless I consider that he should be invited to give evidence, as indeed should Mrs Hartley. I specifically asked her whether she would be prepared to do so in the terrible circumstances in which she found herself, attempting to save the life of her son. Without any hesitation, Mrs Hartley made it quite plain that she is prepared for that and that she does wish that to happen. Such a matter in a forensic setting can and would be handled with care and sympathy and restraint, both so far as Mrs Hartley and also the Carer are concerned. This will be a very difficult moment for both of them and certainly not a moment for an accusatorial approach. It may well be appropriate to consider such evidence should be given in private, after balancing carefully any competing public and private interest. The details of the meeting with the Carer on June 13, 2014 should be given in evidence.

7. The first Investigation - the Critical Incident Review Report - has been criticised and that criticism accepted. I completely agree and for the reasons given.

8. The second Independent Investigation, although unfortunately never finalised or published, was detailed, professional and compassionate. I do commend its analysis, depth and insight. But this unfinished report should not stand in the way of a Public Investigation of the issues I have identified. In my view, such an Investigation is a suitable vehicle for such matters to be considered on the particular facts and appropriate evidence, both expert and otherwise, should called.

9. In my view, the family of Edward Hartley have every reason to feel deeply unsatisfied and devastated by the failure over a long period to investigate and learn the lessons from the death of their son.

10. This is a case where the injustices fall within different parts of the 'Injustice Scale' in the Ombudsman's Ex Gratia Guidelines. There have been 'Material' injustices that fall within Level 4 due to the severity and impact they have had. During the investigation process there have been delays, inadequate Reports and Investigations, a lack of Communication with the family and a failure to provide updates on the implementation of Action Plans and Recommendations. These have been catastrophic and repeated failings.

11. Additionally there are outstanding questions regarding Edward Hartley's chance of survival, which must be further examined at a Public Investigation. One view is that that has the potential to be a further injustice that Mr and Mrs Hartley have suffered and the cause: the failings in care provided by the Trust and TQtwentyone. But that is not a good reason not to act on the present evidence.

12. The duration and severity of the present injustice also falls within Level 5, ‘bereavement’ (B2). That said, I emphasise that it is extremely important and fundamental not to pre-judge any fact-finding Investigation. So the right approach to any ex gratia payment is to consider the position today and not to second-guess any fact-finding to come.

13. Thus the duration of suffering in this case extends to before Edward’s Hartley’s death and is continuing today (six-years later). At this moment the Complaints remain unresolved and the family is left with unanswered questions surrounding the circumstances of their son’s death.

14. This satisfies the Level 4 criteria for a ‘prolonged injustice’ and in my view, also satisfies the criteria in Level 5, as there is no doubt in my mind that ‘recovery will take significant amounts of time’.

15. Additionally the injustice in this case goes beyond ‘ordinary’ distress or inconvenience’ and has had a ‘marked and lasting detrimental effect’: the impact on the family is immeasurable but I have heard from them directly the significant and long-lasting detrimental affects the death of Edward and the investigation process has had on their health, employment prospects and education. In this regard, there is no question that the Complaint and Investigation process has ‘taken over’ the lives of Mr and Mrs Hartley and affected their ability to live ‘a relatively normal life’.

16. The failings in regard to the Investigations clearly fall within Level 4, reserved for ‘only the very worst complaint handling cases’ where there is ‘exceptionally poor complaint handling extending over several years’. However, my recommendation for a Level 5 payment is informed by the Guidance on cases of ‘multiple injustices’, which

are present here. That would justify the payment of the sum of £5000.

17. In making that recommendation I have considered and specifically rejected the possible argument that any ex gratia award should await the result of any Public Investigation. That simply is not fair. Indeed in my view, it is positively unfair. Mr and Mrs Hartley have suffered enough already. But I would make it plain that in the light of the substantial payment which I recommend, it should not be thought that any further sum would be recommended in any event and I am sure that Mr and Mrs Hartley will understand that. They have not sought to raise with me any issue of an ex gratia payment and I have not thought it right to discuss my view with them.

4. MARION MUNNS

1. All Purpose Chronology

September 25, 1941	Birth of Marion Munns. Marion Munns lived with her husband, John Munns, in Southampton. Marion Munns had two adult daughters, Angela Mote and Kim Vella, who lived nearby. She was retired and had grandchildren. Marion Munns had a non-identical twin sister and three other siblings.
August 22, 2014	Marion Munns was admitted as an informal patient to Berrywood Ward, Western Community Hospital, Southampton. This followed a referral by Marion Munns' GP. She had become 'depressed, deteriorating rapidly in previous weeks and had been experiencing suicidal thoughts'. Marion Munns remained there until November 2014. She was under the care of a Consultant Psychiatrist. Marion Munns was diagnosed as having a 'moderate-severe depressive illness' with psychotic symptoms. She was also observed to be having auditory hallucinations and paranoid thoughts. Note. This is the only time that Marion Munns was admitted.
October 2014	Marion Munns commenced ECT treatment as she was not responding to medication and her mental health was deteriorating further (her medication dose could not be increased due to low blood pressure).

	She received ten sessions of ECT during October-November 2014. Note. Marion Munns was reluctant to agree to this course of treatment and her observation levels were increased to every fifteen-minutes. Note. During this period Marion Munns' mental state improved prior to her discharge.
November 27, 2014	Marion Munns was discharged from hospital. A Care Programme Approach ('CPA') meeting was attended by the patient, her husband and one of her daughters, the Care Coordinator and ward staff. She reported feeling "much better". Support with medication and other daily activities was offered. The Care Coordinator arranged a follow-up appointment for December 1, 2014. Note. Patient, daughters and husband were not provided with information regarding Marion Munns' diagnosis, relapse or indicators.
December 1, 2014	Marion Munns received a home visit from her Care Coordinator, and her husband was present. There were no concerns reported and the **Risk Assessment was not reviewed**. Note. This was more than 48-hours after discharge.
December 11, 2014	Marion Munns had a home visit by her Care Coordinator with her husband present. No changes were identified and the records show that she presented as 'well'.

	Note. **A formal Care Plan document was not put in place.**
December 19, 2014	Marion Munns was seen by an Older Persons Consultant for a review.
January 16, 2015	Home visit by the Care Coordinator and another Community Mental Health Nurse. No changes or concerns were identified.
February 19, 2015	Marion Munns was seen by Consultant 5. At this review it was considered that Marion Munns was 'in remission' and would need to stay on her current medication regime for at least two years. The transfer of the Care Coordinator role took place from a Mental Health Practitioner to Consultant 5. Note. The Risk Summary was updated to state: 'no suicidal ideation or plans'.
March 23, 2015	Marion Munns contacted the Community Mental Health Service regarding symptoms from her medication. Note. Her family were unaware of this at the time.
April 24, 2015	The GP wrote to Consultant 5, with concern as to Marion Munns' mental state, who then called the patient's daughter.

April 27, 2015	The Community Mental Health Service received a letter from the GP of Marion Munns, requesting that they review her anxiety symptoms. An appointment was arranged for May 19, 2015.
May 19, 2015	It was reported that Marion Munns had had a ‘blip’ due to an infection and was ‘feeling a little bit anxious’. However no major risk issues were identified and her depression was said to be in remission. Marion Munns was discharged by the Community Mental Health Team back to Primary Care (GP). Note. Marion Munns’ daughters say they were never told she had been discharged.
June - July 2015	Marion Munns’ daughters again had concerns about their mother’s mental health, arising from her behaviour and her lack of engagement. When Mrs Mote contacted the ward, there was a policy in place to see patients again who had been previously referred. However some staff were not aware of this. That included staff to whom Mrs Mote spoke. Mrs Mote set out her concerns and was told to contact the GP. However there was then a wait of three weeks before an appointment with a GP could be obtained.
August 20, 2015	Marion Munns attended an appointment with her GP, where blood tests were done. Her daughters were present. A referral was requested back to the Community Mental Health Team, as Marion Munns was not getting up or getting dressed. Marion Munns agreed reluctantly to this referral.

August 24, 2015	The Community Mental Health Team received the **Second Referral** of Marion Munns by her GP, following her daughters reporting their concerns. Consultant 5 telephoned Marion Munns, who reported no suicidal ideation and that she didn't feel the need to see the Community Mental Health Team and she informed her GP. Note. Consultant 5 received a call from one of Marion Munns' daughters later that day expressing concern about her mother's mental health. Marion Munns was then given an appointment for August 28, 2015, Note. The patient had a psychogenic polydipsia history. When she had been admitted, she had presented mixed behaviour on the ward - in the context of being significantly depressed and then not being depressed.
August 28, 2015	Marion Munns was accompanied by her daughter to an appointment with Consultant 5. No suicidal ideation or other concerns were identified. The Plan was to review Marion Munns in six weeks. Mrs Mote did not have the opportunity to discuss matters in the absence of her mother.
August 30, 2015 and the Bank Holiday weekend.	Mrs Munns showed signs of disturbed behaviour at the home of her daughter, Mrs Mote, which included talking to herself in the mirror. Mrs Mote tried to make urgent contact by email with Consultant 5, but to no avail.

September 1, 2015	Marion Munns was discussed by the Community Mental Health Team at their Multi Disciplinary Team ('MDT') meeting. Consultant 5 spoke to the Team Psychologist to see whether they could be involved with care, but they had no capacity to provide it. Note. The chronology in the prepared records indicates that 'a member of the Multi-Disciplinary Team remembered that when Marion Munns was a patient in Berrywood ward and was unwell, she often seemed well. But at the same time, she would display 'off behaviours' or say 'odd ideas' that she had about people. Consultant 5 tried to contact one of the daughters who had emailed her and requested that she called the duty service.
September 2, 2015	Consultant 5 told Marion Munns and one of her daughters that her medication would be increased and the Community Mental Health Team would provide more input with a Healthcare Support Worker and Community Mental Health Worker. The daughter mentioned Marion Munns' husband's concerns about her. Note. Neither Mrs Mote nor Mrs Vella recalls this telephone call.
September 3, 2015	Consultant 5 called at Marion Munns' house, accompanied by a Health Care Support Worker from the Community Mental Health Team. Marion Munns was not at home.

September 8, 2015	The family of Marion Munns expressed concern that the Community Mental Health Team were not responding to concerns quickly enough and that Marion Munns' husband was finding it difficult to cope. An appointment was made for a medical review.
September 9, 2015	One of the daughters spoke with a health care support worker within the Community Mental Health Team, who then spoke with the duty nurse. They both went out to the patient's home to assess Marion Munns. But no one was there. Both daughters raised concerns about Marion Munns' behaviours again and that her husband was struggling to cope.
September 11, 2015	A Clinic Psychiatric Review meeting was attended by Marion Munns, her husband and Mrs Vella. Marion Munns was assessed as having a deterioration in mental state but that she would not meet the criteria for an informal admission or detention under the Mental Health Act 1983 at this time. A plan for engagement with the Care Coordinator and Health Care Support Worker were put in place. Visits to Marion Munns were to be twice a week, but no staff were available until September 23, 2015.
September 17, 2015	The Community Mental Health Team updated the risk to 'Amber' on the Team Acuity Board, so that all Team members were aware when responding to concerns raised.
September 23, 2015	Marion Munns was visited at home by the Care Coordinator. Her husband was present and reported his concerns, which Marion Munns denied as 'strange'. This was recorded and a follow-up visit was scheduled for one week later.

September 30, 2015	Mrs Munns was visited at home again. Marion Munns' husband was present and again reported his concerns. Records indicate that the next review was scheduled for one month later at the request of Marion Munns. An appointment with Consultant 5 was cancelled on behalf of Mrs Munns. This followed a call from the Care Coordinator, as it was felt that it was no longer required.
October 15, 2015	The Care Coordinator role was transferred from Consultant 5. However Consultant 5 did retain responsibility for the overall care of Marion Munns. This change reflected Marion Munns' increasing support needs. Note. Mrs Mote and Mrs Vella say they were not told about this and the Care Coordinator herself said she was not made aware of this until she saw the note in RiO.
October 30, 2015	Telephone conversation between the Care Coordinator and Mrs Vella recorded on the Rio notes. Monitoring of Marion Munns to continue.
November 4, 2015	Visit at home by the Care Coordinator and a Health Care Support Worker. Marion Munns denied any problems.
November 8, 2015	At the home of her daughter Mrs Vella, Marion Munns was dressed in an inappropriate summer clothing and sandals, and was **'in overdrive, just ranting.'**

November 9, 2015	A voice message was left on the Community Mental Health Team answerphone reporting **a significant deterioration in Marion Munns state of mind over the weekend and reported she had gone "into overdrive"**. Note. The Coroner found this message was left on November 10, 2015. This conflicts with Mrs Mote's recollection of the fact that she left a voicemail message on November 9, 2015. She is certain of this.
November 10, 2015	The Care Coordinator telephoned Mrs Mote, who repeated her concerns about her mother.
November 11, 2015	***Day before the Death of Mrs Munns.*** ***[Note. This is a <u>Summary</u> of Events].*** Mrs Mote is sure that she called the Care Coordinator, in the evening on this date leaving the same message that she said she had left on November 9, 2015 (see above. Rio records indicate that the Care Coordinator attempted to contact Mrs Mote and Mrs Vella that afternoon, but was unable to get in touch. Mrs Mote recalls the Care Coordinator informing her of that contact. Community 5 was not working clinically that day and the Care Coordinator sought advice from a Locum Consultant in Old Age Psychiatry regarding Marion Munns' medication. He advised that it should change. The Care Coordinator arranged to attend Marion Munns' home with the medication.

	At 15:30, the Care Coordinator attended Marion Munns' home. She recorded "there were no new identifiable risks, but Marion did not seem herself." Mrs Mote recalls at the Inquest it was said that her mother had shoved back her medication and was aggressive. It was concluded: "Marion would not have met the criteria for detention under the Mental Health Act at this point if an assessment was undertaken". This was the day before her death.
November 12, 2015	***Death of Marion Munns aged 74.*** ***[Note. This is a Summary of events]*** At 16:00 there was a request to the Care Coordinator from the family of Marion Munns asking for help and leaving messages. A call was made by the Care Coordinator to the Approved Mental Health Practitioner from Southampton Social Services who said that she would be assessed at the hospital, as an ambulance had been called. At approximately 16:30, during the time the Care Coordinator was making this call, Marion Munns went missing. At 16:40 a second call was made by Marion Munns' family for help. **18:10. Marion Munns died.**

	Marion Munns fell from a motorway bridge. It is unclear as to how this happened and there were no witnesses. Note. This followed Marion Munns driving in a chaotic and disturbed manner and then leaving home on foot. The motorway bridge from which she fell was a mile or so away.
November 13, 2015	The family of Marion Munns informed the Community Mental Health Team of her death. The Care Coordinator recorded that this was the first she knew of Marion Munns leaving the house and thus of her death.
November 19, 2015	Start of a Root Cause Analysis Investigation Report.
January 11, 2016	**Root Cause Analysis Investigation Report** prepared by the Head of Nursing and Allied Health Professionals ('AHPs') at the Trust. Note. Marion Munns' daughters say they had no warning of the findings in this Report and that there were errors and inaccuracies in the Report, which were upsetting. For example, the way in which Marion Munns died and the location.
January 18, 2016	Mrs Mote and Mrs Vella met with the Divisional Head of Nursing and AHPs and the Integrated Service Older Peoples Mental Health ('OPMH') matron to go over the draft Investigation Report.
February 9, 2016	The Response Risks Summary was updated.

February 23, 2016	A letter was sent to Marion Munns' daughters from Katrina Percy, Chief Executive Officer of the Trust, **apologising** and informing them that a 'HR investigation' had commenced and offering a meeting. **"your mother's death could have been prevented and I am deeply sorry that we failed her".**
March 9, 2016	Meeting of Mrs Mote, her husband and Mrs Vella with the Doctor 2. At the meeting, it is asserted by family members that inappropriate comments were made by Doctor 2. Note. Mrs Mote does not believe that Doctor 2 has been held accountable for these comments.
June 1, 2016	A Pre-Inquest Review meeting was held with the Coroner, which involved Trust officers and family members. An allegation was made by the family to the Care Quality Commission that Doctor 2 had acted unprofessionally by making inappropriate comments at a previous meeting. The Care Quality Commission ('CQC') were concerned with initiating a complaint against Doctor 2 and requesting that it was independent.
June, 2016	Reports to the Coroner came from the Care Coordinator, Consultant 5, Doctor 2 and a Health Care Support Worker.
July 22, 2016	The Capsticks Investigator sent the draft Report to the Trust, who took two months after that to review it.

	Note. The Ombudsman said that was within the timescale of the appropriate regulations.
September 2016	**Capsticks Investigative Report.**
October 24 - 26, 2016	**Inquest** **A Narrative Verdict was delivered with ’13 failings’ identified.** The on-call Consultant on the night that Marion Munns died, attended the Inquest as an observer, but did not give evidence, and also spoke to the family. Note 1**.** The alleged actions and interaction of Trust representatives with the family at the Inquest gave rise to concerns amongst family members. That is not a matter than can be investigated and determined by this Report. But it is plain that the family were and remain very upset. Note 2. Prior to the Inquest, the Trust made an admission of liability and an award of compensation was made. That is not part of the remit of this Report. Note 3. A limited document following the Inquest was posted on the Southern Health NHS Foundation Trust public webpage. I have been informed that in fact it was an excerpt from a weekly message to staff from the interim Chief Executive Officer. However, by omission of errors made by the Trust, it caused offence on a public website to the family of Marion Munns. The family felt that the picture it painted was incomplete and misleading. The message was removed a few days later.

November 10, 2016	Letter to Mrs Mote and Mrs Vella from Julie Dawes, acting Interim Chief Executive of the Trust. It responded to questions previously raised about the alleged conduct and alleged inappropriate, unprofessional comments made by Doctor 2. A number of further letters were sent by Julie Dawes, as interim Chief Executive of the Trust between September 2016 and February 2017.
January 30, 2017	A **Review** of the Trust's handling on paper of Mrs Mote and Mrs Vella's Complaint was carried out by a representative of Ideas4Use. **21 recommendations** were made. Note. Mrs Mote was contacted by telephone by the Investigator for a '10 minute interview' for the purpose of that Report.
February 24, 2017	Letter from the Trust from Julie Dawes to Mrs Mote responding to her email dated February 6, 2017. **Apologies** were made to Mrs Mote regarding the way **the Trust communicated with the family.** Julie Dawes responded to Mrs Mote's concerns about the comments of Doctor 2 and the way they had been investigated: *"I am afraid with two investigations now having looked at this I don't believe there is anything further that can be done that will lead to different findings".*

March 13, 2017	Email of Julie Dawes to Mrs Mote. **“I am sincerely sorry that we have not been able to resolve all of your concerns”.** Also an offer of compensation was made to Mrs Mote and Mrs Vella.
November 13, 2017 – April 2019	There were a number of group meetings hosted by the Trust that the family attended.
January 18, 2019	A letter to Mrs Vella **apologising** for the way the feedback was handled into the report of Marion Munns’ death and **the way the investigation process was conducted by the Trust.** Note. Mrs Vella said this was unprompted and Mrs Mote described it as worsening the situation.
August 19, 2019	Meeting with Mrs Mote and Mrs Vella for the purpose of this Report. Details were given of the affect of these prolonged proceedings, which are set out below.
November 4, 2019	Further meeting with Mrs Mote for the purpose of this Investigation.

2. Complaints and Investigations

Root Cause Analysis – Investigation Report dated March 11, 2016

Findings

1. The Report made a number of findings where the care and treatment of Marion Munns by the Community Mental Health Team and Care Coordinator fell far below the standard expected and in some places was in breach of Trust policies. The Report summarised these in the form of primary and secondary root causes.

Primary Root Causes

2. The family of Marion Munns were not given clear advice on whom to contact in an emergency or a crisis situation. This should have been captured in a crisis/contingency plan at the point of discharge from hospital and reviewed at each contact.

3. No out of hours service was available for a crisis situation.

4. The message from the family on the day of the fatal incident was not communicated in a timely manner to the Care Coordinator.

5. On the day of the incident when the Community Mental Health Team were informed that there *was* a crisis, they did not telephone for medical advice and speak to a Doctor from within the Team.

Secondary Root Causes

6. The Community Mental Health Team did not monitor adequately and document the effectiveness of the anti-psychotic medication or compliance with the prescribed dose, after the medication had been increased to treat presenting psychotic symptoms.

7. A Care Plan with the level and intensity of support required to engage effectively was not implemented at the time it was required. Further, the home visits were not undertaken frequently enough to meet the care needs and monitor the risks identified.

8. The Community Mental Health Team **did not recognise or respond adequately to the risks** presented by the patient in the month preceding the incident and the day before the incident.

Lessons Learned

9. All teams must ensure there is adequate administrative cover to ensure that telephones are answered and not left to an answer phone.

10. Crisis and contingency plans must be clear and developed with the patient and the family/carer.

11. There should be communication methods and frequency agreed with the patient and the family, as well as key contacts.

12. There is a need to review the role of the Mental Health Practitioners within the Trust. That includes their clinical supervision structure and development opportunities.

Recommendations

13. The Recommendations included,
    - Development of an acute Care Pathway for older patients in collaboration with the Acute Mental Health Team for Adult Mental Health, so that crisis care required can be extended out of hours, if required.
    - Development of the team acuity board, so that it is reviewed by

the staff member on duty daily to monitor those presenting with higher risk, with an agreement regarding appropriate actions.

- Ensure staff in the Community Mental Health Team and the inpatient units are aware of the fast track re-referral process to the Community Mental Health Team for patients who are discharged to Primary Care. Ensure patients know on discharge of the re-engagement plan.
- Facilitate a reflective learning session with the Community Mental Health Team to discuss the learning from this Investigation to ensure the Team change practice.
- Increase awareness and understanding within Older People's Mental Health Service of the Care Programme Approach ('CPA') framework and develop comprehensive care planning; that included a review of all caseloads to ensure patients are on the appropriate level of CPA. Ensure all patients who meet the criteria are on CPA.
- All staff to receive training around reviewing and documenting Risk Assessment in line with Trust Policy requirements and check documentation of Risk Assessment in supervision.
- Regular audit of documentation to ensure compliance must take place.
- Review the frequency of monitoring of Care Plans and risk management plans for those subject to CPA and presenting with risk indicators of relapse at the weekly multidisciplinary team meeting.
- Staff to monitor and document in the clinical records evidence of compliance with medicines prescribed and evidence of effectiveness when there have been changes to the dose.
- Review local partnership arrangements and jointly agreed local policy between Mental Health Services, Police, Ambulance Services, Commissioners and the Local Authority to deal with people experiencing mental health crisis.
- Review arrangements for telephone with the Community Mental

Health Team so that messages are communicated, phones answered and service users and their families are provided with information of how to make contact.

- Review the individual practice of all staff involved in the care of P1 – Marion Munns.
- Complete an emergency peer review of the Team.
- Review the culture and behaviour of the Team.
- Review the care records of all current patients on the Team c

My Conclusions on the Root Cause Analysis

14. The summary of events leading to the death of Marion Munns is deeply concerning. It is clear that there were significant failings and missed opportunities by the Care Coordinator and Community Mental Health Team in relation to the care provided to Marion Munns and also in the support for her family. In that picture, **it needs to be stressed in the clearest terms that the family of Marion Munns throughout were trying repeatedly to get help and to raise the alarm. They were let down badly and so was their mother.**

15. The views of Marion Munns' daughters were incorporated into this Report and they were engaged in the process through meetings.

16. I consider that the detailed and wide-ranging recommendations are a proper recognition of the gravity of the mistakes made in this case and should be recognised as genuine attempts to prevent their repetition.

17. The Report includes 'action already taken' and this also should be welcomed.

18. The Report contains recommended actions which require prompt implementation to prevent future tragedies. Action Plans were created

and presented. The issue that remains is a precise picture of the extent of their full or partial implementation today, four years after the death of Marion Munns.

19. Accordingly the Trust needs to set out in a public document precisely what changes have been made in response to the Report and what remains to be done.

20. That said, I endorse all of the recommendations made in the Report.

Capsticks Report, dated July 2016

1. Three specific areas of concern were raised by Marion Munns' family and investigated, following a Complaint by them,
    - The investigation process to check alignment with Southern Health NHS Foundation Trust Policy and National Guidance.
    - Whether the Trust Investigators followed Policies and Procedures and whether the processes aligned to National Guidance.
    - Comments recorded in the Board Meeting minutes which the family feel misrepresent the actions of the Trust and alleged unprofessional comments by Doctor 2 during a meeting with the family.

Findings

2. The Investigation overall found no evidence of professional misconduct by Doctor 2, but made suggestions as to how Doctor 2 could have improved his communications with the family at this meeting.

3. The Investigation found that there had been a long discussion about this incident at the private board meeting in February 2016. However it noted that the minutes of that meeting and others were not

disclosed to the Investigator. This finding of non-disclosure is a matter of dispute by Marion Munns' family.

4. The Report recorded that the key policies regarding support and guidance following incidents such as this had all been updated since the accident and that "the investigation has been tightened up since this incident occurred. Accordingly the experience of the family in this instance is likely to have fallen short of expectations... [and] had been poor".

5. The Investigation found failings in the approach taken by the Trust following Marion Munns' death, in particular with their engagement and communication with the family and the Investigatory process.

Recommendations

6. There were a number of recommendations made,

   - A **dedicated, independent team, or specialist family liaison contact**, skilled in dealing with bereaved families; advice to be sought from this contact before any meetings with the family; an agenda and key messages for the family should be prepared for these meetings; and a 'neutral colleague' should accompany a Trust officer to 'particularly sensitive meetings' with the family.
   - Investigators should have sufficient seniority, knowledge, training and personal qualities; the **investigation process should be more transparent** with the early dissemination of more, clearer, information to families.
   - More transparency regarding the types of professionals and allied health professionals who care for patients across the Trust.
   - Training in investigatory report writing and quality controls.
   - An investigation as to whether the Consultant responsible for Marion Munns' care had seen the draft Investigation Report before the family had had an opportunity to check their accounts, which would have been in breach of the Trust's data governance policies.

- The investigatory process should be explained to families in some detail at an early stage.
- There should be a review of communication between GPs and the Community Mental Health Team.

My Conclusions on the Capsticks Report

7. Family members were interviewed and thus engaged in this Investigation.

8. The Investigator was not provided with minutes of all of the Board meetings that took place. Those minutes were required to consider and to address fully the family's Complaint and concerns. But the Capsticks Report fails to reach a conclusion or finding in regard to this point. I understand this is an outstanding issue for Mrs Mote and that she feels it is has not been adequately addressed by the Trust.

9. The Capsticks Report was commissioned by the Trust. Capsticks have also been engaged to act as their legal advisors on other occasions. As I have indicated already, *perception* of independence is critical in the investigation of these tragic deaths. In the circumstances surrounding Marion Munns' death, again the question of that necessary perception arises.

10. However that should not obscure the fact that this Report does make some very appropriate and sensible recommendations, which are summarised above and which I commend completely. For example, the need for a **transparent investigation process** and for a **dedicated and independent Family Liaison Officer**. These are matters that I have recommended form part of a Public Investigation.

11. The Report states that the initial Investigation into Marion Munns' death had been carried out under an old investigation process and

says that they were told that at the time of her death **"the Trust could not be sure that the investigation officers were always qualified to carry out investigations".** This is a real cause for concern. However I have received and identified some Trust policies in this regard and they must now be tested for their effectiveness and this must not be repeated in the future.

12. I specifically agree with the Investigator's recommendation that at the time there should have been further investigation into whether the responsible Consultant had had sight of the evidence from the investigation before the Report had been completed. If there had not been an inquiry, this would have compromised the independence of the Investigation and would have constituted a serious breach of Trust policy.

13. The transparency of the Board meetings held by the Trust surrounding Marion Munns' death remains a matter of real concern and distress to Marion Munns' family. However, I note that the Trust have sought to address that issue.

Report of Ideas 4 Use dated January 30, 2017

1. Ideas 4 Use were commissioned by the Trust to review Mrs Mote and Mrs Vella's Complaint.

2. The methodology refers to this as a 'desktop review' and the terms of reference do not cover the investigation into Marion Munns' death.

Findings

3. The findings were,

   - No findings of serious misconduct or unprofessionalism should be made against Doctor 2.

- An email with the content of the statement by the Interim Chief Executive for the Board Meeting was located by the Investigative Team. It is acknowledged that it is “a pity” it was not found sooner, but that an apology to the family had been made in the Report to the Board on November 29, 2016.
- The Trust has made a number of attempts to answer parts of the Complaint elements raised by the family and offered apologies.
- The Report identified **twenty-nine individual elements** of the Complaint which the family feel have not been fully answered or not answered to their satisfaction.

Recommendations

4. There are **twenty-one recommendations** made in this Report. I will summarise some of them for the purpose of this Report,
    - The Trust should respond to complaints in one document. The time frame should be agreed with the family.
    - The Trust should **implement a rigid system of moving from complaint/Serious Incident learning to implementation**.
    - There needs to be **improved communications and involvement** of the people making complaints.
    - There should be reform of the processes for meetings and the way they are conducted.
    - Where there is a death or serious harm, consideration should be given to the need for an **external Independent Investigator**.
    - An explanation of the structure of the Trust should be provided to the family immediately, if it has not taken place already.
    - There should be one person at the Trust who deals with the person who made the complaint.
    - Trusts should work together to ensure independent counselling support is available to family members.
    - The Trust should look at a range of training.

- The **time it takes to respond to complaints needs to be shortened**.

My Conclusions on the Report

5. It is fair and necessary to recognise that the recommendations summarised above are both sensible and also likely to alleviate future crises. In that respect, I welcome those recommendations.

6. However in my view there are aspects of this Investigation which need to be addressed, albeit in a nuanced way.

7. The daughter of Marion Munns', Mrs Mote, was engaged in the Investigation by way of a telephone call on November 28, 2016. But the call was very short (approximately ten-minutes), so that their input was, in relative terms, minimal.

8. The author of the Report is critical of the family's solicitors. I do not think that was a necessary feature.

9. I note that the author reports that Doctor 2 himself agreed that it would have been better if he had not used the examples of his own life experiences or referred to the media and legal representation in a meeting with Marion Munns' daughters. I agree.

10. The author of the Report further finds that the Investigator for Capsticks has not justified his finding that there was 'no evidence of professional misconduct'.

11. In light of those views and findings, it may be thought that the position of Doctor 2 remains an outstanding issue to be resolved in this case. I think it is important to grasp the nettle and to do so fairly. Alleged inappropriate comments may or may not have been a matter for the relevant Regulator. I do not consider that it is helpful now to re-

investigate the issue for a further time. Nor is it an issue in itself which warrants public scrutiny.

12. One contentious issue concerned a meeting between Doctor 2 and family members. Mrs Mote and Mrs Vella did not want Katrina Percy to attend and she did not do so.

13. The author of the Report acknowledges that there have been multiple apologies to Marion Munns' family by the Trust, which has effectively "diluted" their genuineness. I agree with this analysis.

14. However the tone of this Report is not always sympathetic towards the family. It is not surprising that the family is concerned as to its independence. I agree with Mrs Mote in her response to the Report, that the use of the term "reflective" was inappropriate and would have been insulting to the family.

15. I have reviewed Mrs Mote's response to the Report by Ideas4Use, dated February 6, 2017, and the issues raised resonate with the complaints she still has today. It is clear that the Investigator's Report included inaccuracies that could have been prevented by way of further engagement with the family and it failed to address all of the family's concerns. It is evident that, once again, the family was left disappointed and unsatisfied by an investigation.

Ombudsman decision dated January 9, 2018

1. The Ombudsman informed Marion Munns' family that they were discontinuing the Investigation of Mrs Mote's Complaint and referring the issues to a senior manager at the CQC.

2. Mrs Mote's Complaint was about the way the Trust interacted with her and her family during its internal Investigation and the Coroner's Inquest; the adequacy of the Action Plan the Trust produced in

response to her mother's death; the information relating to her mother's death included by the Trust in a Board Report and on its website and the timescale for sharing the Report of one of the Independent Investigations commissioned by the Trust.

3. Mrs Mote was seeking evidence of service improvements and practice and compensation.

Ombudsman's Reasons

4. The Ombudsman's reasons for discontinuing the Complaint were,

    - We cannot establish whether staff's behaviour fell so far short of the standard expected that it amounted to service failure or maladministration, as we were not there at the time.
    - It is unlikely we would recommend the amount of compensation Mrs Mote is seeking.
    - The Trust has taken demonstrable steps to put right the Complaint about the Board Report and website by apologising, providing explanations, making amendments and removing information. The Ombudsman could not achieve any more.
    - The Capsticks Report was prepared within the timescale of the relevant Regulations and expectations set from the outset.
    - The CQC and not the Ombudsman are better placed to provide assurances to Mrs Mote about sustained improvements in the Trust.

My Conclusions on the Ombudsman decision

5. I note that the Ombudsman decided not to pursue Mrs Mote's Complaint. I am informed by the Ombudsman that the reasons for this were given to Mrs Mote in a telephone call in December 2017 linked to issues of compensation. I do not consider that the details require closer analysis in considering the report of the Ombudsman.

6. Mrs Mote had already communicated with the CQC, the body responsible for monitoring, inspecting and regulating services' about her Complaints and not received a satisfactory resolution.
7. However I understand that ultimately it was the role of the CQC rather than the Ombudsman to consider whether change had been embedded in NHS trusts as part of its regulatory function. This was explained by letter when the Ombudsman was discontinuing the investigation. Accepting that to be the case, I can still understand fully just how frustrating it would have been for Mrs Mote and the family.

Trust Pairing

1. This Trust Pairing was unsuccessful and due to concerns regarding the independence of their chosen Trust representative, Hazel Nichols, Mrs Mote and Mrs Vella felt unable to continue with the meetings.

2. I acknowledge some work was done by Hazel Nichols to make progress with their concerns. But once the pairing broke down, it is a matter of regret that an alternative Trust Pairing did not come into effect, notwithstanding efforts and contacts to achieve that. It is not necessary to examine why exactly that did not occur. But it is difficult not to see it as a missed opportunity to consider and address unanswered questions.

3. Views of Relatives

1. I met with Mrs Vella and Mrs Mote for this Report. They brought great insight into their mother's illness and the unsatisfactory level of care that she received from the NHS, as her illness deteriorated. They were very clear that the circumstances that led to her tragic death should not be subject to further examination. This is not a case where the facts of death need to be considered at a Public Investigation

hearing. But they were adamant that there are still questions to be answered by the Trust and matters that call for further investigation.

2. I intend to summarise Mrs Vella and Mrs Mote's complaints and will focus upon those most relevant to this Report and my terms of reference. Their complaints include,

    - The adequacy and content of the Action Plan promulgated by the Trust in response to Marion Munns' death.
    - The inappropriateness and insensitivity with which the Trust communicated with Marion Munns' family during the investigative process, including surrounding the Inquest.
    - The quality of the Investigative process for the Serious Incident Report.
    - The independence, and thus inappropriateness, of Capsticks being appointed to carry out the Independent Investigation.
    - The level of distress and mistrust caused by the Trust's current investigative process – they voiced a need for a "cultural shift" in the way the Trust communicates and deals with families following a death.
    - The adequacy of the care and treatment received by Marion Munns and her family on the day of her death.

3. I then met with Mrs Mote on a further occasion and she reiterated the shared concerns set out above. Mrs Mote was deeply concerned by what the family considered as inappropriate communication and behaviour at the Inquest, which was on top of their needing to deal with the process of grieving.

4. That is not a matter on which I can comment without hearing evidence from all concerned, save that an Inquest can be a very disturbing experience for family members. That reality should never be forgotten by all who attend, where unconsidered behaviour may be seen as deeply insensitive to family members.

5. I also discussed the possibility of a new Inquest with Mrs Mote and I am in no doubt that she understands that first, it is very unlikely that a new Inquest would be granted and second, an alternative verdict is improbable.

6. In our second meeting Mrs Mote also raised her concerns about the fact that there appears to have been **no Care Plans or Risk Assessments** carried out with Marion Munns. In this regard, it is clear that there were multiple failings by the Trust to follow policies. I have recommended these issues be considered as policy issues in a Stage 2 Public Investigation.

Affects on family

1. I have been informed that Mr Munns, Mrs Vella, Mrs Mote and their families have been separately but equally affected. I am satisfied there have been personal, educational and health implications which flow directly from the mishandling of this case by the Trust. Those implications are plainly not just the traumatic fact of the death of Marion Munns.

2. Mrs Mote and Mrs Vella have told me that they both asked the Trust for psychological support following the death of their mother. Whilst efforts were made by the Trust in this respect, Mrs Mote and Mrs Vella were both dissatisfied with the service and options they were given and have expressed their surprise and concern that a more accessible and appropriate **counselling service** is not in place for bereaved family members. I share their concerns and strongly encourage the Trust to give this further serious consideration.

4. Recommendations

1. I do not recommend a Public Investigation into the facts of this case. But there are policy issues, summarised in my Overall Conclusions,

which are common with the concerns of other families. They should form part of a limited Public Investigation.

2. I recommend an ex gratia payment is made in the order of £1750 to the family of Marion Munns. That is made on the strict basis of a careful consideration of the Ombudsman's Guidelines on Ex Gratia payments.

5. Conclusions

1. The decision to not recommend a Public Investigation on the facts of death does not detract from the seriousness of the outstanding matters identified by Marion Munns' family as part of this Report.

2. That includes issues of concern to family members at the Inquest. Such matters require responsible human communication *throughout,* particularly at a time of stress. In so far as the family consider this did not happen, it is plain to me that significant distress and mistrust followed. Again I do not seek to adjudicate in the absence of evidence from all sides. I also do not think that needs now to be elevated into an issue for a Public Investigation.

3. There is, however, a clear need for a Public Investigation to consider the need for and mechanism of a **new robust and Independent Investigative process,** evidenced here by the **prolonged and painful process** experienced by the family of Marion Munns. I have no doubt that the **significant delays** in this case have been unacceptable and the damage caused by that should not be underestimated.

4. There have been independent, external investigations into the death of Marion Munns, and as I have indicated, aspects of the Capsticks Report are both valuable and sensible and should be implemented.

5. The Ombudsman's independent decision not to take matters further is a matter of regret. However it certainly does not change my view at all on the appropriateness and desirability of an appropriate ex gratia payment in this case.

6. I have learnt with deep concern of the injustices that Marion Munns' family has suffered, caused by the failings and poor Complaint Handling and Investigations in this case. There have been a number of occasions where the Trust's Communication with the family has been distressing and insensitive. This has added to the significant hurt and mistrust the family has experienced throughout the investigative process.

7. There have been multiple episodes of failings in this case. My recommendation falls within Level 4 of the 'Injustice Scale' in the Ombudsman's Ex Gratia Guidelines.

8. In considering the level of injustice and 'typology category', I have taken into account the severity and impact on Marion Munns' family. I am in no doubt that the significant and prolonged delay in resolving their Complaints (four-years) has affected the family's ability to find closure and their ability to live a 'relatively normal life to some extent'. In my view, an injustice that extends four years after the death of a patient amounts to 'prolonged', particularly given that the Guidance refers to 'exceptionally poor complaint handling extending over several years'. In this regard, I am struck by Mrs Mote's letter in 2017 listing "48 complaints" about the Trust. This plainly falls into the 'Material' category in Level 4. It is for these reasons that I have recommended a payment in the middle of this bracket. The figure under those guidelines is a modest one and it is open to the Trust to consider it as they think fit.

9. The affects on the family have been far-reaching and significant. It is clear that the injustice they have suffered goes beyond 'ordinary distress or inconvenience', particularly given some of the

inappropriate and ill-judged comments made by the Trust in their communications with the family.

10. On the basis of my analysis of this case strictly within the Guidelines, I would recommend a payment to the family at the mid-range of Level 4, in the sum of £1750.

Views of Southern Health Foundation Trust ('the Trust')

1. In preparing this Report, I met with five senior representatives of the Trust: Dr Nick Broughton (the Chief Executive Officer), Helen Ludford, (then Associate Director Quality Governance), Paula Hull, (Director of Nursing and Allied Health Professionals) Dawn Buck, (Head of Patient and Public Engagement and Patient Experience) and Briony Cooper (Programme Lead Quality Governance). It was vital to obtain their views, particularly where there appears to me to be outstanding issues. By that, I mean policy changes which demand further scrutiny. As with the families, I will not set out all of the matters discussed, but give a summary of the topics and of the information that the Trust shared with me.

2. However it is right to record that, as with the families, all who attended gave me helpful and constructive answers. At no point was there any attempt to avoid blame or to blur the issues raised.

3. It was also plain that, despite their help, those present were not in a position to respond fully to some of the issues which I consider outstanding. But I met experienced professional members, who indicated awareness of the legacy of past failures and I am grateful for their responses.

4. I also bear in mind fully the fundamental changes in the Trust's composition, following very serious published reports and critical public responses. Thus I understand that none of the Board members held executive or non-executive level positions at the time of the deaths which I am considering. Change has included lay representation on the interview panels for a number of new roles.

5. The general picture that emerged from these discussions was of an expressed desire to put into effect a sea change in the culture and spirit of the Trust. That was combined with some submissions that a

number of real and important changes have taken place already. That requires some detached analysis.

6. Again in general terms, plainly some lessons have been learnt from these tragic deaths. This is an Independent Investigation and it is right to record that, in my view, the Trust plainly has sought to move forward from the way it dealt with serious incidents and mortality in 2011. **Appendix C** in this Report carries first a list of new clinical and non-clinical policies introduced since the first death I have been considering in October 2011. Secondly it has a helpful summary of changes to working practices following Serious Investigations into deaths. Both of those documents need to be given proper weight in making a reasonable judgment on this key issue. Broadly, the matters summarised in both documents do support the view I have formed of an improving process, albeit one that is still in need of scrutiny. I also see some evidence of change in the minutes of meetings between the Trust and family members.

7. Frankly, that recognition is necessary, because all the families have very grave suspicions about the real desire of the new management to promote change. The feelings of being constantly fobbed off or ignored are still very strong and it seems to me essential that an independent view should make that plain to all.

8. Thus, notwithstanding some positive changes, I am firmly of the view that a Public Investigation must now hear evidence from persons in the Trust who can speak precisely on the issues that I have set out in my Overall Conclusions. Clarity and precision will be essential, so far as that is possible. It will be for the Trust to decide who is in the best position to provide that evidence.

Delays in Investigations and Complaint Handling

9. I was informed that the Serious Incident and Mortality Investigative processes that were implemented by the Trust in 2015 are robust and truly embedded in their systems and training.

10. The notification functions and monitoring reduces the risk of delays and ensures compliance. Thus, where it would have once been a clinician carrying out the investigations in addition to their busy practice, now there are dedicated investigation officers and panels, who are all trained and qualified to be carrying out the work.

11. Therefore if these deaths were to occur today, I was told that qualified and skilled individuals would carry out the investigation process without the extraordinary and unacceptable delays that these families faced.

12. I was disappointed to learn that Complaint Handling within the Trust has not yet received full rigorous scrutiny and improvement. I understand there is some work being done with some objective improvements. But in my view, it should be a priority for the Trust as it goes forward to a better place. This is an issue for careful detached examination at a Public Investigative hearing.

Communication

13. It is clear that the Trust have recognised that their Communications with patients, families and carers has, in the past, fallen below the standards expected. I am told that the introduction and appointment of a **Family Liaison Officer**, who is independent of the Investigations Team and has relevant experience, will work with a family or carer throughout the Complaints or Investigation process. Their focus is on building better relationships and communicating more effectively in order to reduce the likelihood of problems arising early on or the need for a complaint. That is an important improvement.

14. I was told that this has been embedded in the culture and systems at the Trust, as the officer has an active caseload and has had positive results.

15. However, further evidence of this development should be forthcoming at a Public Investigation. The public are entitled to understand, as far as possible, the positive changes which have taken place to remedy past failure. Such an Investigation can test the progress said to have occurred in a contentious area. It would be helpful for the Family Liaison Officer concerned to give evidence. One issue would be the workload and whether a further Officer(s) is required.

Medical records

16. I was informed that currently the only method of requesting patient records as a carer or family member is by way of a **Subject Access Request** and that the Trust have been working on the issues of consent that attach to such requests.

17. Clearly, this should be given very careful consideration, but that should not lead to further serious delay.

18. Further, I was reassured that any inappropriate comments made within the records, not only would be disclosed as part of that request, but the Trust would not hesitate to report the individual concerned to the relevant regulator if there was evidence of a breach of their code of conduct. Indeed they have done so in the past.

19. I consider that I should respect the Trust's declared response to such a situation. I have had some limited evidence of inappropriate comments. So that issue alone would not require further public analysis. But in my view, the Trust should ensure that all new clinicians and staff are aware of the need to avoid inappropriate comments by highlighting the relevant current guidance contained in the Clinical Record Keeping Policy. For example, Health Records

should not include *offensive subjective statements* or *irrelevant personal opinions regarding the patient.*

Care Coordinators

20. I was informed that work has been done to improve the engagement and involvement of family, carers and the service user in the production of Care Plans, and that this has had positive results.

21. It was said that there has been recognition of the need and desire for a multi-disciplinary approach and continuity across all of the services. I was told this has been implemented with success, but that lack of resources had hindered progress at times.

22. This new spirit of engagement was attributed to the learning taken from the interactions the Trust has had with the families in these cases. The Trust also accepts that their previous structure had led to a lack of confidence and trust and as a consequence, more serious harm.

23. As will be seen, I remain of the view that this important subject requires further public examination as a policy issue, particularly in the light of the Care Coordinator failings affecting a number of families.

Risk Assessment

24. It was conveyed to me that these tragic deaths have driven enormous change in the Trust's approach to assessing risk and that it has been accepted that there is still work to do.

25. Thus I was told that there are regular **Compliance Reports** and that standard definitions are clearer.

26. Further there has been a move away from focusing on the clinician's risk - to focus more on the service user's risk.

27. I was also told that there has been time spent to ensure a multi-disciplinary approach is taken, which should connect with crisis contingency planning.

28. That may be seen as a response to the specific failings which I have been tasked to consider. It was acknowledged that during the period where these deaths occurred, it was not possible for all staff members to have sight of a patient's Risk Assessment. But I was told that this is no longer the case.

29. All of this is encouraging, but I am firmly of the view that this topic should be examined further in public, with evidence of what is happening now from appropriate witnesses.

Meetings of family members and Southern Health NHS Foundation Trust

30. I have read and considered carefully the detailed minutes of the meetings on April 16, 2018; June 4, 2018; October 11, 2018; December 6, 2018; February 5, 2019; March 5, 2019 and April 25, 2019. They repay analysis. They have provided valuable insight into the relationship between the family members and the Trust over a one-year period. They illustrate the complexity of resolution of past mistakes and that there are different views on both sides about what needs to be done.

31. I am grateful that these minutes were shared with me. They have helped me in my Overall Conclusions and the Recommendations which I have made. In particular, they encourage me to recommend a **focused and limited Public Investigation** which seeks, above all, clarity. There is always a danger that policy issues become abstract

in their elucidation. That must not happen in considering the serious issues which arise from these deaths.

OVERALL CONCLUSIONS

1. In the course of this Investigation, I have found that three practical issues must be addressed.

   A. My terms of reference are very widely drawn. The temptation to examine in more forensic detail individual and group actions and also policies beyond the central role of Southern Health NHS Foundation Trust is strong. In this respect, I have considered the position of the Clinical Commissioning Group, who are in a contractual relationship with the Trust. Thus they are part of the picture, notably in the case of Mr and Mrs Hartley, but not the main focus of this Investigation.

2. My strong view is that the primary purpose of this Review is to reach clear conclusions and make clear and tightly drawn recommendations. That has predisposed me to take a stricter view of what needs most to be examined and then seek to present those issues as concisely as I can.

   B. The second issue is how any recommendations may be tested. That might help to avoid the numbing despair which flows from unrealised general promises of change. That has been the source of so much anger and frustration for these families. I have no doubt that this has led to understandable and deep-rooted cynicism amongst the families in the past. A classic illustration is their belief that some of the promised Action Plans have turned out to be completely illusory, for they have not been put into effect.

   C. The third is to recognise that some complaints cannot be resolved fairly or at all by a paper review. Witnesses need to be heard and tested by proper and careful questioning consistent with an investigatory hearing which is not adversarial in character. Any other attempted adjudication is otiose. I am grateful that family members have told me that they do understand that limitation.

3. It will be seen that I have sought to reconcile these difficult issues by recommending first, a limited Public Investigative Hearing on the facts of one case. Second, by recommending a very specific public examination of key policy issues, which arise *directly* from the individual facts of these family tragedies.

4. **In the various deaths between 2011 and 2015 that I have been considering, there have been significant, serious and deeply regrettable failures by the Trust into their proper Investigation and reasonable Communication with immediate family members. Those combined failures, taken with failures of care before death, together have caused real and long-lasting harm.**

5. At the same time, there have, of course, been individual acts of compassion and care by medical and care professionals. That includes some Investigators who have understood the degree of distress caused to the families. I also recognise that some later responses from Trust representatives have sought to address concerns appropriately and with understanding.

6. I further acknowledge the fresh work the Trust has done with these families. There are indications of a greater willingness throughout the Trust to listen and learn from the catastrophic mistakes that were made. By that, I mean mistakes in the care provided to some of these patients during their lifetime and the way the families have been dealt with subsequently during the Complaints and Investigation process.

7. **But overall, excluding those Investigations which I have found to be admirable, what has been presented to me is a truly deplorable and unacceptable saga, which cannot be attributed simply to a lack of resources. At significant and important times, leadership was sadly lacking and too often that contributed to a systemic culture of delay.**

8. **On occasions, there was disturbing insensitivity and a serious lack of proper communication with family members. There have been times when talking to family members, I have glimpsed the true depths of their hurt. This must be made plain and deprecated in the greater public interest. It must never be repeated and the new Trust is plainly aware of the challenge.**

9. I have concluded that in all of the cases, **ex gratia payments** should be made, corresponding strictly with the Guidelines under which the Ombudsman operates. But no sum of money can alleviate the distress which has been caused.

10. I have sought to endorse those clear and sensible recommendations that have been made which seek to guard against future tragedies and the consequential distress caused to relatives. Senior members of the Trust have told me that these recommendations have been or are in the process of being implemented and embedded. This must be tested in respect of some **specific policies** in a Public Investigation.

11. Specifically I find,

    1) There is an absolute need for a **robust, independent professional Investigation structure** that commands respect in the examination of future deaths.

    2) That structure must listen to the full input of the immediate family, including their suggestions for future reform.

    3) Ideally such a framework would benefit from judicial input (e.g. a retired Circuit Judge).

    4) This Investigation has shown that too often the adequacy, timing and standards of **patient Care Pathways and Assessments** were plainly inadequate. That *must* be addressed fully in the future. But I have seen evidence of recognition of the need for change.

5) Operating processes over the period this Report has focused on have led to real or the perception of **real injustice**. I cite, by way of example in the case of Edward Hartley the failure to provide the Serious Incident Report and Care Plan to the Coroner. That course may well have contributed to a decision not to have an Inquest into the death of Edward Hartley.

6) **Delay** in the proper investigation of all these cases has been both **serious** and **unjust.** It has contributed significantly to the distress experienced by all family members. It has been **totally unacceptable.**

7) It is essential that the positive recommendations which have been accepted already are now put into operation without further delay. I heard first-hand that the new Trust Management are committed to continuing constructive reform. The implementation of existing recommendations should be the barometer of their success or otherwise in the future.

12. Because of the past serious failures of investigation, I consider that the **arrangement** of an **independent, robust, Investigative Structure and Process** should be set out by the Trust and then examined in public. They need to explain very clearly what exists today and that demands very careful examination. The issue of a transparent investigation process will help, above all other matters, to build confidence in the working life of this Trust. It is one fervently supported by the families, as demonstrated, for example, by the powerful plea to me of Mrs Small.

13. I recommend a **limited Public Investigation that is specific and focused in nature**. In particular, that Investigation should address issues that I am not in a position on a paper review to resolve and where such a Public Investigation is still in the public interest. Only then can those concerned have the chance to consider that, at long last, justice has been done. The issues are,

1) The **circumstances of the death of Edward Hartley**.

2) The operation and role of **Care Coordinators**.

3) The procedures and practices for conducting **Assessments;** particularly **Risk Assessments,** when a patient is discharged, and when **Care Pathways** are being planned.

4) The implementation of a robust, efficient and effective **Complaint Handling** procedure.

5) The structures and procedures now in place for **Communication and Liaison** with patient's families, both during a patient's life and afterwards.

6) The establishment or confirmation of a totally **independent, robust, Investigative Structure and Process** to conduct transparent and fair investigations into serious accidents, deaths and complaints, particularly but not exclusively where there is a mental health element. **That recommendation demands a rigorous look at what is in place now in this Trust and the extent to which it meets the necessary criteria.** Detailed explanations and submissions need to be made and then properly tested. **That recommendation goes to the heart of this Report.**

7) Evidence of the development, monitoring and implementation of **Action Plans** to be provided, with illustrations of effective working Action Plans in the recent past.

8) Evidence should be provided by the **Clinical Commissioning Group of the supervisory structure that has been in place since 2011 and how it has been exercised towards the Trust and of any planned changes in the light of public concerns.**

14. I conclude that it is essential that in any Public Investigation, all relatives should have the opportunity to give evidence or provide written statements if they wish to do so. The reason is not for them to have to relive their individual traumas, but to give effect to the express wishes of every family member to promote constructive and effective reform of the present processes of this Trust. The

mechanisms and extent of this can be agreed at a later point, but for example, one or more of the family members might be able to speak to the issues of Care Coordinators or Communications with families.

15. In order to have an effective Public Investigation, there must be evidence from members of the Trust and others who can speak precisely and with in-depth knowledge on the narrow topics I have set out above. The Trust should identify such people and statements should be taken before the Hearing and made available to the families and all interested parties.

16. I have limited quite deliberately the topics for further public examination. That is in the hope that it will be focused and results in clear recommendations. But there is one qualification. It should not prevent agreement between the Trust and the families to add other policies to that list. That is for them to decide. However I would repeat my strong view that what is needed is a very specific Public Investigation, examining in a flexible and constructive manner only issues which cry out for fuller public analysis. Only then can mercy season justice.

17. I view it as imperative that such an Investigation should be set up without delay. As at the outset, I confirm that I am prepared to undertake it. I am also happy to discuss practical steps to implement it efficiently. For example, the need for independent and appropriately skilled panel members and the nature of participation of family representatives and the ability to call expert or other evidence which will help the investigating panel to reach clear conclusions.

18. The structure of such an Investigation needs to address the practical issues of venue, length, composition, evidence, format and procedure. It must be investigatory rather than accusatorial in nature. It must be demonstrably open minded in concept and totally independent in character, composition and operation.

19. I recommend a process not unlike a well-ordered regulatory hearing, adapted to the particular focus of this Investigation. One example would be the need to enable some sensitive evidence to be heard in private, deciding such a question on well-established principles of public and private interest. It must be a process designed to reach practical working conclusions to improve, where needed, the policy issues which it is considering. For it is time for further constructive change. The families who are concerned deserve nothing less.

20. The long and complex process of the review of this Final Report has brought home to me just how wide the gulf still is between the family members and the Trust. I have sought to express a fair and balanced independent view, whilst continuing to receive sharply opposed submissions. The reality is that deep distrust remains. It is no part of this Report to assess the degree of reputational damage that this Trust has sustained by their actions and failures towards these families. But I retain the hope that an independent limited Public Investigation at least has the potential to change the narrative of a very troubled story.

21. Finally, I formally consent to the publication of this Report in full.

January 2020 Nigel Pascoe QC.

APPENDIX A

Terms of Reference

Introduction

This programme of work will be carried out in two stages as summarised below.

The work will be commissioned by NHS Improvement and Stage 1 will be chaired by Nigel Pascoe QC.

Stage 1 Overview

An independent review of the quality of investigations carried out to date[1], and implementation of the resulting recommendations, relating to the deaths of five patients who were in receipt of care provided by (“the Trust”). The five deaths occurred between October 2011 and December 2015. The scope of this Stage is described in more detail below.

Stage 2 Overview

Where the independent review undertaken in Stage 1 identifies deficiencies in the investigations carried out to date, and where such action is merited, NHS Improvement will commission a further investigation. This will be on the basis of new terms of reference specific to the death to be investigated.

Shared purpose and aims for the review

The families of the five patients concerned have unresolved questions and concerns relating to the care provided as well as the circumstances leading up to their death and how these have been investigated to date by the parties concerned.

[1] Based on accepted NHS best practice at the time. Documentation relating to these standards will be provided to the Chair of the review and the families.

Specifically, the families' aims are to achieve to their satisfaction the following:

- Acknowledgement by the parties concerned of the evidenced facts;
- Acknowledgment by the parties concerned of clear failings, be they failings of the systems and procedures or be they failing in the application of those systems and procedure by individual staff members;
- Acknowledgment of the wider consequences of the failing to both the patient's family and involved members of staff;
- To determine accountability and responsibility at an individual level for identified failings in systems, processes and people;
- To make recommendations for remedial action and to assign accountability for their completion; and
- To provide demonstrable proof through appropriate outcome measures that the actions completed have successfully addressed the identified failing.

The Trust and NHS Improvement aim to ensure that lessons from any identified failing are learned by both the Trust and the wider NHS.

Scope and purpose of Stage 1

In respect of each of the deaths covered by this programme of work, the review will undertake to:

- Review the quality of the investigations undertaken by the Trust, other NHS bodies and/or external organisations[2] (including the resulting reports) in relation to care received by the five patients;
- Identify whether the investigations appropriately acknowledged and addressed the relevant concerns and issues arising following the deaths, including governance issues;

[2] External organisations include the Parliamentary and Health Service Ombudsman.

- Establish if recommendations were accepted and appropriate actions implemented by the Trust and other NHS bodies, within timescales identified, and whether the intended outcomes were achieved;
- Consider how the families and friends of the patients were engaged by the Trust, other NHS bodies and/or external organisations during those investigations and subsequently (including inquest proceedings);
- Reserve the right to undertake a second-stage review of primary cases if recommended by Stage 1 of the review;
- Draw conclusions and make recommendations on any lessons to be learned for both the Trust and the wider NHS to secure the delivery of high quality care; and
- Present a report of the findings of the review to families of the deceased, the Trust and NHS Improvement.

The review will actively engage and communicate with families and friends relevant to the specified cases, where they have expressed a preference for such engagement.

The review will focus on the actions, systems and processes of the Trust. The review will also consider the actions of regulators and commissioners insofar as they appertain directly to care received by the five patients.

Access to documents

All relevant NHS organisations, regulators and the Department of Health and Social Care are expected to cooperate with this review, as is normal professional practice, including supplying documentation as and when requested by the review chairman.

Timeframe

The Stage 1 review should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected, based on current information, that the Stage

1 review will complete work and produce its report by December 2019. NHS Improvement will publish the report of the review.

Scope and Purpose of Stage 2

To be determined following the completion of Stage 1. Any Stage 2 investigation will be carried out on the basis of new terms of reference specific to the death to be investigated.

NHS Improvement is committed to resourcing Stage 2 of the programme of work, should this be required following the Stage 1 review.

APPENDIX B

Summary Note on NHS Improvement's powers and actions taken relevant to the review

Background to NHSI

NHS Improvement comprises two distinct legal entities: Monitor and the National Health Service Trust Development Authority (TDA). Each has a different legislative basis and different powers.

The TDA is a Special Health Authority and part of its role is to oversee NHS trusts in England. Monitor is a statutory body and part of its role is to authorise and regulate NHS foundation trusts (see NHS Act 2006, ss. 30 to 64 and the licence provisions of HCSA).

Monitor's main duty when exercising its functions is to protect and promote patient interests by promoting economic, efficient and effective health care services whilst maintaining or improving quality (s. 62 Health and Social Care Act 2012 – "HCSA"),

Since the trust is a foundation trust, Monitor's powers are relevant here and therefore this note will not set out detail around the TDA's powers.

However, in 2016, the organisations were brought together operationally as NHS Improvement to oversee foundation trusts and NHS trust under a harmonised approach. Therefore, although the legal basis for the exercise of certain functions are technically different, where possible, from an operational point of view, NHSI oversees and regulates NHS trusts and foundation trusts under this harmonised approach.

Regulation of NHS foundation trusts

Monitor (NHSI) performs its oversight and regulation role through the licensing provisions (ss. 81 to 114) and enforcement provisions (ss.104 to 114) of the HCSA.

Foundation trusts are required to hold a licence in order to provide healthcare services and must comply with the standard licence conditions. The licence can be found here: Provider Licence

NHSI may take formal enforcement action against a foundation trust only where the relevant tests in the enforcement provisions are met.

Under HCSA, Monitor has enforcement powers to:

- **Require information** (s.104)
- **Impose discretionary requirements** in the event of a breach of licence conditions (s.105)
- **Accept enforcement undertakings** from the provider if Monitor has reasonable grounds to suspect a breach of licence conditions (s.106)
- **Impose an additional licence condition** if the governance of a foundation trust is such that it is failing, or will fail, to comply with one or more of its licence conditions (s.111) and if that condition is breached, the foundation trust can be required to remove/replace board members

NHSI publishes Enforcement Guidance, setting out: when it may decide to take action; what action it may take; and how NHSI is likely to decide on the kind of sanctions to impose and the high-level processes NHSI intends to follow when exercising these powers.

Taking a harmonised approach to oversight of NHS trusts and foundation trusts, NHSI oversaw providers through the Single Oversight Framework (SOF) until August 2019. Since NHSI has come together under a joint operational model with NHS England as of April 2019, NHSI now uses the NHS Oversight Framework, which is in large part similar to the SOF approach.

Under the Oversight Framework, the performance of providers is measured against five key themes (which themselves relate to the

licence conditions). Depending on any support needs identified, providers are placed into four segments:

- **Segment 1 – maximum autonomy** (no potential support needs identified. Lowest level of oversight)
- **Segment 2 – targeted support** (some concerns and support offered, but providers are not obliged to accept)
- **Segment 3 – mandated support** (for significant concerns. There is an actual or suspected breach of the licence)
- **Segment 4 – special measures** (actual or suspected licence breach with very serious and / or complex issues)

All NHS trusts and foundation trusts are placed into a segment, which is reviewed through continuous monitoring.

The segmentation for each provider can be found here. The trust is currently in segment 3 (mandated support in relation to quality of care).

Since the trust is in segment 3, there are undertakings in place (pursuant to s.106).

From an operational point of view, NHSI has regional teams who oversee providers within the region. Southern Health is within the South East regional team.

Under the Oversight Framework, providers submit information to the regional team for routine monitoring, which is used to determine a potential need for support / intervention.

NHS Improvement uses various metrics and information it gathers from trusts (including through its review meetings with trusts) to measure performance. Performance against those metrics have indicators and triggers, which from a legal perspective can be seen as the process by which NHSI identifies whether there is a potential breach of the licence conditions.

If there is a trigger and a support need is identified, further information is gathered which usually involves an investigation by the regional team. This might include trust visits, requesting information, consulting with third parties (eg local commissioners, the CQC) and reviewing existing evidence. An assessment is then carried out whether there is an actual or suspected breach of the licence and what enforcement action, if any should be taken.

Decisions to take regulatory action and change segmentation are taken at committees at various levels within NHSI depending on the level of regulatory action recommended by the regional team.

Typically, NHSI takes action by agreeing undertakings with the provider (s.106).

Where regulatory action has been taken, the provider's performance is measured and where the regional team considers that improvement has been sufficient to comply with the undertakings or discretionary requirements, NHSI will (subject to NHSI's governance scheme through decision-making by committee) issue a compliance certificate.

In cases where there has been improvement in only some areas or where the relevant actions in undertakings need to be updated over time, refreshed undertakings may be agreed with the provider.

To note, although the TDA cannot use Monitor's enforcement powers and NHS trusts cannot hold the Provider Licence, the TDA can exercise equivalent powers, treating NHS trusts as though they are subject to equivalent licence conditions, in order to agree equivalent undertakings with NHSI.

Regulatory action and NHSI support

As above, the trust is in segment 3 (mandated support) and therefore regulatory action has taken place in the form of undertakings given by the trust, which NHSI has accepted. These have been in place since

June 2018, relating to quality of care (which replaced undertakings from 2014 and 2016).

Undertakings were issued in 2014 as a result of CQC warning notices being issued as well as other external reviews, investigations and reports of governance failings. These undertakings required the trust to:

1. lift the CQC warning notices
2. implement a turnaround plan for former Oxford Learning Difficulties Services
3. review and improve quality governance

The first two 2014 undertakings were met in June 2015 and April 2017 respectively (and compliance certificates issued), however during 2016 a number of new undertakings were issued.

In January 2016 undertakings were issued as a result of governance failings highlighted in the Mazars report. The undertakings required the trust to:

1. prepare and implement an action plan that implements the recommendations of the Mazars report
2. cooperate with an Improvement Director appointed by Monitor
3. commission independent expert advice to provide assurance that the trust's action plan is robust and to confirm once the action plan is finalised that the new systems and processes are fully embedded and operating as intended

In April 2016 an additional undertaking was issued as a result of a CQC warning notice (pursuant to s.111 HCSA). This aimed to ensure the trust has in place sufficient board, management and clinical leadership capacity and capability to address the significant governance failings identified. Monitor's powers under the s.111 additional licence condition were subsequently used to appoint interim Chairs.

In June 2016 an undertaking was issued in response to a CQC report being issued (April 2016). The undertakings required the trust to:

1. take immediate steps to address patient safety concerns and any further action to ensure the warning notice is lifted;
2. implement all recommendations arising from the planned joint review (by NHSI and the CQC) into the governance and culture at the trust;
3. carry out a review of the trust's policies and processes for stakeholder engagement and implementing all recommendations arising;
4. carry out an external review of board capacity and capability and implementing all recommendations arising; and
5. prepare a consolidated action plan to deliver all outstanding undertakings

In July 2016 the Quality Oversight Committee (QOC) first met to oversee the trust's CQC, SIS and Mortality Action Plans. The QOC was a monthly meeting chaired by NHSI up to October18 when the final meeting was held. The committee included representatives from NHSI, NHSE, CCGs and the trust. The CQC were kept up to date through inclusion on distributions of QOC papers and minutes.

Following a CQC re-inspection in September 2016, the warning notice in place since March 2016 was lifted (CQC report published in November 2016).

In 2018 NHS Improvement issued a revised set of undertakings to the trust. This was due to the trust requesting that a compliance certificate be issued against the January 2016 undertakings and for the remaining undertakings to be replaced with one set of undertakings to increase transparency of expectations and to better align with support being provided.

Support made available to the trust has included:

- NHSI approved and funded buddying support and quality improvement methodology from Northumberland Tyne and Wear

Foundation Trust (NTW) to effectively implement the necessary changes. NTW is a segment 1 provider

- Between 2017 and 2019 the trust received a total of £947,000 from NHSI to support the relationship with buddy trust (NTW) and to support internal quality improvement transformation.
- The trust also received regular ad-hoc advice and support from NHSI to identify how best to initiate and roll out a trust-wide quality improvement methodology.
- There are quarterly meetings between the trust and NHSI's regional multi-disciplinary team. The focus of these meetings has included out-of-area placements for service users, quality improvement, patient safety, workforce, financial risks and capital requirements

APPENDIX C

New clinical and non-clinical policies introduced since October 2011

The Trust has numerous policies, procedures and working practices which were in place prior to 2011 and which are reviewed and updated at set intervals or earlier if the need arises.

Revisions/updates are made following changes in national guidance or as a result of learning from a number of sources including learning from incidents.

Reference	Document title
SH CP 01	Management of Seizures: What to do when an inpatient has a seizure
SH CP 27	The Assessment and Management of Clinical Risk Policy
SH CP 43	Physical Assessment and Monitoring Policy
SH CP 47	Dual Diagnosis Policy
SH CP 48	Rapid Tranquilisation Policy and Guidance
SH CP 137	Intravenous Therapy and Peripheral Cannulation Policy
SH CP 150	Assessment and Management of Fixed Point Ligature Risks Policy
SH CP 152	Elective Services Access Policy – Access to Elective Care Pathways
SH CP 176	Safer Staffing Policy
SH CP 184	Chaperone Policy
SH CP 188	Management of leave for the Informal Patient
SH CP 202	Safeguarding Supervision Policy
SH CP 208	Prevent Policy
SH NCP 55	Standards of Business Conduct Policy (Conflicts of Interest)
SH NCP 75	Policy and Procedure for Reporting and Investigating Deaths

Changes to working practices following serious incident (SI) investigations into deaths

There have been ongoing changes to working practices over time as a result of learning from both the specific SI investigations reviewed as part of this Investigation and learning from a wider range of sources including other SI investigations.

Although improvements have been made in many areas, the Trust recognises that further work is required to make sure improvements are embedded into daily practice and are in place consistently across the Trust.

(note: TQTWENTYONE services were transferred to other providers in 2016).

Themes	Changes to working practices
Involvement of carers Support for carers	• Increased emphasis on involvement of families in assessment and treatment and in risk management. • Care navigators to support patients and carers in understanding services in place in Acute Mental Health Teams (AMHT)/crisis services. • Multi-disciplinary team (MDT) meetings take place at least weekly and include discussion of carer's involvement and any support required. The details of the MDT meetings are recorded on the electronic patient record system (RiO). • Practical written information for families following a death is now available, for example, leaflet 'Help is at Hand' (2013). • Increased involvement of carers in workshops and projects, for example, the new Quality Improvement (QI) Programme launched across Trust (2017) routinely invites patients and carers to QI workshops to work alongside staff in identifying issues and proposing

	solutions for improved services. • Triangle of Care, a national initiative, launched in 2010 by the Carers Trust for mental health and inpatient services was re-launched in Adult Mental Health services (2018). It focuses on the therapeutic relationship between patients, carers & staff to promote safety, support communication and sustain wellbeing. Achievements to date include: identification of carer's leads in inpatient and Community teams, carer's communication plan co-produced and added to electronic patient record system (RiO) allowing identification of carer and recording of their views, carers groups set up in West and East Hampshire, training programme for staff in how to better support carers with over 300 staff trained since June 2019, carer's brochures with practical information and signposting to local carer's groups developed collaboratively for inpatient services with Community team brochure in progress. Note: some carer's groups are long standing, for example, Melbury Lodge. • New post 'Head of Patient and Public Engagement and Patient Experience' (PPEPE) appointed (2018). • New 'Working in Partnership Committee' set up (2018) which is co-chaired by a carer and Head of PPEPE and which reports to Board. • Carer's Strategy co-produced and published (2018).
Involvement of patients	• QI Programme (2017) – 'expert by experience' trained as one of original six QI Facilitators and appointed to QI team. • Service User Involvement Facilitators (x2) appointed (2018) to support understanding the

	experience of patients and involving patients in developing services. 3rd appointment started November 2019 – Expert by Experience in QI communications. • People and Partnership Commitment 2018-2022 co-produced and launched. • Experience Involvement and Partnership Strategy co-produced and launched (2018). • 20 QI redesign programmes completed – all of which had people who use the services equal members of the redesign teams.
Adult Mental Health services (secondary care)	• The model of adult mental health services has been comprehensively revised over recent years. Between 2012 and 2014 secondary mental health services were changed with the Access and Assessment Teams dissolved, and individuals presenting with acute mental health needs now referred directly to the Acute Mental Health Team (AMHT) in the first instance, allowing early relationship development and simpler access for individuals and their families. If the individual requires care and input over a longer term, the Community (COMMUNITY MENTAL HEALTH TEAM) becomes involved. • There is also the provision of Shared Care which may involve AMHT, COMMUNITY MENTAL HEALTH TEAM and other agencies, for example, alcohol and drug misuse services and which can jointly support an individual. • The Adult Mental Health service has developed specific pathways for some conditions, for example, crisis care arrangements, which are based on best practice and linked with specific outcome measures. More are in development.
Access to	• Acute Mental Health service now available

crisis/Out of Hours services	24/7 enabling patients improved access to services when needed. • April 2019: 12 month pilot scheme offering expert advice, assessment and support for those experiencing mental health problems 24/7 across Hampshire via the NHS 111 helpline. New initiative delivered by the Trust, Solent NHS Trust and South Central Ambulance service provides direct access to specialised nurses in the new Mental Health Triage Service. Nurses have access to patient records and crisis plans and deal with range of requests from arranging an appointment with GP to dealing with urgent crisis response. MH nurses can also support GPs, other health workers and police officers who feel a person may require mental health support. Initiative well received with 95% of callers in first month receiving support they needed over the phone and required no further support. • October 2017: Trust pilots new Crisis Lounge in Southampton for adults who experience a crisis with their mental health. Provides safe haven and access to mental health services/peer supporters and avoids people having to visit A & E services which are not always most suitable place for someone in crisis. (note: there were some staffing issues when first introduced which led to crisis lounge being closed on some days). • Psychiatric Liaison service expanded at Portsmouth Hospital with the Trust partnering with Solent NHS Trust to provide a 24 hour service enabling easier access to specialist care. Ongoing discussion with commissioners in Southampton to provide similar 24 hour service – at present AMHT provides cover for

	the times when the Psychiatric Liaison service is not available.
Suicide and Self Harm	• Suicide & Self Harm Prevention Strategy launched (2019) based on national guidance and best practice. 'Every life matters' focuses on raising awareness, providing suicide prevention training to staff, ensuring all mental health patients have a safety plan and working in partnership to reduce self-harm and suicidal crisis. • Key areas of focus include: all patients discharged from an acute Mental Health inpatient setting will be contacted within 48 hours by a clinician to ensure they are receiving the support they need, every patient supported by our mental health services will have a safety plan developed by them, with our staff, to help identify what will keep them safe when they have suicidal thoughts and are in crisis. • Suicide prevention steering group is co-chaired by a family member bereaved by the suicide of a patient in our care. • 2019: it is now mandatory for all trust staff to complete 'Let's Talk about suicide' HEE accredited training. As of last week 63% of staff had completed within 6 weeks of its launch- approximately 4000 staff.
Engagement /Did not attend/discharge	• SH CP 97 Clinical Disengagement /Did Not Attend Policy currently under review. • Updated SH CP 37 policy on therapeutic observation & engagement • Current practice: MDT reviews patient and makes decision about planned discharge, patient is asked about their preferred method of communication, up to date risk assessment indicates how often patient will be contacted, if

	unable to contact will do cold call to home and pop contact card through door, phone family/carers/friends to check whereabouts, send discharge summary to GP and if concerned about patient safety will contact police/support services. • Regular audits of discharge summaries with performance discussed at commissioner led contract meetings.
Care plans / Care Programme Approach /crisis plans	• The Care Programme Approach (CPA) is for the most complex patients in the mental health services who will have a named care co-ordinator and care plans as part of the CPA which is reviewed annually. • CPA guidance is currently under review to provide clarity on the criteria for CPA in order to provide consistent approach across Trust. • Improvements in care planning is ongoing with recent workshop aiming to simplify the number and format of care plans with policy to be revised based on work underway. • Regular audits of care plans with improvements identified for individual teams/services • 2019: completed a review and redesign of the Trust record keeping group to ensure in the next 12 months records are simplified and streamlined for service users, families and staff to record care in a co-produced way.
Risk assessments	• Risk assessments reviewed with revised template added to electronic patient record system (RiO) – performance on numbers of risk assessments completed reviewed at team/service level. • Compliance with completion is monitored with 92.4% patients having a completed risk assessment in June and 95.7% in October

	2019. • Ongoing piece of work to make sure risk assessments are up to date and of high quality.
Dual diagnosis	• SH CP 47 Dual Diagnosis Policy – new policy in 2012 with major review in 2016 to reflect learning from serious incidents. • Southampton/East Hampshire have multi-agency approach with trust and drug and alcohol services meeting to discuss working together and discuss individual cases. • Dual diagnosis pathway group in place.
Serious incident investigations	• New policy and procedures for investigating and reporting on deaths introduced (SH NCP 75 Policy and Procedure for Reporting and Investigating Deaths 2015) setting out the standards to be met and procedures to be followed. • Strengthened process for the initial review of incidents recorded as moderate severity and above with daily panels chaired by senior clinical leaders reviewing incidents and making decisions for future actions, including the requirement for a serious incident investigation using root cause analysis. • Increased divisional and corporate oversight of the quality of serious incident investigations via assurance review panels where the investigation report is reviewed against a set of quality standards based on national best practice and learning is identified (2015). If the report does not meet the required standard it is returned to the service with a request for amendments to be made and re-reviewed at panel for approval. • Commissioner led panels review and approve final investigation report using quality

	standards framework as described above. If a report does not meet the required standards, amendments are requested and the revised report re-submitted for final approval. Requested amendments often relate to the detail of the action plan included in the report. • Evidence of improvement panels, chaired by a Clinical Director, for most serious incidents introduced (2016) where clinical teams present evidence of the changes made as a consequence of the recommendations of the serious incident investigation. • Two day training for staff who undertake serious incident investigations introduced (2016) with a 1 day refresher training every three years. • Terms of reference for serious incident investigations are now shared and developed with patients and carers where appropriate. Timelines for the investigation and report are discussed with the families and requests for extensions made where appropriate. • Central team of senior investigating officers (IO) set up (2015) in Adult Mental Health services which provides specialist experience and expertise in the investigation of serious incidents leading to improved quality of investigations and reports. These IOs are independent of the clinical teams where the incident took place. • Being Open Policy revised to incorporate national requirement for 'Duty of Candour' (2015) to be implemented with guidance to staff and amended reporting system to measure performance in meeting requirements. • Family liaison officer (FLO) appointed (2016)

	who provides support to families to guide them through the SI procedure, clarify details in the investigation report where needed and provides support through the inquest process and beyond. The FLO is not involved in the actual investigation and is independent of the clinical team where the incident took place.
Complaints process	• Quality Improvement project (2019) – complainants and complaints team identified issues and proposals for improvements including: • Simplified process with removal of unnecessary steps leading to quicker responses • Revision of complaints leaflet to be more user friendly • Increased use of local resolution with training provided to front line staff • Tracker for complex cases to ensure all issues raised in complaint are answered • Setting up of central team of investigators who will be independent of the services where complaint made and will have specialist experience and expertise in investigating complaints leading to improved quality of complaint responses • Completion of action plans from complaints tracked on electronic system giving greater oversight of progress with actions and transparency • 39/54 (72%) of complaints received since April 2019 were completed within agreed time frame (April- September 2019). It is difficult to make comparisons with earlier data due to changes in processes. • PHSO feedback has been positive about these improvements.

Sharing learning	• Strengthened learning from incidents with development of 'Could it happen here?' case study approach guiding reflection and learning, Quality Conferences to share learning, patient/carer presentations to events/Board, learning events and workshops, newsletters and 'hotspots'. • Leadership development programme 'Gone Viral' refreshed in 2015 with a focus on new models of care and patients invited to share their experiences of care within the trust as part of learning for staff. • Monthly Trust-wide Mortality & Serious Incident Review Committee (2016) reviewed performance and progress with new procedures, responsible for carrying out thematic reviews, auditing quality of initial management assessments, identifying key themes and disseminating learning. This meeting has evolved into Learning from Events: Mortality, Serious Incidents and Complaints. • Governance systems within clinical services ensure learning is shared at team/service meetings.
Training	• The Learning and Development (LEaD) team introduced an electronic system which lists all training, including statutory and mandatory courses, and which allows staff to book training courses directly, relevant to their role. • In addition to mandatory training topics based on the Skills for Health – Core Skills Training Framework, the Trust also includes training on: medicines management, epilepsy, slips trips and falls, prevention and management of violence and aggression (sSs), being open and duty of candour, suicide awareness and

	clinical record keeping. • LEaD worked with clinical services to identify a framework of clinical/care staff roles and the essential training that each role type was required to complete. Each member of staff therefore has an identified list of training to complete based on their job role. Automated reminders are sent when training is due with overdue training escalated to line managers for their action. • Where appropriate, e-learning programmes have replaced face-to-face training enabling easier access for staff. • Performance data for all training is available at individual, team, service and trust level and is reported and monitored at team/committee meetings and to Board. • Epilepsy: training was revised following serious incidents (2014/15) and there are now several training courses, both face to face and eLearning, which are available to all staff with some of the courses being required by role (mandatory) for certain staff groups. • Basic Life Support/Immediate Life Support: new staff are required to complete resuscitation training as soon as possible once commencing their induction period within the Trust. Some staff will have received training by another organisation and this is passported in to ensure it is recorded on our training system. Should any staff not have completed resuscitation training there should be a risk assessment completed by the line manager to ensure the member of staff is not lone working prior to completing resuscitation training. SH CP 30 Medical Emergencies and Resuscitation Policy and SH NCP 89 Lone

	Working Policy revised. • Carers: as part of re-launch of Triangle of Care, a training programme for adult mental health staff was launched mid 2019 with over 300 staff accessing this face to face training to date. Training focuses on identifying carers, recognising their role and raises awareness of their needs and how to include in supporting their loved ones. A video by a carer of their experiences is used in the training. Beginning to roll out the training programme to Older People's Mental Health services. • There is ongoing QI work to ensure that there is minimal delay in staff attending all of their training during the induction period. • Clinical supervision is recorded on LEaD system. Policy reviewed in 2019.

APPENDIX D

Bibliography

Guidance documents and policies in place for the period under review

Name	Waterford House CTT Discharge Liaison Service
Date	Undated

Name	Local Operating Procedure, Shared Care: The Access and Assessment Team, Community Treatment Team
Date	Undated

Name	Care Planning & Care Programme Approach – Standard Operating Procedure Mental Health Division
Date	January 2010

Name	Policy for the use of Leave under Section 17 of the Mental Health Act 1983
Date	April 7, 2011

Name	Medical Emergency and Resuscitation Policy
Date	July 2012

Name	Admission Discharge & Transfer Policy
Date	September 2012

Name	Adult Mental Health Division: Standard Operating Procedure, The Access and Assessment Teams
Date	December 7, 2012

Name	Standard Operating Procedure: The Access and Assessment Teams
Date	December 7, 2012

Name	Care Planning Policy
Date	September 2014

Name	Managing Clinical Risk Practice Guidance
Date	July 2012, November 2014

Name	The Assessment and Management of Clinical Risk Policy
Date	November 2014, March 2016

Name	Procedure for the Management of Serious Incidents that Require Investigation
Date	March 2016

Name	CHC Brokerage Pilot Outcome Report and associated documents
Date	March 16 2016

Name	Policy for Managing Incidents and Serious Incidents (SI)
Date	May 2016

Name	Procedure for Reporting and Managing Incidents
Date	May 2016

Name	Duty of Candour Policy
Date	June 2016

Name	The Being Open Procedure
Date	June 2016

Name	Mental Health Service Division, Service Strategy 2014 – 2017
Date	2014 - 2017

Name	Serious Incident and Mortality Action Plan
Date	February 2018

Name	Policy and Procedure for Reporting and Investigating Deaths, Learning From Deaths
Date	February 2019

Reports

David West

Title	Critical Incident Review Report
Date	November 27, 2013

Title	Capsticks Investigation Report into the death of David West
Author	Capsticks
Date	September 2014

Title	Coroner's conclusions into the death of David West
Author	Coroner
Date	October 23, 2014

Title	Parliamentary and Health Service Ombudsman Service Report on behalf of David West (deceased)
Author	Parliamentary and Health Service Ombudsman Service
Date	April 26, 2016

Title	Report into the review of the care of Robert Small
Author	Dr Mayura Deshpande
Date	September 17, 2018

Robert Small

Title	Initial Management Report and Initial Management Report Notification Form
Date	September 18, 2012

Title	Reports for the Coroner
Date	Various dates

Title	Critical Incident Review Report
Author	Jane Thomson
Date	November 29, 2012

Title	DRAFT Report Review Following the Death of Robert Small and Opportunities for Improved Experience of Care and terms of reference
Author	Dr Gil-Rios and Jane Druce
Date	November 2015

Edward Hartley

Title	Investigating Officer's Report into the 'teeth incident' at Tamerine TQtwentyone Care Home on 14 July 2013 (and the corresponding complaint, incident notes, investigation plan, timeline, notes of meetings dated 6 August 2013, 12 September 2013, root cause analysis, statutory notification to the CQC, SIRI notification)
Date	October 2, 2013

Title	Critical Incident Review Report for Edward Hartley
Author	Nicki Duffin
Date	July 1, 2014

Title	HASCAS Independent Investigation into the Care and Treatment of Mr EH (and the key documents establishing this joint investigation, statement from Helen Ludford and correspondence with Mr and Mrs Hartley regarding Helen Ludford's involvement)
Author	Health and Social Care Advisory Service and Helen Ludford
Date	March 2016

Title	Hampshire County Council Learning Review of the response to a safeguarding incident
Author	Hampshire County Council
Date	March 2016

Marion Munns

Title	Root Cause Analysis – Investigation Report
Date	March 11, 2016

Title	Draft and Final Capsticks Investigation Report, letter from Capsticks and the Trust
Author	Capsticks
Date	July 2016, September 2016, November 10, 2016

Other

Title	Independent Investigation into the death of CS
Author	Verita
Date	February 2014

Title	Independent Review of Deaths of People with a Learning Disability or Mental Health problems in contact with Southern Health NHS Foundation Trust, April 2011 to March 2015
Author	Mazars
Date	December 2015

Title	Final report: Mortality Review Assurance Action Plan
Author	Niche
Date	November 2017

Title	The Assurance Findings Report for Southern Health NHS Foundation Trust in relation to your Mortality and Serious Incidents Requiring Investigation Action Plan
Date	December 2017

Title	An Independent Assurance Review of Serious Incident Investigation Reports for Southern Health NHS Foundation Trust
Author	Niche
Date	May 31, 2018

Correspondence

David West

Title/summary	Letter from Mr West to unknown setting out his concerns following the publication of the Francis Report
Date	June 30, 2014

Title/summary	Letter from Katrina Percy to Mr West following the Capsticks' Report into the death of David West
Date	October 20, 2014

Title/summary	Letter from Katrina Percy to the Ombudsman following the Ombudsman's report into the death of David West
Date	April 26, 2016

Title/summary	Letter to Mr West from Doctor 1 and Nicki Duffin with agreed actions following the Ombudsman's report
Date	May 25, 2016

Title/summary	Handwritten letter from Katrina Percy to Mr West
Date	June 2016

Title/summary	Letter from Julie Dawes to Mr West following the Ombudsman's report into the death of David West
Date	October 6, 2016

Title/summary	Letter to the Ombudsman from Julie Dawes updating them on the implementation of their recommendations
Date	November 8, 2016

Title/summary	Letter from Julie Dawes to Mr West
Date	November 22, 2016

Title/summary	Letter to Mr Richard West (and other family members) from Lynne Hunt following sessions with the Board
Date	April 13, 2018

Title/summary	Letter sent to Lynne Hunt of Southern Health NHS Foundation Trust from Suella Braverman MP
Date	February 5, 2019

Robert Small

Title/summary	Letter to Mrs Small from a Trust representative setting out her verbal Complaint
Date	July 25, 2014

Title/summary	Letter of complaint by Mrs Small
Date	August 27, 2014

Title/summary	Letter to Mrs Small from Doctor 1 setting out her ‘dissatisfaction with the service’
Date	August 29, 2014

Title/summary	Letter to Mrs Small from Katrina Percy with a response to her Complaint on July 21, 2014
Date	November 20, 2014

Title/summary	Letter to Mrs Small from Doctor 1 with an apology
Date	July 20, 2015

Title/summary	Internal Trust email trails
Date	August 2015

Title/summary	Letter of complaint by Mrs Small sent to Katrina Percy by Suella Fernandes MP on her behalf
Date	February 29, 2016

Title/summary	Internal Trust emails regarding meeting with Mrs Small
Date	April 25, 2016

Title/summary	Handwritten letter to Mrs Small from Julie Dawes with an apology
Date	September 26, 2016

Title/summary	Letter to ‘Rob’s family and friends’ from Julie Dawes with an apology
Date	October 4, 2016

Title/summary	Letters to Mrs Small from Dr Nick Broughton
Date	September 24, 2018, April 24, 2019

Edward Hartley

Title/summary	Correspondence from HHFT Pediatrician
Date	July 2012

Title/summary	Correspondence with the Clinical Commissioning Group regarding the release of documents
Date	August 7, 2013, June 22, 2018

Title/summary	Correspondence with Mr and Mrs Hartley and internal emails regarding the ‘teeth incident’ at Tamerine TQtwentyone
Date	September 11, 2013 - June 10, 2014

Title/summary	Emails regarding the funding of services for Edward Hartley
Date	April 8, 2014 and May 23, 2014

Title/summary	Emails between Mrs Hartley and West Hampshire Clinical Commissioning Group
Date	July 7, 2014 – September 23, 2014

Title/summary	Correspondence between Paula Anderson, the Clinical Commissioning Group and Mr and Mrs Hartley
Date	July 14, 2014, August 9, 2018, October 10, 2018

Title/summary	Emails between Mr and Mrs Hartley and TQtwentyone
Date	December 2014 - January 2015

Title/summary	Correspondence with Mr and Mrs Hartley, internally and externally regarding the joint investigation by the Clinical Commissioning Group and the Trust
Date	April - June 2015

Title/summary	Correspondence between Mr Hartley, West Hampshire Clinical Commissioning Group and Members of Parliament regarding the HASCAS Report and subsequent meetings
Date	June 2015, July - December 2016, February - June 2017

Title/summary	Letter to West Hampshire CCG from Great Ormond Street Hospital with their response to the HASCAS report
Date	July 29, 2016

Title/summary	Letter from HASCAS to the Trust with an update on the investigation
Date	March 31, 2017

Title/summary	Letter from the Trust to Mr and Mrs Hartley regarding the HASCAS report and subsequent correspondence
Date	April 10, 2017, April 13, 2017, April 26, 2017, May 18, 2017

Title/summary	Correspondence Timeline between Mr Hartley and the Clinical Commissioning Group
Date	October 30, 2017 – August 2, 2018

Title/summary	Letter to Mr and Mrs Hartley and Richard West from Lynne Hunt regarding their input in Board meetings
Date	April 13, 2018

Marion Munns

Title/summary	Email correspondence between Mrs Vella, Mrs Mote and the Divisional Head of Nursing
Date	January - February 2016

Title/summary	Redacted letter to Marion Munns' family from Katrina Percy
Date	February 23, 2016

Title/summary	Letters to Mrs Mote from Julie Dawes regarding family input and feedback
Date	September 12, 2016, September 27, 2016

Title/summary	Letter to Mrs Mote from Julie Dawes responding to her concerns raised in an email dated February 6, 2017
Date	February 24, 2017

Title/summary	Letter to Mrs Mote from Julie Dawes regarding compensation
Date	March 13, 2017

Title/summary	Letter to Julie Dawes from the Ombudsman confirming that Mrs Mote's complaint is discontinued
Date	January 9, 2018

Miscellaneous

David West

Title/summary	Process Review Timeline (2013 – 2018), David West
Date	Undated

Title/summary	‘David West Questions’ by Mr West
Date	Undated

Title/summary	The Implications and Consequences for David West of Dr Adam’s Actions on June 26, 2013 by Mr West
Date	Undated

Title/summary	Case 6093 - Issues raised by Mr West
Date	March 13, 2014

Title/summary	Notes from a meeting with Mr West, a Trust representative and Doctor 1
Date	March 25, 2014

Title/summary	Issues to be investigated by Capsticks relating to Dr Adam
Date	May 1, 2014

Title/summary	Issues to be investigated under the NHS Complaints Procedure
Date	May 1, 2014

Title/summary	Adult Mental Health Services ‘Change Evidence Action Plan’ for David West
Date	October 15, 2014

Title/summary	Complaint Ref: 6337 – outstanding issues to be investigated by Mr West
Date	April 25, 2015

Title/summary	Copy of cheque sent to Richard West
Date	May 27, 2016

Robert Small

Title/summary	Interview with Mrs Small
Date	October 23, 2012

Title/summary	Investigating Officer's Report completed by Doctor 1
Date	October 28, 2014

Title/summary	Suicide Note of Robert Small
Date	Undated

Edward Hartley

Title/summary	Night time file kept in Edward's home
Date	Undated

Title/summary	Report by Mr Hartley outlining the differences between 2 versions of the minutes of a Serious Incident panel meeting held on 9 July 2014
Date	Undated

Title/summary	Decision support tool for NHS Continuing Healthcare
Date	October 25, 2012

Title/summary	TQtwentyone Care Plan, Risk Assessment, Young Epilepsy Assessment and Support Plan files for Edward Hartley
Date	December 2012 - April 2014

Title/summary	Back-up for invoice to Hampshire County Council Children's Services

Date	March 31, 2014 – May 25, 2014

Title/summary	Epilepsy Guidelines for Edward Hartley
Date	April 1, 2014

Title/summary	Carer Training Record, TQtwentyone Workplace Induction, record of supervision and statement
Date	April 4, 2014, May 29, 2014, July 25, 2014

Title/summary	Agenda and minutes from the Trust Serious Incident Panel
Date	July 9, 2014

Title/summary	Police report of the incident
Date	September 30, 2014

Title/summary	Minutes of West Hampshire CCG meetings
Date	February 26, 2015 and March 26, 2015

Title/summary	Notes of a meeting between Mr and Mrs Hartley and Paula Anderson
Date	February 14 and 19, 2018

Marion Munns

Title/summary	Statements and Reports for the Coroner
Date	Various dates

Title/summary	Minutes of the Serious Incident 48 Hour Panel
Date	Undated

Title/summary	Timeline/chronology of the treatment and care Marion Munns' received
Date	Undated

Title/summary	Management Line for Care Coordinator
Date	November 2015

Title/summary	Notes of meetings for the Serious Incident (and comments by Mrs Mote and Mrs Vella)
Date	December 21, 2015, December 15, 2015, December 11, 2015, January 7, 2016

Title/summary	Serious Incidents Review Panel Feedback Forms
Date	February 2, 2016, February 19, 2016, March 11, 2016,

Other

Title/summary	Parliamentary and Health Service Ombudsman Ex Gratia Payment Guidelines
Date	Undated

Title/summary	Old People's Mental Health Team and Community reviews, feedback and quality and training plans
Date	Various dates in 2016

Title/summary	Learning Out of Concerns Action Plan: Southampton Old People's Mental Health Services
Date	February 2016, September 2016, October 7, 2016, March 14, 2017

Title/summary	Evidence of Improvement Panel
Date	September 2016

Title/summary	Meeting of family members, NHSI and Southern Health NHS Foundation Trust – actions and minutes
Date	April 25, 2019, March 5, 2019, December 6, 2018, December 20, 2018, April 16, 2018, October 11, 2018, June 4, 2018

Documents, letters and emails from family members received as part of this Investigation (some of which were duplicates of documents provided the Trust)

Robert Small

Title/summary	Note by Mrs Small regarding a meeting she attended with the Trust on January 29, 2019
Date	Undated

Title/summary	Suicide Awareness poster produced by Mrs Small
Date	Undated

Title/summary	'What I Want From Southern Health' document produced by Mrs Small
Date	Undated

Title/summary	Emergency Department record addressed to 'Portchester Health Centre'
Date	August 11, 2012

Title/summary	Letters regarding Robert Small's appointments and treatment by the Adult Mental Health Team
Date	August 14, 2012, August 15, 2012, August 29, 2012, August 30, 2012, September 12, 2012, September 21, 2012

Title/summary	Coroner's Report for Mr Robert Small by the trainee psychiatrist
Date	October 15, 2012

Title/summary	Letters from the Trust to Mrs Small regarding reviews of Robert's treatment
Date	October 17, 2012, October 18, 2012

Title/summary	Letters from the Adult Mental Health Team to Mrs Small
Date	October 26, 2012, March 14, 2013

Title/summary	Handwritten card from Doctor 1 to Mrs Small
Date	May 19, 2016

Title/summary	Email from Mrs Small to Julie Dawes with an apology
Date	September 12, 2016

Title/summary	Letter to Mrs Small, Robert's family and friends from Julie Dawes
Date	September 30, 2016

Title/summary	Emails from Mrs Small to Nigel Pascoe QC
Date	September 12, 2019, October 9, 2019

David West

Title/summary	Documents regarding David West's support needs and psychiatric assessments as a child
Date	Various dates in 1995, 1996

Title/summary	Referral to the Fareham Adult Community by the Community Psychiatric Nurse
Date	June 28, 2007

Title/summary	Mr Richard West's response to the Ombudsman's findings
Date	Undated

Title/summary	'Questions to be Answered' by Mr Richard West
Date	Undated

Title/summary	Chronology of evidence and documents produced by Mr West for David West review
Date	Undated

Title/summary	Local press articles regarding Southern Health NHS Foundation Trust
Date	Various dates

Title/summary	An extract of David West's RiO medical records
Date	April 8, 2013 – June 28, 2013

Title/summary	Presenting Situation & Referral Outcome Decision by Whittington Mental Health Liaison Team
Date	May 31, 2013

Title/summary	Initial Management Assessment
Date	October 22, 2013

Title/summary	David West's Funeral reading
Date	November 4, 2013

Title/summary	Medical Report
Date	November 6, 2013

Title/summary	Correspondence between Mr West and the Trust
Date	August 20, 2014, August 26, 2014, September 10, 2014, October 20, 2014

Title/summary	Change Evidence Action Plan for David West produced by the Trust
Date	October 15, 2014

Title/summary	Correspondence between Mr West and the Clinical Commissioning Group
Date	May 29, 2015

Title/summary	Letter to the Chief Constable of Hampshire Police and the Chief Coroner from Mr West
Date	December 22, 2015, April 27, 2016, November 13, 2016

Title/summary	Correspondence between the Trust and the Ombudsman
Date	April 20, 2016

Title/summary	Policy on the Use and Administration of Section 117 Mental Health Act 1983
Date	June 15, 2016

Title/summary	An Independent Investigation into the Care and Treatment of a Mental Health Service User (JK) in Southampton by Niche
Date	December 2016

Title/summary	Documents and correspondence regarding the General Medical Council investigations into the treating Consultant Psychiatrist and Dr Adam
Date	2017 - 2019

Title/summary	Correspondence between Mr West and Julie Dawes
Date	June 2, 2017, June 28, 2017,

Title/summary	Correspondence between Mr West and his MP
Date	August 17, 2017

Title/summary	Maintaining Momentum: driving improvements in mental health care by the Ombudsman
Date	March 21, 2018

Title/summary	Contents and chronology of additional disclosure provided by Mr West
Date	October 31, 2019

Edward Hartley

Title/summary	Summary timeline of interaction with NHS Services and Investigations and timeline of engagement of West Hampshire Clinical Commissioning Group in the care of an investigation into the death of Edward John Hartley
Date	2012 – 2018, 2013 – 2017

Title/summary	Spreadsheet of 'Mental Health Related Deaths in Hampshire and wider area covered by Southern Health'
Date	November 23, 2018

Title/summary	Email with 'thoughts for Suella Braverman MP meeting 26/4/2019'
Date	April 26, 2019

Title/summary	Email from Mr Hartley with a YouTube link to 'Broken Trust' and photographs of their home
Date	August 1, 2019

Title/summary	Mr Hartley's Unresolved Questions
Date	August 7, 2019

Title/summary	Emails from Mr Hartley regarding a complaint to the Information Commissioner's Office and the disclosure of documents by the Clinical Commissioning Group
Date	September 29, 2019, October 24, 2019, November 7, 2019

Marion Munns

Title/summary	Document from Mrs Mote and Mrs Vella to Nigel Pascoe QC setting out their outstanding questions and issues
Date	August 19, 2019

Title/summary	Email from Mrs Mote regarding disclosure from the Trust
Date	September 16, 2019

Other

Title/summary	Associated emails between the family members, the Trust, NHSI and Nigel Pascoe QC
Date	August 2019 – January 2020

As part of this Independent Investigation I have received factual representations on my draft Report from family members of the deceased; Trust members, representatives and employees; and the external independent investigators. This resulted in further emails and meetings taking place.