NHS
Sussex Partnership
NHS Foundation Trust

Office of the Chair & Chief Executive
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29 June 2023

Dear Ms Schofield

Inquest into the Death of Caroline Forte - Letter of Concern

Thank you for your letter dated 5 May 2023, addressed to my predecessor, [redacted].

I was sorry to learn of the concerns relating to the Serious Incident (SI) investigation into Caroline's death and I'm grateful to you for affording the Trust the opportunity to review matters and provide you with this response. I understand that this response, along with the letter I sent you last week, responding to the Regulation 28 Report, will be shared with Caroline's family. As such, I would also like to extend, through this letter, my sincere apologises to them regarding the quality of the Trust's SI report. I am truly sorry that it did not fully consider all matters relating to Caroline's death and thus enable the comprehensive learning that should have happened following Caroline's death. I sincerely hope this this letter, coupled with the response to the Regulation 28 report, provides assurance.

I understand that, during the Inquest, three areas of concern regarding the quality of the SI arose, namely, that the:

1. SI investigation did not identify the four issues that the Jury found contributed to Caroline's death and, indeed, found that '*all care provided was responsive and appropriate*';
2. SI reviewer did not record or consider, within the SI, the important issue of Caroline ligature tying on the ward; and

3. 'Lessons learnt' were not captured within an action plan, so there was no evidence that they were actually actioned.

I am particularly disappointed to read of these concerns as, when I first joined the Trust, as Chief Nurse, nearly 2 years ago now, I quickly recognised that our internal incident investigation processes required improvements. That being said, any significant change, of course, takes time and I recognise that the SI report into Caroline's death was completed in August 2022. The improvements specific to the SI investigation process have been taking place over the course of the last 18 months and have led to the Trust's central investigation team undergoing significant and ongoing change. A number of senior personnel changes, coupled with the need to prepare for the forthcoming national change from the SI framework to the Patient Safety Incident Response Framework (PSIRF) has meant that the SI team has required significant support to enable the necessary changes to occur, whilst also continuing to operate. Whilst this does not in any way excuse any SI's being below the standard we expect, and the SI into Caroline's death was certainly below that standard, I feel the aforementioned context is important to share with you to enable me to provide you with the assurances you, and Caroline's family, understandably, seek as to the quality of other and future SI/PSII reports.

Turning to your specific concerns, I will address the first two concerns jointly as they relate to the intrinsic quality of the SI review itself. The most significant change the Trust has made since last year is the way in which SI reports are quality assured. Specifically, now, SIs are subject to a higher level and layered quality review process, including, ultimately, sign-off by either the Trust's Chief Nursing Officer or the Chief Medical Officer. Additionally, multi-disciplinary panel sign-off approaches are now used so that quality can be assessed and discussed with the benefit of a range of expertise to provider richer scrutiny and thus learning. This multi-disciplinary/panel approach is also now being used during earlier stages of investigations by the use of subject-matter experts, in more complex cases, as well as wider use of independent chairs. These new wider multi-disciplinary approaches are also key as the Trust transitions to PSIRF.

PSIRF provides the Trust with a clear and welcome opportunity to affect the nationally recognised need to change from the SI framework to a more effective model of responding to incidents. So, this is where the Trust has invested in and is focusing upon, to ensure we have robust processes in place to sustain meaningful improvements to the way we respond to incidents. The Trust is aiming to transition to PSIRF at the end of August 2023. Prior to that transitioning the Trust's Legal Director would welcome the opportunity to meet with you to discuss the transition and the Trust's key priorities for future investigations, to ensure that they are in line with those matters that you feel ought to be prioritised in the forthcoming year. I understand that the Legal Director has a planned meeting with you, on other matters, in a few weeks' time, and I will ask that she takes the opportunity to initiate the conversation with you in relation to PSIRF.

Regarding your third concern, I confirm that, earlier this year, the SI team adapted their processes to enhance the 'lessons learnt' section, within all SI reports, to seek to widen the scope, for capturing learning. It is right to say that, initially, this learning, particularly if already effected, did not always have an action plan. However, since our new Chief Nursing Officer has been overseeing SIs, all 'lessons learnt' have had a corresponding action within a monitored action plan. I can also confirm that all action plans are overseen by the central SI team and their monitoring feeds into the governance structures within the clinical directorates, who are then responsible for ensuring completion of the actions. We have a newly established Quality and Risk Management Committee, co-chaired by the Chief Medical Officer and Chief Nursing officer, where assurance and risks relating to the learning from SIs and the action plans are overseen.

I hope that the aforementioned actions are of assurance to you. We believe that the current Executive led governance of SI reports, followed by the implementation of PSIRF has and will continue to lead to sustainable improvements in the quality of the learning we extract from SIs, to reduce incident recurrence and thus improve patient safety. As indicated, this is an ongoing piece of work, with national change being implemented, and the Trust welcomes your involvement. We will, of course, continue to monitor both the effectiveness of the recent improvements and how we achieve the best future improvements, as we transition to PSIRF. I will add an update on the

transition when I write to you in 6 months' time to update you on the Regulation 28 related improvements. In the meantime, if you have any questions regarding the content of this response or if I can further assist please do not hesitate to contact me.

Yours sincerely,

[redacted]

Chief Executive Officer

Sussex Partnership NHS Foundation Trust