OX3 8AH

Dear Dr Ryan

Thank you for your letter to me dated 17 August 2014 which was received on 22 August. Please accept my apologies for the delay in responding. I was absent from the office both on holiday and on business and when I returned I asked for additional information to be provided to me to enable me to respond.

As this is the first time that we have had direct correspondence between us, may I firstly take this opportunity to express my sincerest condolences for the loss of your son. I completely understand that in stating this, it will not even begin to address your considerable distress caused by this terrible and preventable tragedy.

Thank you for the questions that you have raised in your correspondence; I understand that some of these questions have been posed by you previously via Jan Fowler at the Thames Valley Local Area Team (NHS England) and we had provided her with a response to pass on to you. Others have been dealt with in correspondence with your solicitor.

I fully recognise and respect the fact that you do not wish to meet with representatives from the Trust, however, it would also seem that the information sent to date, whether through your solicitor or through NHS England has not answered your questions satisfactorily. Katrina's suggestion to you in her letter of 18th August 2014 that the written medium is not necessarily the optimum one for continued communication of this nature was made in recognition of the above.

Following discussion with Katrina and other relevant colleagues, I have endeavoured to answer your questions below as best I can in the order you raised them. In some instances, this is simply to reiterate information that has already been provided.

I strongly believe and concur with the view that social media is not the appropriate vehicle for communication about these matters and if this response does not adequately address the questions that you have raised, I would please ask you to contact me again.

Yours sincerely

Simon Waugh
Chairman

Southern Health NHS Foundation Trust response

1. Can you explain why Southern Health did nothing about the state of the unit between LB's death in July and the CQC inspection in September?

The Trust did take action in a number of areas following Connor's death, both within the STATT unit, and across the Trust, such as implementing immediate changes to the epilepsy care pathway.

Following a serious incident, the Trust is usually required to carry out an internal investigation and report back to commissioners within 45 working days. This process will involve site visits, interviews with staff/family and a review of available data and is carried out by someone removed from the service in question.

Therefore, in the weeks immediately following an incident, there is a significant amount of activity being carried out at the site of the incident that not only looks at the specific events in question but indirectly allows a view to be taken on the performance of the team/unit as a whole.

Following Connor's death, the police investigation took longer than we expected and we were specifically asked not to commence our own investigation during this time. This is standard practice during police investigations and it was entirely appropriate in the circumstances for the Trust not to have interviewed staff or to have begun an investigation of any kind.

Re-assurance as to the state of affairs was being given by senior managers from the service, but we now know that this was not entirely accurate and we have picked this up with the individuals concerned through HR investigations.

We recognise that the police investigation meant that we did not have the ability to scrutinise the unit in the way that we would have done had we been able to immediately commence our own internal investigation. Whilst we will always work in full cooperation with the police, this is something that we will be mindful of in future.

2. Can you explain why patients were not offered support to help them come to terms with LB's death in the unit when staff were?

I believe that the 5 patients on the unit at the time were offered appropriate support following Connor's death. I have copied below the response that was provided by the Trust in an email to Jan Fowler in March 2014 when you first posed the question through her. I trust this was forwarded to you at the time as we requested:

> "Following Connor's death all efforts were made to ensure the patients on STATT were supported to understand what had happened. On the morning of Connor's death most of the patients were in bed and were not immediately aware of what had happened. Patients were informed later that day and where possible, their families were contacted to let them know that Connor had died which may have caused their relative some distress.
>
> In the days following Connor's death all patients on the STATT unit were offered support from the multi-disciplinary team to talk about what had happened and how they were feeling. This included the offer of psychological support provided on an individual basis or in a group situation depending on how each patient wished to access support. The Trust was very aware that given the level of learning disability and other co-existing diagnoses such as

autism, psychosis and complex physical health issues each patient was affected by Connor's death in a different way and so the support provided was tailored accordingly with patients choosing to express their grief in different ways.

There were occasions when patients on the unit wanted to talk about Connor among themselves and staff were available to offer reassurance and, when required, answer any questions.

In the following weeks patients were offered the opportunity to talk about Connor's death at the weekly patient's support group, the psychological therapy group and in one to one sessions with staff as they wished.

Unfortunately patients on the unit were unable to attend Connor's funeral because of the family's understandable restrictions on staff attending, however those patients who wished to express their grief were supported to do so."

3. *Can you explain what the phrase 'Mum is known to the Trust' means and why it was used in the SIRI documentation?*

The use of this phrase is ambiguous but I do not believe it to be derogatory in the way you suggest. You clearly had a keen interest and active involvement in Connor's care and in the wider sphere of learning disabilities, and staff were likely to have been aware of this and felt that this should have been highlighted. I can only apologise if you feel that this was inappropriate, however, I can assure you that it had absolutely no bearing on the way subsequent investigations were carried out or other matters handled.

4. *Can you provide a more convincing explanation of why your Board minutes stated LB died of natural causes and all due processes were followed, when he didn't and they clearly weren't?*

As has already been explained, we have been unable to trace where the use of this sentence first originated as it does not form part of any email correspondence.

The quarterly Board Governance report template, in which this statement featured, includes as an appendix any items that we notified Monitor of during the quarter; it was within this section that this sentence appears. Whilst I am aware of how much distress this has caused you, I am entirely confident that there was no intention to distort the facts of the case.

The day after Connor died, the following email was sent to Monitor by the Trust notifying them of his death. Whilst subsequent investigations showed that he may in fact have had seizures following admission, the email provided the information as was understood at the time. It has no mention of the phrase natural causes and it explains that the police were investigating and that a SIRI investigation would be undertaken:

> "Further to our conversation this morning, I would like to notify you of an incident that occurred yesterday which has resulted in the death of a service user receiving care within our Learning Disabilities Division. The service user had a known history of epilepsy, but had no seizures witnessed since

admission in March. The service user was taking a bath yesterday morning, and was found by a member of staff not breathing and submerged in the water. CPR was commenced prior to transfer to hospital however the service user died without regaining consciousness. We have reported this as a SIRI and will investigate accordingly; in addition the police are investigating. This has been reported to commissioners and the CQC."

As such, I genuinely do not believe there was any intent to deceive in the subsequent Board paper as Monitor, CQC, commissioners, the police and safeguarding bodies had already been notified of the matter.

The section of the Board paper where the phrase 'natural causes' is used was meant to summarise the communication to Monitor. It is clear however that this is not an accurate reflection of the email that was actually sent.

The Board paper appendix in which this was written is authored by administrative and not clinical staff. We are required to report to Monitor on matters such as suicides, homicides and other identified reportable incidents. The use of the phrase "natural causes" was an attempt by a non-clinical member of staff, I believe, to communicate that there was no immediate evidence of foul play or suicide. The comment that 'all processes were followed' most likely was intended to refer to the fact that correct processes were followed after Connor was found in the bath.

The use of the terminology was misleading, albeit not intentionally so, and I can do nothing more but to say once again how sorry I am for the distress it caused.

5. Can you let us know what the situation is with staff disciplinary actions and whether you intend to refer any staff to their disciplinary bodies? (and)
6. Can you explain why the process of staff disciplinary actions has taken over 14 months so far?

I understand we have communicated with you previously about this via Jan Fowler and our position has not changed. We contacted professional bodies at the beginning of the year to advise them of the situation and they agreed that we should complete our own HR investigations before making any referrals.

As you are aware, none of the HR investigations started until Verita had concluded their investigation in January this year, which in turn required the police investigation to be concluded. I am confident that this order of things was appropriate and allowed for the most comprehensive basis to be made available for the HR processes.

The Verita report formed the basis for only some of the HR investigations and the CQC report into the inspection on the STATT unit published in November 2013 formed the basis for the others. Not all the HR investigations are linked to Connor's death.

HR disciplinary investigations can take a significant length of time to complete. In this instance, we commissioned external investigators for all the different HR investigations and this took a while to arrange. As is often the case, allowing flexibility for union representation and responding to union concerns can also take considerable time. We were keen that as the investigations all centred around a single team, that we dealt with them in a particular order so that where one investigation impacted on that of another individual, information could be

appropriately shared. Some staff were signed off sick for periods of this time and in some cases this held up not only their investigation process but that of others.

The HR process for two of the more junior members of staff has been completed and no grounds were found to refer either of them to their professional body. The final hearings for the remaining investigations are scheduled to be completed in the coming weeks and we will let you know what action will be taken once these are concluded. We will share this information with you via Jan Fowler unless you advise me otherwise.

7. Can you explain why we had to fight so hard to get the final copy of the independent report into LB's death published?

Whilst we advised you from the outset that we intended to share the final report with you, the matter of wider publication was not raised until January 2014. There was detailed communication between the Trust's legal advisors and your solicitors about this approach. This was not a straightforward decision to make and whilst I understand your viewpoint, I am satisfied that it was in fact necessary to undertake the deliberations that we did over the period of a few weeks in January / February, whilst other parties were commenting on factual accuracy.

Serious incident investigations are conducted with the express intent of making recommendations for learning within a team or the wider Trust. We can only improve the services we provide if staff are not afraid to come forward and admit to mistakes and if they willingly and openly engage in seeking to understand why things went wrong and in making changes as a result.

Serious incident investigation reports are not routinely published by any NHS Trust as there is a concern that to do so would be counterintuitive to the wider objectives of the process if staff felt intimidated or threatened as a result. The National Patient Safety Agency who historically provided training for organisations in how to carry out investigations of this nature, were strong advocates of an inclusive, non-threatening approach as evidence suggests this brings about the most meaningful engagement and ultimate improvement in practice. Staff have all sorts of concerns about the consequences of publication of reports and it would have been remiss of us not to consider the impact of our approach as carefully as we did.

8. Can you un-redact and re-send the large set of blacked out documentation received as access to records requests?
I have received assurance as to the way in which subject access requests are handled and any redactions will have been made in line with the requirements of the Data Protection Act (1998). I am therefore not able to make any changes to what has been provided to you to date.

9. Can you explain why you felt it necessary to construct a trolling/hacking issue around your employees twitter accounts and attribute this to me in a veiled statement to Monitor?
I do not agree that this was attributed to you; in fact we explicitly stated that we did not believe it to be you in our communication to Monitor:

> "Sadly, since the publication of the independent report the Trust has been subject to trolling on Twitter, a number of staff have been directly targeted

and have felt intimidated by the Twitter traffic, we are aware of at least one staff member's account having been hacked and a bogus Trust Twitter account has been set up.
We should be clear that there is absolutely no evidence that Sara Ryan is personally responsible for this trolling, hacking or intimidation."

Any information provided about Twitter activity has been based on fact and I do not accept that it was 'constructed' in any way.

10. Can you provide evidence of the alleged account hacking of your staff?
A senior and well respected member of staff reported to our communications team that a tweet had been sent purporting to be from their account but they had not written it themselves. A bogus Twitter account was also set up in the name of Southern Health at around the same time. Both incidents were reported to Twitter. I believe this was enough for us to voice our concerns in the way that we did.

11. Can you explain why you circulated an edited version of Trust communications/interactions with us to your Board members (and wider) which omitted a whole series of interactions including those around bullying and sacking our advocate?
The document outlining Trust communications/interactions with you is not an account of every interaction; indeed anyone with whom this was shared with was made aware of this. The document was collated in response to both internal and external questions being asked about whether we offered you the chance to meet with us in the months after Connor's death.

The matter of your advocate was made known both to me and to the Board and I know that the commissioners were also fully briefed by our Interim Director of Nursing as to the difficulties with her particular appointment and whether she was conflicted.

12. Can you provide a more convincing explanation for not disclosing the full set of LB's records before February 2014 despite repeated requests by our solicitor from July 2013 onwards?
I know Katrina provided an explanation to you in her letter sent in February 2014 and I am afraid there is no other explanation I can offer. It was human error on the part of the staff dealing with the print out from the electronic system. This was caused to some extent by them bypassing the normal system which would have required you to formally request the notes under the Access to Health Records Act, something we felt at the time would be an unnecessary additional burden for you. We have learnt from these mistakes and have made changes to our processes to ensure this doesn't happen again. A key point to note is that there was nothing within the documents sent to Verita in February 2014 that made a material difference to their findings, or influenced the conclusion that they reached.

13. Can you explain the discrepancies between the minutes of the Community Team Meetings we received and the set eventually received as part of the disclosure of records?
The draft notes for the Clinical Team Meetings (CTM) and the Care Programme Approach (CPA) meetings are taken by a non-clinical administrator and then

reviewed by the senior clinician in attendance. The key information from the draft is then inputted into various sections of the electronic record (RiO).

Regrettably, in this instance, as I understand, it appears that both the draft and the final reviewed version were uploaded to RiO and it is for this reason that there are two separate entries for the same meeting. I do not believe there to be material differences between the two versions, and certainly none that impacted on Verita's investigation, but I am sorry for the confusion this caused.

14. Can you explain how an independent investigation into deaths in your learning disability/mental health provision, commissioned by David Nicholson, was apparently concluded in June (according to your Board minutes) when it hasn't yet started?

The Trust Board action log is intended to capture actions agreed at previous meetings and provide assurance and updates to the Board on progress against these. The action, as articulated within the action log, did not refer to the investigation itself being completed, but to a regular update being provided to the Trust Board and / or Quality & Safety Committee. As such, it was agreed that this item would be closed, on the basis that this has been added as a standing agenda item to the Quality & Safety Committee agenda framework, with updates provided at each meeting, and reported to the Board as appropriate. The update was therefore in no way intended to reflect that the independent review had been concluded, but that this had been added to the regular reporting framework for the Quality & Safety Committee and the Board.

15. Can you confirm the 'bath ban' has been lifted at John Sharich House?

I can confirm there is no longer a 'bath ban' in place at John Sharich House, and that this was addressed as soon as it was brought to our attention.

16. And finally can you explain why you closely surveil our social medial activity and yet listen to nothing that is said?

I feel very strongly that the Trust has listened to what has been said about this terrible tragedy and that we certainly do not surveil you.

Although we don't believe that social media is the appropriate forum for detailed and sensitive discussions on specific issues, we do recognise and fully support the power of social media for transforming the ways in which we are able to listen and engage. Like all other organisations who use social media, we do our best to listen across a wide range of channels, the material on which is freely available to anyone. However, this does not mean that we actively carry out "surveillance" via social media.

We have listened and acted upon the findings of the CQC and those of Verita and continue to work to make improvements in the services we provide for people with learning disabilities.