Strictly Confidential

Independent Investigation into the Services Provided at The Haven, Whitechapel

Barts Health NHS Trust

April 2013

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Acknowledgements

The members of the independent investigation panel in this case, were asked to examine the services provided at the Haven, Whitechapel for the period since it was first commissioned in 2004.

The independent investigation panel revisits the circumstances and events in great detail causing all of those involved to re-examine often difficult and sometimes disturbing experiences. The independent investigation panel acknowledges this, as well as the discomfort caused by the process itself.

Those who attended to give evidence were asked to account for their roles, and provide information to the independent investigation panel. All have done so in accordance with expectations and candour for which they must be commended. We are grateful to all of those who have given evidence, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. This has allowed the independent to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

In particular we would like to thank the Trust for their support in obtaining the necessary information and help in arranging the interviews.

Executive Summary

A senior managers meeting held at the request of the Whitechapel Haven managers on the 26th January 2012 raised issues that were causing concern in relation to the service which was provided by Barts Health NHS Trust. The service's [redacted], [redacted], reported in discussions that [redacted] was aware that there were patient non-police referral forensic samples at the Whitechapel Haven that had not been sent off to the police for testing when they should have been. The [redacted] was asked to identify the nature and number of the samples and report back to a subsequent meeting on the 8th February 2012.

At this subsequent meeting it was reported that a substantial number of outstanding forensic samples were being held at the Whitechapel Haven. Further investigation found that a number of other areas of concern in regard to patient information, forensic articles and other issues were outstanding,

An internal investigation was set up in March 2012 to examine the circumstances of the areas of concern and make recommendations for future service provision. The report was completed in April 2012 and made nine recommendations for the Trust to consider and complete.

An independent investigation was commissioned in July 2012 by the Trust at the request of NHS London. The Terms of Reference were jointly agreed between the Trust, Primary Care Trust, Specialist Commissioning Team and NHS London.

Background to the Service

The Whitechapel Haven is a Sexual Assault Referral Centre (SARC) service which is commissioned jointly by the London Metropolitan Police and the Specialist Commissioning Team at NHS London from the Trust.

The Whitechapel Haven opened in 2004 and is one of three SARCs commissioned for clients across the Greater London area. The other two SARCs are situated in Camberwell and Paddington. The Whitechapel Haven serves 13 London Boroughs but a client can chose to present themselves for assessment and treatment at any of the three pan London centres.

The service accepts police and non-police referrals (self referrals).

Findings and Recommendations

The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed examination of the evidence, both written and oral, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust, Police, and Commissioners to put into progress any actions required to prevent a similar occurrence. It also sets out areas of notable practice.

While writing this report the independent investigation panel is mindful of the proposal to change the management and SARC service being provided in London.

Notable Practice

It is normal process in investigations to set out areas of notable practice. In this case there are several areas of good practice that the independent investigation panel wish to single out as examples.

Whitechapel Haven Staff

The independent investigation panel would like to have noted that all staff who were interviewed, or that they had contact with, during the investigation responded in an open and honest manner. There was evidence that the staff team had worked very diligently since the incident to ensure that a similar event did not occur and to discover and correct the extent of the issues.

Asian Worker

The independent investigation panel would like to commend the introduction of an Asian Worker into the staff team. It was considered that having identified the needs of their client groups this was an appropriate initiative as many of the Whitechapel Haven's clients came from this ethnic group.

Patient Survey

Despite the issues that are under investigation the feedback from patient surveys were very good. The independent investigation panel would like to commend the Whitechapel Haven staff team on the high quality of individual care provided to those accessing their service.

Safeguarding Adults and Children

Since the incident the Trust's safeguarding team now attend a Whitechapel Haven meeting on a weekly basis to review cases that might, or have fallen, within the auspices of safeguarding adults and children. Evidence was provided that the Whitechapel Haven is appropriately referring individuals to the relevant safeguarding leads. The weekly meeting provides an audit of these cases and the initiative is commended.

General Findings and Recommendations

The independent investigation panel have made some individual recommendations later in this section but consider that generally there was a whole system failure that does not relate specifically to individuals. It was found that there were missed opportunities in all parts of the system that if noted could have in some part reduced the incident.

The internal investigation and safeguarding review have made recommendations to improve both the service and practice. It is not intended to replicate these or devalue the importance of the Trust to continually review, evaluate and monitor their application.

The independent investigation panel recognise that the Trust has gone through a major reorganisation during the process of this serious incident and many of the managers previously involved with the Whitechapel Haven, both clinically and managerially have moved into other areas of work within the Trust. The informal intelligence about the service and the history behind its development therefore will be diluted.

Recommendations

The information gathered from the analysis of the submitted material and the interviews echoed many of the underlying failures identified in the Francis Report[1] in terms of clinical and business standards, corporate and clinical governance, accountability, induction and training and staff failing to effectively raise their concerns. The Francis Report's recommendations are summarised as follows:

- *Foster a common culture shared by all in the service of putting the patient first.*

[1] Francis R (2013): Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationery Office.

- *Develop a set of fundamental standards, easily understood by patients and healthcare staff, the breach of which should not be tolerated.*
- *Provide professionally endorsed and evidence-based means of compliance with standards which can be understood by staff.*
- *Ensure openness, transparency and candour throughout the system about matters of concern.*
- *Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.*
- *Make all those who provide care for patients accountable and to ensure that the public is protected from those not fit to provide such a service.*
- *Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.*
- *Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare to integrate the essential shared values of the common culture into everything they do.*
- *Develop ever improving means of measuring performance of individual professionals, teams, units and provider organisations for patients and all other stakeholders in the system.*

The following recommendations are in addition to those previously identified by the earlier investigations and or reviews. They are not in any priority of order and apply to the Trust unless otherwise indicated.

Failing Service

Many members of staff were aware of problems and in some cases had reported concerns to their line managers. Senior managers had access to information that they could have intervened on, but they didn't. A frequently used phase as an answer to questions by the independent investigation panel was "I assumed it was being dealt with".

It is considered that if there had been a mechanism or system for systematically bringing this information together the awareness of a service not functioning well would have been raised.

Recommendation One

It is recommended that the Trust develops an audit process that recognises issues that need addressing and could be used to review, evaluate and identify when a service is not functioning to the required standard.

Organisational Structure

The independent investigation panel found that the organisational structure was unnecessarily complicated with direct line management and professional supervision being provided in isolation from each clinical line. It is acknowledged that for services comprising of different professionals the management and supervision can be complex, however there should be a forum to bring those strands together.

Recommendation Two – Trust and Commissioners

It is recommended that the organisational structure is reviewed with an aim to making simple and clearer the lines of accountability and overall responsibility for the service.

Staff Engagement

The specialist nature and relatively small size of this service places it at higher risk of isolation from mainstream NHS services which in turn increases the risk of poor working practices within the team.

Recommendation Three

To reduce the risk of a recurrence of a dysfunctional team working environment it is recommended that an anonymised staff survey should be carried out at regular intervals with the outcomes transparently shared and fed into governance arrangements.

It was found that the opportunity to gain a better insight to the concerns in regard to the Whitechapel Haven's service was missed when exit interviews were not offered to staff leaving the service.

Recommendation Four

It is recommended that ALL staff leaving the service, including those on the out of hours team, have exit interviews offered and any intelligence gained from such is used to improve the service.

Peer Review

The independent investigation panel consider that opportunities for shared learning, multi-agency working and joint training was missed by the absence of formal peer review.

Recommendation Five

It is recommended that there is regular clinical peer review with attendance by individual clinicians monitored. These sessions should cover review of cases in their entirety including record keeping, safeguarding issues, quality of statements. The sessions should be used for clinicians to voice ideas and concerns about the service and how it can be improved upon.

Recommendation Six

It is recommended that on a regular basis there is external peer review by an independent clinician who is invited to attend, take part in the peer review process and give feedback on the observed processes and learning environment. Feedback of these sessions should be shared with all the staff team.

Recommendation Seven – Commissioning

It is recommended that a peer review framework is developed within the new model for the pan London SARCs that audits and evaluates all three service delivery areas and reports on a regular basis to the commissioners.

Specialist Expertise and Clinical Leadership

The independent investigation panel found that across the pan London SARCs few medical staff had a forensic qualification. It is considered that a forensic qualification is vital to maintain the specialist clinical care required. The SARC aims to meet the medical, psychological and forensic needs of the individuals that use the service. It is important that the staff have the correct training and qualifications to undertake this.

Recommendation Eight

It is recommended that there is a review of the qualifications of the team and an action plan developed to address any gaps. In their January 2013 Quality Standards the FFLM have recommended that "The contracted workforce should have a minimum of 25% of forensic physicians with FFLM Membership." (http://fflm.ac.uk/upload/documents/1358340451.pdf)

Recommendation Nine – Commissioners

It is recommended that the service specification for the new model for pan London SARCS sets out that there is a medical lead with a forensic qualification employed at each of the three London sites to ensure that high standards of care are delivered.

Consideration should also be taken in regard to a specialist Paediatrician with forensic expertise to lead on children services.

Governance

The lack of accountability for clinical governance in the Whitechapel Haven, combined with a weak infrastructure of human resource management was repeatedly identified as a major contributor to the service failure.

Recommendation Ten

It is recommended that clinical governance expertise is always available and appropriately utilised, and that recruitment, induction, appraisals and training is reviewed to enable the team to foster a common culture of shared values and accountability for all their actions.

Complex Service

The independent investigation panel found that generally within the Trust the complexity of the service was not understood resulting in a service that it is considered was not well supported and isolated from the mainstream services.

Recommendation Eleven

It is recommended that effective support structures are put in place which would also define the roles and responsibilities of the host Trust in relation to performance management.

Clinical Environment

The independent investigation panel have concerns regarding the environment at Whitechapel Haven, in particular, the Forensic Suite. It was considered that this did not meet the standards required in terms of a safe forensic assessment area.

Recommendation Twelve

It is recommended that the physical environment of the SARC is monitored in particular with respect to its cleanliness and forensic integrity and also to its appropriateness of seeing children (the age of a child being under 18 years old) in a child unfriendly environment.

Recommendation Thirteen

It is further recommended that the environment at Whitechapel Haven is reassessed jointly by both health and police to identify areas for improvement and that a timetable for completion of these improvements is developed and adhered to.

Multi-disciplinary Team Case Reviews

The independent investigation panel found that a method to regularly review cases was not in place at the Whitechapel Haven.

Recommendation Fourteen

It is recommended that there are regular multi disciplinary case reviews, looking at random cases as well as cases where potential problems have been identified.

NST

The NST found a number of issues that they considered needed addressing. The independent investigation panel consider that these were not acted on nor was a plan put in place to monitor progress against the concerns raised

Recommendation Fifteen

It is recommended that the Trust revisits the NST Recommendations and includes these in the action plan that id developed in response to the other recommendations in this report.

1. General Introduction

1.1. At a senior managers meeting held at the request of the Whitechapel Haven managers on the 26th January 2012 to discuss issues that were causing concern, the [redacted], reported in discussions that [redacted] was aware that there were patient non police referral forensic samples at the Whitechapel Haven that had not been sent off to the police for testing when they should have been. The [redacted] was asked to identify the nature and number of the samples and report back to a subsequent meeting on the 8th February 2012. At this subsequent meeting it was reported that a substantial number of outstanding samples were being held at the Whitechapel Haven. Further investigation found that a number of other areas of concern in regard to patient information, forensic articles and other issues were outstanding.

1.2. Whitechapel Haven is a service provided by the Barts Health NHS Trust (the Trust). An internal investigation was set up in March 2012 to examine the circumstances of the areas of concern and make recommendations for future service provision. This was led by a senior manager. The report was completed in April 2012 and made nine recommendations for the Trust to consider and complete, (see Section 9).

1.3. The Whitechapel Haven was initially closed to all new referrals in March 2012 but at the request of NHS London reopened in a limited way in July 2012, primarily to accommodate possible clients during the London Olympics. The senior management team have been redeployed elsewhere in the Trust. The service reopened in a limited way for adults in July 2012 whilst the service is under review but did not provide a service for children under 14 years as it had done previously. A paediatric service was provided by the Paddington Haven.

1.4 This independent investigation was commissioned in July 2012 by the Trust at the request of NHS London. The Terms of Reference were jointly agreed between the Trust, Primary Care Trust, Specialist Commissioning Team and NHS London, (see Section 3).

1.5 The investigation panel is referred to as the independent investigation panel throughout this report and the Trust initial incident report as the internal investigation.

Background to the Service

1.6 The Whitechapel Haven is a Sexual Assault Referral Centre (SARC) service which is commissioned jointly by the London Metropolitan Police and the Specialist Commissioning Team at NHS London from the Trust. Prior to 1st April 2011 it was commissioned jointly between the Metropolitan Police and Tower Hamlets Primary Care Trust (PCT).

1.7 The Whitechapel Haven opened in 2004 and is one of three SARCs commissioned for clients across the Greater London area. The other two SARCs are situated in Camberwell and Paddington. The Whitechapel Haven serves 13 London Boroughs but a client can chose to present themselves for assessment and treatment at any of the three pan London centres.

1.8 The service accepts police and non-police referrals (self referrals).

2. Purpose of the Investigation

2.1 The purpose of the independent investigation panel was to understand what was known, or should have been known, by the relevant professionals at the time of the Serious Incident regarding the situation at the Whitechapel Haven. Part of this process is to examine the robustness of the internal investigation and to establish whether the Trust has subsequently implemented changes resulting from the internal investigation findings and recommendations. The purpose is also to raise outstanding issues for general discussion based on the findings identified by the independent review team.

2.2 The independent investigation panel is required to make recommendations for service improvements. Members of the panel have been alert to the possibility of misusing the benefits of hindsight and have sought to avoid this in formulating this report.

2.3 The independent investigation is intended to be a positive process which examines systems and procedures in place in the Trust at the time of the incident, and works with the Trust to enhance the care it provides. The wider aim is that we all learn from incidents to ensure that the services provided to our patients are safe and quality assured; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering services.

2.4 It is also recommended that the learning from this independent investigation should be shared more widely than the Trust and Whitechapel Haven. Lessons should be disseminated across the other two London Havens and to SARCs in general.

3. Terms of Reference Haven, Whitechapel

Background for commissioning of external review June 2012

Brief Background

Sentinel event

3.1 The Haven Whitechapel is a sexual assault referral centre opened in 2004 and managed by Barts Health NHS Trust (and Barts and the London NHS Trust prior to April 1st 2012). It is commissioned by the Metropolitan Police and London Specialised Commissioning Group. A member of staff disclosed in January 2012 that forensic swabs that should have been sent to police, for non-police referrals were in fact retained on the premises. An investigation determined that 55 such swabs were retained from as far back as 2004 and a further 5 were in process but delayed. Additionally in a further 50 cases, forensics results had been obtained but the clients not informed.

Second finding

3.2 In May 2012 around 100 telephone contact records were found on the premises that indicated that safeguarding issues had not been concluded/signposted in 3 cases.

Investigation

3.3 An internal serious incident was declared and escalated to NHS London. A senior internal investigator was appointed and made recommendations. As a result of this, management arrangements for the service were changed and the service closed for new clients and the other London Havens have taken up this caseload. The investigation revealed a long standing issue with interpersonal difficulties in the Haven and some significant interventions had taken place.

3.4 As a result of the second finding, the Trust has instituted a look back investigation to determine if any further safeguarding concerns exist in safeguarding records going back to 2009.

Proposed Terms of Reference for the external review

3.5 The external review will explore:

1. Whether appropriate standards of service were in place and communicated to staff and other stakeholders as appropriate?

2. Whether standard operating procedures were in place to meet those standards and if there where arrangements for audit of these processes?
3. Were these systems designed to give adequate oversight of the service quality so that actions could be taken (at all levels) if issues identified?
4. If not operating effectively, why were they not?
5. Review how the service was connected into the governance/ divisional management arrangements within the Trust and the effectiveness of these relationships. For example, in the assurance evidence used to demonstrate compliance with CQC essential standards, risk registers, performance reports and quality reports to the risk and quality committee.
6. To review the effectiveness of working relationships across all levels (for example, divisional director/general manager to head of service, head of service to clinicians and administrators) and to review how dysfunctional teams are identified and managed within the Trust.
7. To review the effectiveness of the role of the LSCG in quality assuring the service and managing and escalating issues of concern.
8. Make recommendations to ensure that the service can in future provide an efficient, safe, high quality service that is well governed.
9. To make recommendations to commissioners on how to strengthen assurance arrangements of such specialised services.

Materials

1. Internal investigation report
2. Minutes of the incident management meetings
3. Sample material of 10 cases of investigatory pathway for non-police referrals
4. Investigation report and statement s from staff. Spring 2012
5. Procedures, guidelines and reports from the service and to the divisional management team, board and risk and quality committees
6. Risk, incident, complaints logs – 2 years
7. Contract specifications from the Commissioner and QA reports – 2 years
8. Interviewers with relevant staff and commissioners
9. Visit to Haven Whitechapel

Membership of Investigation team:

Chair: Caroline Alexander, Director of Nursing and Quality, NHS North East London and the City (NELC)
Caroline will commission and chair the investigation on behalf of Trish Morris Thompson, Chief Nurse, NHS London

3.6 Members of investigation team:

- Cath White, Clinical Director of Sexual Assault Referral Centre, St Mary's Manchester
- Angela Lennox, Deputy Medical Director, NHS North Central London
- Lynda Winchcombe, Senior external management consultant

Process for the investigation

3.7 The investigation team will undertake the site visits, interviews and review of paper evidence.

3.8 An investigation panel meeting will be convened where the investigation team will present their draft findings and recommendations to the chair of the panel for discussion and decision.

3.9 A report will be produced by the lead investigator that includes the conclusions of the panel along with the detail of the investigation.

Proposed timelines

3.10 It is aimed to undertake the interviews and site visit between the 27th and 29th of June 2012. Briefing materials will be supplied to the investigators at least one week before then.

3.11 Investigation panel meeting in the first two weeks of July
Report to be finalised and submitted to the Trust by the end of July.

4. Method

4.1 Barts Health NHS Trust commissioned the independent investigation under the Terms of Reference set out in Section 3 at a meeting held on 18th July 2012, and attended by representatives of Barts Health NHS Trust, the independent investigation chair and two of the three panel members.

4.2 Shortly after this meeting the proposed chair of the investigation moved from their post and it was agreed that the three remaining members would continue as an independent investigation panel.

4.3 Documentation and relevant information regarding the Whitechapel Haven service was collated and sent to the three members of the independent investigation panel during August 2012. This was outside the timetable as set out in the Terms of Reference.

4.4 Further documentation was identified during the investigation and these were indexed and included with the original documentation. A full list of the documents seen as part of the investigation can be found at Appendix One

4.5 Two members of the independent investigation panel met on 6th September 2012 to discuss their initial perusal of the documentation.

4.6 The third panel member was unable to attend this meeting due to prior commitments. A second meeting on 18th September 2012 with all three independent investigation panel members was held to agree the process and diary dates for interviews.

4.7 A programme of visits, interviews and report drafting was agreed with a finish date of the end of November 2012.

4.8 A presentation was provided to two members of the independent investigation panel on 12th October 2012 by the Clinical Director, who was currently responsible for the Whitechapel Haven service. The purpose of this was for the independent investigation team: -

- To gain an understanding of the services provided by the Whitechapel Haven.
- Understand the actions taken following the internal review.
- To provide an opportunity to meet the service's senior managers and discuss the process that the investigation would follow.

4.9 Some members of the Whitechapel Haven also attended the meeting where the investigation process was discussed. This provided an opportunity for staff to ask questions about the investigation and informally meet members of the independent investigation panel. A further aim was to reassure those that were to be called to interview that the process was one of learning lessons via systems and processes and not one of blame.

4.10 A visit to Whitechapel Haven by two members of the independent investigation panel was undertaken on 16th October 2012 to view the premises and understand where the service was provided from and issues that might arise from the environment.

4.11 Previously arranged interview dates during October were cancelled due to Trust organisational difficulties and rearranged to commence on 6th November 2012 thus further delaying the independent investigation and the proposed completion date. Further evidence was received from 27 individual witnesses during November and December 2012.

4.12 A letter detailing the areas of questions to be discussed was prepared for sending to each individual prior to the interview together with copies of the Terms of Reference and Investigation Procedure. This process was undertaken by the Whitechapel Haven's interim service manager at their request, however some individuals reported that they did not receive letters or the accompanying documentation.

4.13 Each interview was recorded and transcripts sent to the individuals to check for accuracy and amend as necessary. The amended version was the one that the independent investigation panel have used to evidence their report.

4.14 One member of the independent investigation panel spent a morning at Whitechapel Haven on 12th December 2012 to observe a team meeting and discuss in detail the forensic assessments undertaken there.

4.15 The following week photocopies of ten individual sample case notes were sent to the independent investigation panel for review in regard to structure, information collection and process. These included both non-police and police referrals.

4.16 An interim paper was provided to the Trust on 1st March 2013 that outlined the areas under consideration within the main report. This report was presented to Barts Health NHS Trust on 11th April 2013.

5. Service Profile

5.1 Whitechapel Haven is one of three pan London Sexual Assault Referral Centres (SARC) and is based in the Whitechapel area of East London.

5.2 The service is currently jointly commissioned by the Specialist Commissioning Team from NHS London and the Metropolitan Police Service. Prior to April 2011 the service was jointly commissioned by Tower Hamlets Primary Care Trust and the Metropolitan Police.

5.3 Whitechapel Haven originally opened in 2004 and supports the population of 13 London Boroughs although individuals can present at any of the three London centres for support. The service is part of the Trust's Infection and Immunology Clinical Academic Unit based in the Ambrose King Centre, although it has a separate service manager exclusively for the service.

5.4 Individuals enter the service either via the police following an allegation of sexual abuse, that is under investigation, or as a self referrer. Other health and or social care professionals can refer individuals to the service for assessment. The former route is identified as "police referral" and the latter as "non-police referral."

5.5 The service prior to January 2012 was provided 24 hours a day, seven days a week with on-call doctors and crisis workers managing the referrals outside office hours. Most of the on-call referrals were police referrals. Since reopening in July 2012, the service has slowly increased its opening hours and is yet to reach the previous level of service. Since the service reopened children under 14 years are now seen by the Paddington Haven; currently there are no plans to provide this part of the service at the Whitechapel Haven.

Clinical Team

5.6 The clinical team at Whitechapel Haven consisted of three senior managers: -

- Lead clinician who was a Consultant specialising in Sexual Health, and responsible for a medical team consisting of a Speciality Doctor and Trainee doctors.
- Clinical Nurse Specialist responsible for the nursing staff which consisted of one Band 6 and two Band 5's.
- Service Manager responsible for the administration and reception staff. The financial management and service review also came under this remit.

5.7 There are other members of the team managed both clinically and managerially by individuals outside the Whitechapel Haven service.

- Lead Psychologist
- Health Advisor
- Young Person's Development Worker
- Asian Development Worker
- Crisis Workers (14)
- Specialist Paediatricians

Service Provided

5.8 The service provides support and counselling to a wide range of clients including children (over 14 years old since reopening) who present to the Whitechapel Haven either as: -

- A police referral to the service following a report of alleged sexual abuse.

- A non-police referral when an individual seeks support directly from the Whitechapel Haven. These referrals can also be made by the individual's GP or other health and social care services.

5.9 Self referrers to the Whitechapel Haven have a number of choices:

1. To have a forensic examination with the samples and intelligence obtained to be forwarded to the police including details of the individual.

2. To have a forensic examination with the samples and intelligence obtained to be sent to the police anonymously.

3. To have a forensic examination with the samples and intelligence to be stored allowing the individual to make a decision at a later date to refer the case to the police.

4. To decline a forensic examination but still receive support and aftercare from the Whitechapel Haven service.

5.10 Once the forensic examination and samples have been taken they are stored in a freezer (this was a change in practice in 2011, prior to this it was acceptable to store samples in a fridge).

5.11 If the individual chooses for the sample to go to the police it is collected by the police. These collections should happen on a weekly basis. The sample is then reviewed by the police forensic team and a decision is made by that team as to

whether to test the samples for DNA. This decision is based on the likelihood that the case will be taken up by the Crown Prosecution Service (CPS).

5.12 The decision of the police to test and the subsequent results of such tests, are reported back to the individual. As this could be a known or anonymous person to the police it is the responsibility of the Whitechapel Haven staff to communicate this information back to the relevant individual. The Whitechapel Haven also has the responsibility to liaise with the police for their decision or results.

5.13 The individual continues to be supported by the relevant Whitechapel Haven staff and offered a range of after care services and follow up clinics. The service offers healthcare follow up appointments for STI screening, review of HIV tests and Hepatitis B prophylaxis.

5.14 The complexity of the presenting individuals to the service can be difficult and challenging. The individuals span all elements of society, with many being amongst the transient community. The individuals can present during both day and night hours. The out of hours work is usually undertaken by the on-call crisis workers.

6. Timeline of the Events

6.1 The following is a timeline of the events that relates to prior to the identification of the incident and the date that significant events occurred.

Date	Event
2004	The Whitechapel Haven was commissioned and opened. Operational policies were developed which related to the local service.
2008	The [redacted] at Whitechapel Haven raised concerns about the service at the Whitechapel Haven to [redacted] line manager. These were construed by managers as being related to poor relationships between the three managers of the service, [redacted] as well as the general staff team.
March 2008 to March 2009	An audit was completed during this period to examine the referrals to the service and what outcomes resulted from these referrals. The results showed that 28% of clients were not offered follow up appointments as per the agreed Operational Policies for the Whitechapel Haven.
2009 to 2010	Senior management from within the Trust discussed the audit results and having continued to understand that there were poor working relationships within the staff team decided to commission the Tavistock Institute to facilitate better working relationships between the team. This review was undertaken by conducting individual interviews and team workshops. A report was prepared and the findings presented to the Trust and staff team (see Section 11).
October 2010	Commissioning for the Whitechapel Haven transferred from Tower Hamlets Primary Care Trust, (this commissioning was transferred to Croydon Primary Care Trust who had pan London responsibility for specialist services for a short while), to NHS London's Specialist Commissioning Group who then jointly with the Metropolitan Police commissioned the service. This resulted in a revised service specification and clearer contractual management arrangements were put in place. A Police led pan London protocol for non-police referrals was developed and the Whitechapel Haven service was requested by the Commissioners to implement the protocol.

January 2011	A tracking database was developed for use in the pan London Havens and was to be implemented by the Whitechapel Haven. This system was set up to monitor both police and non-police referrals.
September 2011	The Whitechapel Haven's sample storage freezer broke down and some samples were transferred to the pathology department at the Royal London hospital for safe storage.
December 2011	A meeting was held between [redacted] of the Whitechapel Haven and their line managers as a number of different concerns had been raised about the service and continuing poor relationships. Sometime prior to this meeting the Human Resources department had been sent an anonymised letter from staff at the Whitechapel Haven expressing concerns about the service, (the independent investigation panel have not seen this letter)
26th January 2012	A second meeting was held to review the actions agreed at the December meeting. The specific issue of storing of samples that should have been sent to the police was raised by the [redacted], the number and detail was not known at this time.
8th February 2012	A third meeting was held where the scale and severity of the issues were acknowledged, in that there were samples from at least 60 cases that had not been documented or stored correctly, however there was still no information on the exact details. It was during this period that the Specialist Commissioning Team (SCT) was informed of the SI by the Trust. NHS London had also been informed of the Serious Incident but the commissioner for the police was informed by the SCT. At the request of the Commissioners an urgent meeting was set up with the Trust to establish the extent of the SI.
14th March 2012	The Police's lead commissioner held a meeting with the Police's Continuous Improvement Team (CIT) and informed them of the SI at the Whitechapel Haven. The CIT made arrangements to meet with the Whitechapel Haven to establish the issues. Operation Liberty was set up by the police to investigate the SI.
March 2012	Whitechapel Haven managers redeployed and interim managers seconded to the service.
May 2012	An estimated one hundred telephone contact records were found at Whitechapel Haven that indicated safeguarding issues had not

	been concluded and or signposted in three cases. The normal process had not been followed.
June 2012	Safeguarding Review commissioned by the Trust.
August 2012	Safeguarding Review report completed with recommendations for the Trust to implement.

7. Analysis of the Evidence

7.1 The following section details the independent investigation panel's analysis based on the evidence both written and oral that had been provided to them during the course of the independent investigation. It sets out the background to the issues raised in regard to the Whitechapel Haven service and consideration of additional issues raised within the independent investigation. The issues raised are not in any priority order.

7.2 The Terms of Reference sets out seven areas for the independent investigation panel to explore. In addition recommendations should apply to both the Trust and Commissioners. The independent investigation panel have set out their consideration of the Whitechapel Haven according to the seven areas that were identified. It has to be acknowledged however that there may be some duplication within the individual sections.

Service Standards

7.3 The first four areas that were identified for examination were whether appropriate standards of service were in place and communicated to staff and other stakeholders as appropriate. In addition the independent investigation panel was asked to consider what systems were in place to ensure service quality was maintained. To meet this objective the independent investigation panel have included the action taken immediately after the disclosure regarding concerns, staffing and environment.

Actions taken Post Disclosure

7.4 Following examination of the issues underpinning the Serious Incident and the completion of a initial internal investigation of the circumstances of the SI prior to the commissioning of the independent investigation the following was found:

a. Items that require exhibiting in criminal cases had not been exhibited correctly.

b. Packaging of exhibits, especially clothing was poor and some were left in plastic bags instead of the required paper bags to prevent the deterioration of the evidence.

c. A large bag of clothing was found that was not packaged, labelled or exhibited correctly.

d. Possible contaminated clothing was found to be mixed with clean items brought in by the individuals.

e. The Book 105 was poorly maintained with approximately 50% of cases not recorded correctly.[2]

f. Paperwork was not completed properly, including case notes.

g. It was estimated that samples from at least 60 individual cases had not been dealt with and were found in the Whitechapel Haven's fridge and other storage areas within Whitechapel Haven without having followed the correct procedure.

h. Letters, correspondence and other patient related data covering several years was found to be not appropriately processed at the Whitechapel Haven.

i. 100 telephone contact records were found that indicated safeguarding issues had not been concluded and or signposted to the relevant service in three cases.

7.5 As an initial response to the SI the police established "Operation Liberty", which together with staff from the Whitechapel Haven identified the immediate issues that required attention. This included the need for tracking individuals who used the service to inform them of the situation and give them the opportunity to reassess any risk. This activity continues and several alleged perpetrators have been dealt with by the Criminal Justice System.

7.6 The results of the initial internal investigation identified a serious service deficit in completing the tasks necessary to ensure that the standards required for the service were delivered and maintained. The independent investigation panel heard evidence that when the service transferred to the SCT in October 2010 the service specification across the three pan London SARCs was generally considered to be inadequate; performance indicators had not been put in place and the only structured process was the Service Level Agreement which did not set out detailed service requirements.

7.7 Contract monitoring meetings had not taken place since the Whitechapel Haven service commenced and therefore benchmarks in relation to care pathways and protocols were not available.

[2] A police record book used to record all items held as exhibits and used to monitor the transfer of items between custody and health in this case.

7.8 It has to be noted that concerns were being raised for several years by staff working at the Whitechapel Haven and the audit undertaken in 2008 showed that the Operational Policy for Whitechapel Haven was not being followed.

7.9 The independent investigation panel could find no evidence that the Trust took action to review and implement the necessary actions following the 2008 audit. The action that was taken at the time was to commission the Tavistock Institute to examine working relationships within the Whitechapel Haven staff team, and in particular between the [redacted] of the service.

Staff Relationships

7.10 The issue of poor interpersonal relationships between the [redacted] and some staff working at the Whitechapel Haven was well known by staff working in the Infection and Immunity Directorate and senior managers within the Trust. The independent investigation panel heard that the difficulties posed by the situation were raised with the line managers of the involved staff within the Trust during clinical supervision but no action was initially taken. The independent investigation panel were informed by one senior manager within the Trust, but external to Whitechapel Haven managers, that the situation was "a perfect storm".

7.11 In 2009 the Tavistock Institute was commissioned to work with the staff group to identify the issues relating to their working and interpersonal relationships. They concentrated on interviews with staff and in particular the [redacted] and their relationship. The independent investigation panel heard that once the review was completed some staff who had been interviewed were not provided with feedback on the report's findings and recommendations. This left them feeling frustrated that their views were not considered important and helped them to feel disempowered. A fuller analysis of the Tavistock Institute's report can be found in Section 11 of this report.

Staff Communication

7.12 Communication between staff working within both large and small teams is vital to ensure that good working practices are followed and standards met. Effective communication is also fundamental to maintaining good working relationships and sharing information, both written and oral.

7.13 The independent investigation panel heard evidence that suggested communication between staff at the Whitechapel Haven was poor. It was also apparent that this extended to other agencies and within the wider Trust services as the following examples show.

7.14 Separate two monthly meetings took place for the out of hours crisis workers which did not include the general Whitechapel Haven staffing team and it has to be queried as to how communication about developments, policy and initiatives was shared between the two staff groups. It is understood that the crisis workers did not have to attend these meetings and therefore attendance was on an ad hoc basis.

7.15 Joint meetings between service and clinical managers did take place with the other pan London SARCs but poor relationships tended to limit the positive aspects that could have resulted and been implemented. The independent investigation panel heard that learning and joined up initiatives were not part of the routine process for these meetings. This was considered to be a missed opportunity.

7.16 Without getting into specifics it was generally understood by staff that [redacted]. This was reported to senior managers but no formal action was taken thus further perpetuating the situation and the perception that the difficult relationships between the staff was the cause of everything "going wrong".

Working Relationships

7.17 The independent investigation panel reviewed the effectiveness of working relationships across all levels, both within and outside the Trust.

7.18 To develop good working relationships these have to be established with all colleagues who are relevant to the work of a given service.

7.19 It is important to understand, agree and respect the roles and responsibilities of all those working to provide a service. Conflicts of interest and disagreements with colleagues need to be identified and addressed in a timely manner to minimise damage to service provision as well as to assure quality standards.

7.20 Part of the process in establishing good working relationships is to: -

- Have clarity on the roles and responsibilities of team members.
- Share information.
- Understand colleagues' needs and motivations.
- Make time available to support each other.
- Agree what is expected of others.
- Develop professionalism and mutual support.
- Develop mutual respect.

Establishing Working Systems.

7.21 The independent investigation panel heard that since the SI the Whitechapel Haven staff now meet each morning to review the previous day's work and to plan that day's individual tasks. It is understood that this has greatly improved staff relationships, morale and the sense of belonging to the team. It has provided the opportunity to explore outstanding issues and to discuss cases with colleagues. The meeting was originally initiated by the interim service manager.

7.22 An understanding of each other's roles and responsibility is developing and mutual support taking place, not only during the meeting, but throughout the working day. The independent panel commend the initiative.

7.23 Although there were structured processes in place previously, a forum to constantly review, evaluate and audit the work being undertaken to agreed service standards was not available. In addition although the [redacted] examined all the referred individuals' case notes there were no formal audits carried out in line with best practice. It appeared that most of the audit processes concentrated on activity rather than quality.

7.24 It was indicated that both the police and Whitechapel Haven services worked to different systems and without robust structures in place to constantly evaluate and audit; the opportunity to learn and constantly improve the service was lost. The independent investigation panel consider that the service was micro-managed whilst key overarching points were missed. No evidence based risk management process was identified nor was there an actively managed risk register in place as indicated later in this report.

Working Environment

7.25 During the course of the independent investigation many issues were raised in relation to the cultural issues that were present within the Whitechapel service, the wider pan London Haven services and the Trust and management. In order to understand some of the processes and systems in existence, a detailed examination of these issues was made.

7.26 The Whitechapel Haven service was regarded by the Trust and Commissioners as a high profile one which was winning awards, being visited by politicians and other dignitaries. It was reported as being a successful service that met the complex needs of the individuals who required the service, indeed client feedback was overwhelmingly positive. Based on the regular submissions of performance metrics it was never raised as a struggling service on the Trust's

management's radar, nor was it considered a service that needed reviewing with the exception of the working relationship review undertaken by the Tavistock Institute. Senior management were aware of underlying concerns relating to staff and it was reported as a "volume of unhappiness and noise coming out of the department".

7.27 Due to the nature of the service it was not required to demonstrate that it was meeting the routinely collected Trust performance data, for example the service was exempt from the 18 week wait target. The service was also not being audited in a similar way to other services within the Trust such as meeting the number of contacts. Formal alarms were not raised from any direction and although there were issues being raised in regard to working relationships, there was an over-reliance on considering that these relationship issues were the sole cause of the concerns raised.

7.28 The independent investigation panel heard that Whitechapel Haven was "an uncomfortable place to work in" due to the atmosphere and culture among the team rather than anything else. The independent investigation panel heard from several sources internally that particularly junior staff were fearful and there were rumours of bullying. This led to people leaving the department. Some of the staff apparently left to return to working in the wider sexual health team. They were seen as "Haven refugees". That said, it was clear that individually the staff team were committed to their work and the individuals requiring the service. This was borne out by the results of patient satisfaction surveys.

7.29 On examination of the evidence provided to the independent investigation panel it was considered that some staff were working to their own rules, not sharing workloads and not taking responsibility for the overall effective running of the service being provided. Delegation of tasks was not undertaken resulting sometimes in extra work for the few and not enough work for others.

7.30 Evidence was provided to the independent investigation panel that staff were raising concerns in clinical and professional supervision relating to the service, working relationships and forensic examinations. They reported that they were not encouraged to identify issues and in some cases actively encouraged to ignore the issues being raised. On closer examination it was not possible to ascertain why these issues were not raised at a higher level although senior managers did acknowledge that the concerns had been reported to them and therefore were known.

7.31 It was found that when some of the issues were raised at line management level outside of the Whitechapel Haven service management structure, no action was taken. This further reinforced the belief by some staff that they were not able to

raise concerns. [redacted]

7.32 Other staff considered that concerns about the forensic sample build up was not their responsibility and that the staff's perceived complacency from both the service managers and the Trust's senior managers reinforced that view. It was clear that some staff were aware of the situation in particular to the forensic samples but not able or willing to take action to correct the situation. The full extent of the problem however was not known to the staff team and all interviewed reported their shock and surprise.

Leadership, Training and Supervision

7.33 As indicated earlier the Whitechapel Haven in reality had three managers, clinical, nursing and operational. This caused friction both between the three post holders and the staff working within the service. It was difficult to ascertain how these roles interlinked and also how they were separated out into responsibilities and accountability. The independent investigation panel consider that there was no overall leader of the Whitechapel Haven and therefore no one was actually taking full responsibility for the service. This lack of understanding was apparently reinforced by managers of the Trust who did not understand the nuances of the service. One example was the attendance at the monthly Board meeting by the service operational manager at which the clinical lead for Whitechapel Haven was not invited, thus limiting the clinical input to governance.

7.34 The independent investigation panel heard that for some staff the Trust had not provided adequate induction into new posts in the Whitechapel Haven service. This lack of procedure also extended to the Trust not undertaking exit interviews with staff, a particular concern as there was a rapid turnover of staff just prior to the issues surrounding the incident being discovered. There is no evidence that staff leaving the service were doing so because of the situation and perceived difficulties within the working environment but as there were no exit interviews there is no evidence to the contrary either.

7.35 It was considered by the independent investigation panel that service induction was inadequate not meeting the required standard for this complex service. Essential training on clinical governance was also probably inadequate. Professional accountability at every level of the workforce was not visible – silos existed across managerial, medical and nursing lines of accountability. Annual appraisals were carried out in these silos but there was no evidence that a

training plan closely aligned to the needs of the service was identified during the induction of staff or in staff appraisals.

7.36 Interviewees repeatedly stated that there was a lack of overarching leadership in the senior operational team. It was unclear as to who was professionally responsible for coordinating and signing off clinical governance, quality assurance and compliance and whether those responsible were appropriately trained or experienced.

Physical Environment

7.37 The Whitechapel Haven is located down a small side street approximately half a mile from the Ambrose King Centre on the main hospital site where the wider Trust management team are located. Both staff and senior managers indicated that it was a site that was not routinely visited as although only 10 minutes away from the hospital it was too far for managers to visit on passing. Staff reported that this created a feeling of isolation and a sense of remoteness from the main hospital.

7.38 The Whitechapel Haven is part of the Directorate for Infection and Immunity, a service provided by the Trust but managed separately, although a general manager was responsible for both parts of the service. A plan had been agreed by managers that the Whitechapel Haven staff would rotate with staff from the Infection and Immunity service to ensure that skills were shared and to provide additional support to the Whitechapel Haven staff. This would have also reduced the feeling of isolation and included staff in the wider sexual health service. The independent investigation panel were informed that staff refused to participate in this plan and that no further action was taken regarding this. It is considered that an opportunity was lost to integrate the Whitechapel Haven staff into the Directorate. In addition this might have created opportunities for staff to discuss their concerns about the service away from the Whitechapel Haven environment.

7.39 Although the building is able to provide the service presently commissioned it is a small site that would not be able to be extended if necessary. Some staff reported that there was a lack of space available and that they often have to hot desk. This was considered to be difficult with the confidential issues relating to the service that they have to provide.

7.40 It is acknowledged that the location of the Whitechapel Haven provides a discrete service for the individuals, in particular for those who self refer into the service as it is not easily identifiable as a sexual assault referral centre.

7.41 Two members of the independent investigation panel visited the Whitechapel Haven to have a tour of the premises and assess how the service was run from the existing accommodation. It was found that the Forensic Examination Suite did not meet the required standards and a letter detailing their concerns was sent to the Trust for action. The concerns raised were:

- The Forensic Examination Suite was very cluttered with equipment standing around the room which could cause cross contamination.
- Stores were overflowing on to cupboard surfaces.
- The work surfaces were cluttered including the desk and computer areas.
- There was a general air of grubbiness and poor decoration.
- The Suite was not child friendly.
- Fabric covered chairs in the small waiting areas which could create cross contamination for acute forensic cases.

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7.42 The Trust did respond to the letter and it was understood that the Suite was tidied up and that the fabric covered chairs were to be replaced. A subsequent visit by one of the independent investigation panel found that although changes had been made the Suite was still not child friendly and therefore needed further action taken. A comment made by two members of staff during interview was "you should have seen the suite before".

7.43 During interviews with the police it was evident that the poor standard of the forensic examination suite was not a surprise to them. The independent investigation panel were told by one officer that a recent audit completed by the Metropolitan Police's Forensic Department had reported that the rooms "were not fit for purpose" and were not forensically clean. It is understood that the police commissioner was to follow this up with the Trust using their governance process. The independent investigation panel requested to have a copy of this police audit but this was not provided.

7.44 Security provided at the Whitechapel Haven includes intercom access and CCTV video monitoring. When dealing with a case out of hours (either non police referrals or police referrals, the latter being the majority), two members of staff would be in attendance. At least one police officer would also attend each police referral case.

Governance Framework

7.45 In addition to service standards, the independent investigation panel were tasked with reviewing governance, and how assurance compliance met the essential professional and regulatory standards.

7.46 Fundamentally the independent investigation found that there was little evidence of a service developed within a framework of standards, accountability and responsibilities. Neither was there evidence of appropriate management support in place to ensure:

- Effective management of the service.
- Efficient management of the service.
- Implementation of organisational policies and procedures.
- Evidence of delivering the service within best practice and to comply with current practice.

7.47 The independent investigation panel acknowledges however that professional accountability for the service is the responsibility of all levels of the Whitechapel Haven (Barts Health NHS Trust, Health and Police Commissioners), and not just the operational team.

Clinical Governance

7.48 There was also little evidence of a systematic approach to maintaining and improving the quality of patient care within a health system. Clinical Governance has been defined as: -

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. (Scally and Donaldson, 1998)."

7.49 There was a lack of accountability for clinical governance in the Whitechapel Haven, with the clinical lead either unable to take leadership or not suitably qualified or experienced to assume this role.

7.50 Although there was a comprehensive suite of clinical governance policies and procedures available to read, including incident and significant event reporting, there was very little evidence to suggest that that these policies and procedures were effectively applied. For example, in the minutes of the monthly Whitechapel Haven Business meetings, the agenda item named as clinical governance defaulted to Datix incident reporting but it lacked evidence of thematic analysis or learning from these incidents – the focus was on collecting and filing. Similarly, audits were mainly related to activity or research interests of staff rather than being prioritised to address the greatest risks and to monitor quality and provide evidence of compliance with service standards.

7.51 Underpinning the evidence-based framework of Clinical Governance is the requirement to achieve a working environment that is open and transparent. This has to be one in which staff feel able to raise concerns and expect to see action resulting from their concerns. There should be an environment in which there is a no-blame culture where the team can learn from incidents and reduce the risk of recurrence. This picture of good clinical governance did not appear to exist in the Whitechapel Haven service. Nor did the independent investigation panel identify systems in place for dealing with poor performance. As a result the staff team wasn't able to learn from failures to evolve a quality assured service.

7.52 The service failed to identify and prioritise risks and as a result there was no mitigation in place to minimise both the likelihood and impact against failure of the service. In view of the fact that this was a high risk service, provided to the most vulnerable clients, this is all the more a significant omission.

7.53 Risk management involves consideration of several components: -

- Risks to patients which includes compliance with statutory regulations to minimise risks.
- Risks to practitioners by ensuring their health, working in a safe environment and kept up to date with processes.
- Risks to the organisation by ensuring that there is high quality employment practice, a safe environment, well designed policies and operating procedures.

7.54 There was one reference in the documentation examined to the existence of a risk register in August 2010, however this was never seen by the independent investigation panel nor was the risk register present in the materials available. It was clear from the description that this wasn't a living document upon which risks were repeatedly reviewed and managed with actions adjusted in line with risk management procedures.

7.55 A consequence of this omission is the fact that some staff were 'shocked' to learn that there was a problem with non-police forensic samples. Had a risk management process been in place, forensic sample management would have not only formed a key risk but mitigation, monitoring and allocated responsibility would have been in place to ensure compliance against quality standards.

7.56 Following the transfer of the SARC service in October 2010 to the Specialist Commissioning Team performance management of the Whitechapel Haven was routinely monitored. This took the form of key performance indicators (KPIs) and data was diligently completed to form the basis of the commissioner's

assessment. These KPIs however were activity-driven, related more to waiting times and patient numbers that in demonstrating service quality, create quality improvement benchmarking or evidence of good clinical governance.

Safeguarding Children and Adults

7.57 Policies and procedures in regards to safeguarding children and adults were in place at the Whitechapel Haven. The Trust commissioned a detailed evaluation of safeguarding through analysis of the case notes held by the service. This is dealt with later in this report, but outcomes demonstrate multiple deficiencies in putting these procedures into operation.

7.58 For example, referrals to agencies were demonstrated to have failed in a small number of child protection and vulnerable adult cases. The system in place was that staff would refer adults and children to social services by sending a faxed referral. However these were not routinely checked to ascertain that the communication had been received and acted upon by the relevant department. If a risk management process had been in place mitigation would have identified the need for all faxes and or referrals to be followed up with confirmatory evidence of receipt and acknowledgement that action was being taken. Monitoring the process being taken through audits would have confirmed compliance with that process.

Human Resources

7.59 Human resource management is the management of an organisation's workforce. It is responsible for selection, training, and assessment of employees whilst overseeing organisational leadership and culture.

7.60 The underlying infrastructure of Human Resources and service induction was repeatedly highlighted as an issue throughout the independent investigation. There is a serious question as to whether the operational staff team at the Whitechapel Haven were suitably qualified to undertake the roles required of them. The independent investigation revealed that the clinical lead was not originally forensically trained – an essential requirement for this role. In addition this was the [redacted] Although there was some training provided at the onset of the manager's role, the independent investigation panel found that there was little evidence of managerial supervision, support or mentoring being provided by the Trust.

7.61 It was found that there was a lack of robust HR policies and procedures. Although there was a plethora of policies and procedures to view, including a

whistleblowing policy, these did not appear to be put into practice. For example, staff described raising concerns (including the chaotic management of forensic samples), making complaints about the poor relationship between staff and describe a working culture of bullying, "an oppressive, tense environment in which to work." Staff also described being fearful of raising concerns and one described themselves as dreading their shifts. This working environment was reinforced by a high staff turnover.

7.62 Exit interviews which should have been carried out were not carried out. Staff reported that there was an assumption that having raised the concern it would be dealt with, however when no action was taken they felt there was no point in repeating their concerns. The information gathered in these interviews echoed many of the underlying failures identified in the Francis Report in terms of staff failing to effectively raise their concerns, having their concerns openly discussed and resolved.

7.63 Some staff described being actively encouraged not to follow up their concerns. Escalating concerns to the Trust didn't appear to resolve these issues as there appeared to be a lack of understanding of what the service entailed. When concerns were voiced to the Trust regarding the impact of the dysfunctional relationship between the three service managers the action the Trust took was to commission the Tavistock Institute to provide coaching and or mentoring. An investigation of the underlying service and reasons behind the relationship difficulties did not appear to be carried out or considered when these concerns were raised other than that completed by the Tavistock Institute.

7.64 Staff describe that they felt isolated from mainstream health services both service-wise and geographically, even though the Whitechapel Haven is only situated less than 0.5 miles from the Trust Headquarters. Staff did not feel the service was integrated into the Directorate of Infection and Immunity Sexual Health. One member of staff stated "my impression was that the Trust had set up the service and then had pulled out to leave Haven to get on with it". It was described as a "Cinderella service, divorced from the Trust". Furthermore there appeared to be relationship barriers between the [redacted] and police, further isolating the Whitechapel Haven service. It was also noted that the [redacted] was not invited to attend the strategic Whitechapel Haven Board and so there was no [redacted] voice on the Board.

7.65 In addition to services, the physical facilities were judged as not fit for purpose – particularly the forensic examination room. This was recently highlighted as a result of an audit carried out by the Police Metropolitan Forensic Department.

7.66 It is acknowledged that the independent investigation panel heard evidence from staff during interview that described the service as much improved since

the service closed and then reopened. This appeared to be as a direct result from the implementations of the recommendations of the internal investigation.

Police Relationships

7.67 The Metropolitan Police have a dual role within the Whitechapel Haven service both as commissioner and provider. As indicated earlier the SARC services are commissioned and provided jointly by both health, via the National Specialist Commissioning Team, and police. This can create frustrations as each organisation has different structures and objectives. Health's main aim is to ensure that the individuals can access the service are appropriately assessed and their therapeutic needs taken care of. The police are working towards successfully apprehending the alleged perpetrators and ensuring that they are dealt with under the criminal justice service.

7.68 The independent investigation panel heard the Metropolitan police describe staff as trying hard to meet the requirements of their clients, and of the police, particularly in the balance between clinical care and criminal proceedings. It was indicated by the Whitechapel Haven staff that the police's main concern was that the service met the 90 minute target for a forensic examination.

7.69 The police did report that they were aware that there were problems with the service but were not aware of precisely what these were and considered that it was a Trust issue and therefore addressed. They were however surprised when the full circumstances of the incident became known. Once they were aware of the situation "Operation Liberty" was set up in March 2012 to undertake a full investigation. Health and police teams worked closely together on this investigation, a priority of which was to ensure that the consequences of the SI were minimised as much as possible on the individuals who had been using the service.

7.70 During the period under examination the police also had their own concerns regarding the actions of their Sapphire Unit. [redacted]. This was not however thought to have had any impact on the service being provided by the Whitechapel Haven staff.

7.71 The independent investigation panel were informed that there appeared to be [redacted] although how or whether this impacted upon the service is unclear. It was also indicated that the police considered that the forensic examination room was not fit for purpose as found when a police forensic team undertook an audit of the

pan London Haven forensic suites. The outcome of this audit was not available at the time of completing this report.

Forensic Qualifications

7.72 The Whitechapel Haven in line with other SARCs, provides a forensic assessment service for individuals who have been allegedly sexually assaulted.

7.73 The permanent clinical lead obtained a forensic qualification during the course of employment at the Whitechapel Haven, but it was found that certainly pan London this was not the case, with many clinicians not holding a forensic qualification and although the commissioners of the services were aware of this situation, it was not considered to be a priority in relation to service standards.

7.74 At the Whitechapel Haven neither the interim clinician, nor the Clinical Lead from the Trust, who were seconded to the service following the incident, held a forensic qualification and their expertise was therefore limited in this speciality.

7.75 It was considered by the independent investigation panel that this would have negatively impacted on the necessary training, supervision and staff support they could offer their staff. This clinical leadership was regarded as all the more important following the incident when it was vital to move the service forward, and prevent a similar incident recurring.

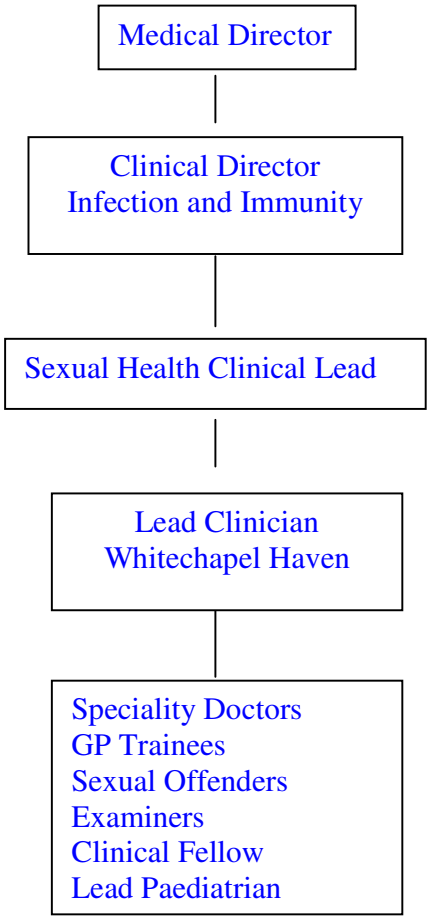
7.76 The independent investigation panel found that the [redacted] was well aware of [redacted] lack of forensic knowledge. It was clear to the independent investigation panel that [redacted] was working very hard to try to bring the service up to standard. However it was not clear how [redacted] would be in a position to provide a forensic lead to the service. The independent investigation panel were concerned that the Trust and the Police either did not recognise that as a potential problem or did not give it sufficient priority. The police interviewed expressed their opinion that it was the role of the Trust to ensure that any clinician appointed would be suitably qualified as this was outside their realm of knowledge and expertise.

Organisational Structure

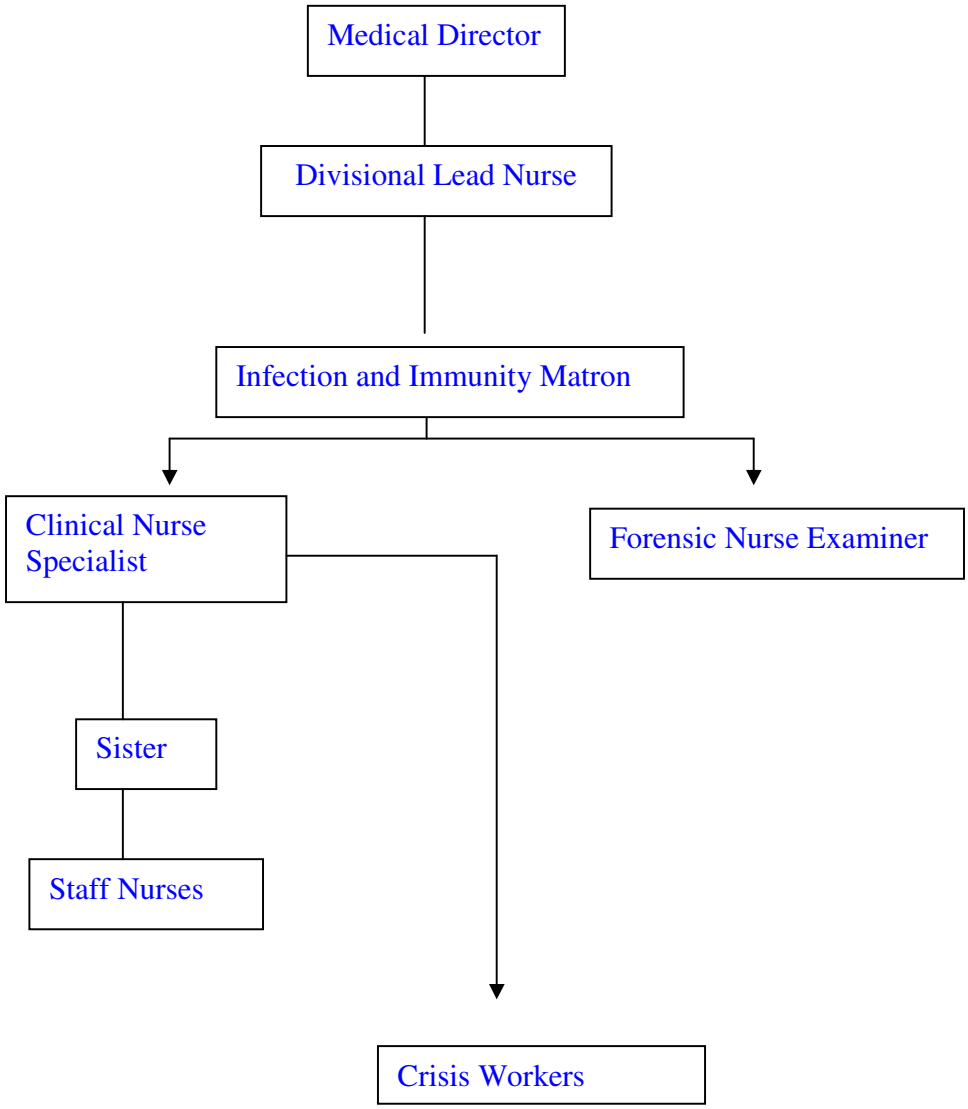
7.77 The independent investigation panel were provided with the management structure of the Whitechapel Haven and how it linked into the Trust's main management structure. It was seen that there were several different levels of management with a separation of professional and managerial processes.

7.78 During the course of the independent investigation the Trust were undergoing a reorganisation that has resulted in most of the senior managers being transferred into other Clinical Academic Groups (CAG). This has left the service with a new senior management team who have limited knowledge of the history of the Whitechapel Haven Service.

7.79 The medical line of accountability leads down from the Medical Director through the Clinical Director for Infection and Immunity as per the following diagram.



7.80 The nursing line of accountability is also under the Medical Director's responsibility and is as follows:



7.81 The structure above means that the forensic nurse examiners are not being supervised/managed by anyone with a forensic qualification. It is unlikely that any of the forensic nurse examiners have a forensic qualification either.

The remaining part of the structure falls within general management and the Whitechapel Haven service manager reports to the General Manager of the CAG. The administrator and Data Entry staff report to the service manager.

7.82 Other professional staff such as the psychologist, HIV counsellor, Asian Development Worker report to either their own professional lead or to the Head of Health Advisors in the Infection and Immunity Directorate.

7.83 An external psychologist had been commissioned to provide supervision and counselling to the psychologist in the team. This role did not take into account formal supervision or a review of case notes thus limiting the input available to the member of staff.

7.84 The independent investigation panel found that the management structure was confusing and did not show strong lines of accountability with the separation of each strand of the structure.

7.85 Many of the staff team were supervised by line managers with no responsibility for the Whitechapel service nor were they then accountable in regard to the service. This further fragmented the management of the service and limited the opportunities to resolve difficulties.

7.86 It is considered that this management structure created a situation where informal corridor discussions took place with little ability to action the outcome of these discussions. It became too easy to ignore taking appropriate action; discuss formally or to escalate the issues to a more senior level.

Review of Ten Sample Case Notes

7.87 The independent investigation's Terms of Reference included reviewing ten sets of case files. These were sent to two members of the independent investigation panel in the middle of December 2012. The photocopied case notes were not of sequential patients and it was not clear on what basis they had been selected for review. Parts of the notes had been anonymised to preserve patient confidentiality.

7.88 Within the 10 case files [redacted], the remainder were adults. [redacted]. The cases were a mixture of police and non-police referrals.

7.89 Overall the standard of notes appeared good, although only a few included a written statement by the examining doctor and therefore assessment of statement quality was very limited.

7.90 The following general points were identified;

- The paperwork appeared very long and repetitive. For example, the documentation of alcohol consumed by the complainants; this required the examining doctor to record the same information at least three times during the examination. This was considered to be time consuming but also creates an opportunity for mistakes to be made.

- Risk assessment for domestic violence; it was not clear from the paperwork examined what the process was for a risk assessment for domestic violence, including immediate safety when leaving the Whitechapel Haven premises. It is possible that this was undertaken and recorded elsewhere. If this is not recorded then this should be addressed by the service and documented.

- HIV PEP; the notes were found to be of variable quality and detail in regard to documenting how a decision was made as to whether a particular client should or shouldn't be offered HIV PEP. For example, one set of notes just said HIV PEP "declined" without giving detail as to the risk, or what the clinical advice had been and how the decision was reached.

- Injury documentation; the description of injuries to the individuals was variable. There was very little evidence of injuries being described in terms of their position from a fixed bony point, or to their severity.

- Occasionally anatomical terms were incorrect. For example, one doctor used the term labium minorae (rather than labium minus for singular, labia minora for plural).

- Lack of opinion; it was noted that on the summary of examination findings (page 37 of 39 of the proforma) for the police, this never extended to putting the examination findings in context. For example there was a tendency to simply list any injuries or state that no injuries were found. Given that there are many misconceptions about what findings, in terms of injuries, should be found post rape, explanation of the findings, putting them in context should be routine. A sexually active adult female who makes an allegation of penile vaginal rape would not be expected to have any genital injuries. Therefore it may be useful to record the findings in context such as "The absence of genital injury is a neutral finding and neither confirms or refutes the allegations as known to me".

- Use of Foley catheters. [redacted].

7.91 The independent investigation panel were informed that two sets of notes were kept on each case and understand that this system is under review. If the present system remains in place the independent investigation panel consider that there would remain a risk of missing relevant information and actions that should be taken forward.

Independent Investigation Process

7.92 The independent investigation panel found that the Whitechapel Haven staff had a lack of knowledge and awareness of their role within the investigation. It took a long time to obtain documents and with some documents, such as reports, the independent investigation panel had to ask several times before the reports were forthcoming.

7.93 Interviewees were ill prepared and some had not received the relevant paperwork and therefore were not clear of the process to be undertaken. Generally this had the effect of hindering the investigation.

8. National Support Team Visit

8.1 In June 2010 the National Support Team (NST) for Response to Sexual Violence visited the pan London Havens over a three day period to review the services.

8.2 The report identified issues that were thought to be the greatest challenges requiring addressing. It is important to note that ALL issues raised by the NST were re-identified by the independent investigation panel as significant problems some two years after the NST published their findings.

8.3 The following issues were identified: -

a. "The NST was informed that there were concerns in relation to staff morale, staff development and overall communication within and across the Havens and between the key stakeholders.

b. The NST was unclear what the corporate and clinical governance arrangements were for the totality of provision across the London area.

c. There were currently no designated SARC provision for children and arrangements for examinations were inconsistent.

d. The NST noted that the current facilities at each of the pan London Havens did not take account of the specific needs of children. Consideration as to how current accommodation could be adapted to create a child friendly environment when child examinations are being conducted was to be undertaken by the relevant Trusts.

e. The NST was informed that management structures within the Havens including lines of accountability are unclear, with operational teams expressing confusion. The NST noted that the current organisational charts did not make clear who provides leadership and has ultimate accountability for overall service. The NST recommended that the Acute Trusts, in partnership with the Havens Strategic Board, review current management, clinical governance arrangements and lines of accountability should be clarified and clearly communicated to all staff.

f. The NST was informed that the practice of identifying, assessing risk and addressing the issues of domestic abuse and safeguarding children were not routinely applied at all three pan London Havens. This led to an inconsistent level of service for clients and an increase in risk for all

organisations. The NST recommended that the Strategic Board ensure that common policy and practice be developed, agreed and implemented at all three Havens.

g. The NST was informed of communication difficulties between the clinicians and nursing teams across the Havens with some lack of agreement on clinical issues. The NST recommended that the clinical teams within the Havens agree a communication strategy, which facilitates agreed clinical service provision and effective communication.

h. The NST was informed that recruitment and retention of staff was an issue with concerns expressed in relation to:

- Staff morale
- Staff development
- Communication

i. The NST recommended that the Haven management teams, in conjunction with the Acute Trust service managers, review the staff turnover patterns, staff satisfaction and internal communication systems in order to understand the issues in relation to recruitment and retention and specific team issues.

j. The NST noted that all three Havens were generally short of space. The storage facilities for forensic modules within the examination rooms were limited and at Camberwell and Whitechapel there is clutter of general stocks and equipment, including in the immediate vicinity of the medical couch. It was apparent that these aspects could lead to challenges in ensuring that each of the three Havens were forensically fit for purpose from an anti-contamination perspective.

8.4 The NST report and recommendations were discussed at the Haven Management Group on 16th July 2010.

8.5 The minutes state that;

"In regards to this report, the group felt that it was based on 10 people coming to the Havens for 2 days and spending very little time with each Haven. NST were not aware of any case files assessed and did not focus on the excellent nursing care the Havens provide. In conclusion, it was very much a flying visit. There were six key recommendations made by the NST and a further 58 recommendations.

The group discussed these to agree on these or discharge as seen appropriate(sic)".

8.6 A Management action plan was written. Here are some examples of said plan;

Point d. *"Each site to review. Consider involvement of Play Specialists from Trust Aped Services. Funding to be prioritised."*
Point e; *"Review on appointment of Specialist Commissioner".*
Point f; *"Included in Business plan. Discharged".*
Point g; *"TOR of Clinical and Training and Paed Group be reviewed and staff reminded that issues can be raised through their professional forums."*
Point h: *"Review on appointment of Specialist Commissioner".*
Point j: *"priority action. Staff tasked.*

8.7 It is of concern to the independent investigation panel that it would appear that the NST recommendations were treated in a dismissive manner and yet some of their observations were issues that featured strongly in the observations of this Independent investigation into the circumstances of the 2012 incident and contained within this report.

9. Internal Investigation Process and Report

9.1 The Trust's internal investigation followed a clear set of Terms of Reference that was commissioned by the Divisional Nurse for Regional Services within the Trust. The Whitechapel Haven commissioners were in agreement with the proposed process.

9.2 The Terms of Reference concentrated on the non-police referrals, reporting mechanisms and adherence to Standard Operating Procedures.

9.3 A Director of Therapy within the Trust was the lead investigator and was supported by a Patient Safety Advisor and Administrator.

9.4 Nine members of staff provided information to the investigation and included senior managers and commissioners. Frontline staff were not interviewed.

Staff Support

9.5 Trust staff were informed of the support services available through the Trust's Health and Wellbeing Centre. In addition they were encouraged to consider how to best use their informal support networks during the course of the investigation.

Internal Review Methodology Undertaken

9.6 A Root Cause Analysis process was undertaken and the report included: -

- A Chronology of Events.
- Care and Service Delivery Problems/Contributory Factors.
- Root Causes.
- Lessons Learnt.

9.7 The report made ten recommendations which were set out in an Action Plan by the Trust. All have been implemented and are monitored by the Infection and Immunity CAG Board.

9.8 The independent investigation panel endorses the recommendations and actions taken and saw evidence of the actions taken and completed.

10. Safeguarding Records Review

10.1 The Trust commissioned a separate review of Safeguarding Practice which was completed in August 2012 by an independent consultancy.

10.2 The aim of the review was to assess whether safeguarding procedures within the Whitechapel Haven had been adhered to by staff, identify areas of good and poor practice and make recommendations for the future management of safeguarding practice within the Whitechapel Haven. In addition the review aimed to provide both the organisation and its commissioners with assurance that safeguarding procedures were being adhered to and that client safety was not being comprised.

10.3 The review was structured into five parts to ensure that there was an exploration of all aspects of operational procedures that could contribute to safeguarding practices within the service. The five parts included: -

- Safeguarding Practice
- Records and Information Management
- Management of Telephone Enquiries
- Procedural and Operational Management
- Staff Health and Well-being

10.4 The initial plan was to review all records for both adults and children over the period between 2004, when Whitechapel Haven opened in 2012. However it became clear that the resources needed to undertake this process would be beyond the capabilities of the current reviewer and would take several years to complete. It was decided to concentrate on a shorter period, January 2009 to May 2012.

10.5 An Action Plan was put in place in July 2012 which reflected the findings of the review ,which can be found in Appendix Two.

11. Tavistock Institute of Human Relations Report

11.1 As indicated earlier in this report the Tavistock Institute were commissioned by the Trust in 2009 to address various inter-personal relationship problems at the Whitechapel Haven between the senior management team.

11.2 It was found that staff at Whitechapel Haven were frustrated with their managers due to a lack of agreement of strategic objectives, and an inability to carry out operational policy.

11.3 Improvements were noted after intensive contact with all staff but particularly with the three senior managers. It was noted that inter-personal relationships had improved and more effective collective leadership was taking place. It was agreed to withdraw the Tavistock Institute at the beginning of 2012.

11.4 Following the Serious Incident the Tavistock Institute were asked to work with the whole staff group at the Whitechapel Haven and to provide regular support. The report relating to this latter work is quite critical of the Trust and actions taken in regard to Whitechapel Haven staff. This, in particular, applied to the three senior managers.

11.5 The report has not apparently been accepted by the Trust and therefore the independent investigation panel consider it is not their role to comment further. The Tavistock Institute continues to support two of the Whitechapel Haven senior managers.

12. Findings and Recommendations

12.1 The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed examination of the evidence, both written and oral, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust, Police, and Commissioners to put into progress any actions required to prevent a similar occurrence. It also sets out areas of notable practice.

12.2 While writing this report the independent investigation panel is mindful of the proposal to change the management and SARC service being provided in London.

Notable Practice

12.3 It is normal process in investigations to set out areas of notable practice. In this case there are several areas of good practice that the independent investigation panel wish to single out as examples.

Whitechapel Haven Staff

12.4 The independent investigation panel would like to have noted that all staff who were interviewed, or that they had contact with, during the investigation responded in an open and honest manner. There was evidence that the staff team had worked very diligently since the incident to ensure that a similar event did not occur and to discover and correct the extent of the issues.

Asian Worker

12.5 The independent investigation panel would like to commend the introduction of an Asian Worker into the staff team. It was considered that having identified the needs of their client groups this was an appropriate initiative as many of the Whitechapel Haven's clients came from this ethnic group.

Patient Survey

12.6 Despite the issues that are under investigation the feedback from patient surveys were very good. The independent investigation panel would like to commend the Whitechapel Haven staff team on the high quality of individual care provided to those accessing their service.

Safeguarding Adults and Children

12.7 Since the incident the Trust's safeguarding team now attend a Whitechapel Haven meeting on a weekly basis to review cases that might, or have fallen, within the auspices of safeguarding adults and children. Evidence was provided that the Whitechapel Haven is appropriately referring individuals to the relevant safeguarding leads. The weekly meeting provides an audit of these cases and the initiative is commended.

General Findings and Recommendations

12.8 The independent investigation panel have made some individual recommendations later in this section but consider that generally there was a whole system failure that does not relate specifically to individuals. It was found that there were missed opportunities in all parts of the system that if noted could have in some part reduced the incident.

12.9 The internal investigation and safeguarding review have made recommendations to improve both the service and practice. It is not intended to replicate these or devalue the importance of the Trust to continually review, evaluate and monitor their application.

12.10 The independent investigation panel recognise that the Trust has gone through a major reorganisation during the process of this serious incident and many of the managers previously involved with the Whitechapel Haven, both clinically and managerially have moved into other areas of work within the Trust. The informal intelligence about the service and the history behind its development therefore will be diluted.

Recommendations

12.11 The information gathered from the analysis of the submitted material and the interviews echoed many of the underlying failures identified in the Francis Report[3] in terms of clinical and business standards, corporate and clinical governance, accountability, induction and training and staff failing to effectively raise their concerns. The Francis Report's recommendations are summarised as follows:

[3] Francis R (2013): Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationery Office.

- *Foster a common culture shared by all in the service of putting the patient first.*
- *Develop a set of fundamental standards, easily understood by patients and healthcare staff, the breach of which should not be tolerated.*
- *Provide professionally endorsed and evidence-based means of compliance with standards which can be understood by staff.*
- *Ensure openness, transparency and candour throughout the system about matters of concern.*
- *Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.*
- *Make all those who provide care for patients accountable and to ensure that the public is protected from those not fit to provide such a service.*
- *Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.*
- *Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare to integrate the essential shared values of the common culture into everything they do.*
- *Develop ever improving means of measuring performance of individual professionals, teams, units and provider organisations for patients and all other stakeholders in the system.*

12.12 The following recommendations are in addition to those previously identified by the earlier investigations and or reviews. They are not in any priority of order and apply to the Trust unless otherwise indicated.

Failing Service

12.13 Many members of staff were aware of problems and in some cases had reported concerns to their line managers. Senior managers had access to information that they could have intervened on, but they didn't. A frequently used phase as an answer to questions by the independent investigation panel was "I assumed it was being dealt with".

12.14 It is considered that if there had been a mechanism or system for systematically bringing this information together the awareness of a service not functioning well would have been raised.

Recommendation One

It is recommended that the Trust develops an audit process that recognises issues that need addressing and could be used to review, evaluate and identify when a service is not functioning to the required standard.

Organisational Structure

12.15 The independent investigation panel found that the organisational structure was unnecessarily complicated with direct line management and professional supervision being provided in isolation from each clinical line. It is acknowledged that for services comprising of different professionals the management and supervision can be complex, however there should be a forum to bring those strands together.

Recommendation Two – Trust and Commissioners

It is recommended that the organisational structure is reviewed with an aim to making simple and clearer the lines of accountability and overall responsibility for the service.

Staff Engagement

The specialist nature and relatively small size of this service places it at higher risk of isolation from mainstream NHS services which in turn increases the risk of poor working practices within the team.

Recommendation Three

To reduce the risk of a recurrence of a dysfunctional team working environment it is recommended that an anonymised staff survey should be carried out at regular intervals with the outcomes transparently shared and fed into governance arrangements.

It was found that the opportunity to gain a better insight to the concerns in regard to the Whitechapel Haven's service was missed when exit interviews were not offered to staff leaving the service.

Recommendation Four

It is recommended that ALL staff leaving the service, including those on the out of hours team, have exit interviews offered and any intelligence gained from such is used to improve the service.

Peer Review

The independent investigation panel consider that opportunities for shared learning, multi-agency working and joint training was missed by the absence of formal peer review

Recommendation Five

It is recommended that there is regular clinical peer review with attendance by individual clinicians monitored. These sessions should cover review of cases in their entirety including record keeping, safeguarding issues, quality of statements. The sessions should be used for clinicians to voice ideas and concerns about the service and how it can be improved upon.

Recommendation Six

It is recommended that on a regular basis there is external peer review by an independent clinician who is invited to attend, take part in the peer review process and give feedback on the observed processes and learning environment. Feedback of these sessions should be shared with all the staff team.

Recommendation Seven – Commissioning

It is recommended that a peer review framework is developed within the new model for the pan London SARCs that audits and evaluates all three service delivery areas and reports on a regular basis to the commissioners.

Specialist Expertise and Clinical Leadership

The independent investigation panel found that across the pan London SARCs few medical staff had a forensic qualification. It is considered that a forensic qualification is vital to maintain the specialist clinical care required. The SARC aims to meet the medical, psychological and forensic needs of the individuals that use the service. It is important that the staff have the correct training and qualifications to undertake this.

Recommendation Eight

It is recommended that there is a review of the qualifications of the team and an action plan developed to address any gaps. In their January 2013 Quality Standards the FFLM have recommended that "The contracted workforce should have a minimum of 25% of forensic physicians with FFLM Membership." (http://fflm.ac.uk/upload/documents/1358340451.pdf)

Recommendation Nine – Commissioners

It is recommended that the service specification for the new model for pan London SARCS sets out that there is a medical lead with a forensic qualification employed at each of the three London sites to ensure that high standards of care are delivered. Consideration should also be taken in regard to a specialist Paediatrician with forensic expertise to lead on children services.

Governance

The lack of accountability for clinical governance in the Whitechapel Haven, combined with a weak infrastructure of human resource management was repeatedly identified as a major contributor to the service failure.

Recommendation Ten

It is recommended that clinical governance expertise is always available and appropriately utilised, and that recruitment, induction, appraisals and training is reviewed to enable the team to foster a common culture of shared values and accountability for all their actions.

Complex Service

The independent investigation panel found that generally within the Trust the complexity of the service was not understood resulting in a service that it is considered was not well supported and isolated from the mainstream services.

Recommendation Eleven

It is recommended that effective support structures are put in place which would also define the roles and responsibilities of the host Trust in relation to performance management.

Clinical Environment

The independent investigation panel have concerns regarding the environment at Whitechapel Haven, in particular, the Forensic Suite. It was considered that this did not meet the standards required in terms of a safe forensic assessment area.

Recommendation Twelve

It is recommended that the physical environment of the SARC is monitored in particular with respect to its cleanliness and forensic integrity and also to its appropriateness of seeing children (the age of a child being under 18 years old) in a child unfriendly environment.

Recommendation Thirteen

It is further recommended that the environment at Whitechapel Haven is reassessed jointly by both health and police to identify areas for improvement and that a timetable for completion of these improvements is developed and adhered to.

Multi-disciplinary Team Case Reviews

The independent investigation panel found that a method to regularly review cases was not in place at the Whitechapel Haven.

Recommendation Fourteen

It is recommended that there are regular multi disciplinary case reviews, looking at random cases as well as cases where potential problems have been identified.

National Support Team (NST)

The NST found a number of issues that they considered needed addressing. The independent investigation panel consider that these were not acted on nor was a plan put in place to monitor progress against the concerns raised

Recommendation Fifteen

It is recommended that the Trust revisits the NST Recommendations and includes these in the action plan that id developed in response to the other recommendations in this report.

Documents Examined Appendix One

File 1

Section 1

- Hepatitis B Vaccination Audit
- CT Results
- Service Evaluation – Management of Sexual Assault in Primary Care in Tower Hamlets
- The Haven GP Survey 2011
- BASHH/ASTDA Spring Meeting 2012 – 27-29 June
- Post-exposure prophylaxis following sexual assault
- Clinic Coordinator audit
- Questionnaire

Section 2

- Emails

Section 3

- 3 year business plan 09/12
- London Sexual Health Programme
- Haven Contract Monitoring Meeting Quarter 1 – 11.05.2011
- Haven Contract Monitoring Meeting Quarter 2 – 2011-12 – 5th September
- Haven Contract Monitoring Meeting Quarter 1 – 23rd January
- Havens Contract Monitoring Meeting Quarter 2 – 2011-12 – 8th September
- Havens Contract Monitoring Meeting Quarter 2 – 2011-12 – 23rd January

Section 5

- Schedule 2 – The Services

Section 6

- Emails

Section 7

- Infection and Immunity CAU Board Meeting 28.4.11
- Infection and Immunity CAU Board Meeting 24.06.10
- Infection and Immunity CAU Board Meeting 27.01.11
- Infection and Immunity CAU Board Meeting No Date
- Infection and Immunity CAU Board Meeting 23.06.11
- Infection and Immunity CAU Board Meeting 24.03.11

- Infection and Immunity CAU Board Meeting 27.10.11
- Infection and Immunity CAU Board Meeting 26.04.12
- Infection and Immunity CAU Board Meeting No Date
- Infection and Immunity CAU Board Meeting 23.09.10
- Infection and Immunity CAU Board Meeting 24.05.12
- Infection and Immunity CAU Board Meeting 29.04.10
- Infection and Immunity CAU Board Meeting 20.12.11
- Infection and Immunity CAU Board Meeting 27.05.10
- Infection and Immunity CAU Board Meeting 25.11.10
- Infection and Immunity CAU Board Meeting 28.10.10

Section 8

- Sexual Offences Forensic Directorate & Haven Meeting

Section 9

- Infection & Immunity CAU GU Business Meeting 22.09.10
- Infection & Immunity CAU GU Business Meeting 23.06.10
- Infection & Immunity CAU GU Business Meeting 28.04.10
- Terms of Reference – Infection & Immunity Clinical Academic Unit (CAU) GUM Business Meeting 09
- Infection & Immunity CAU GU Business Meeting – 25.05.11
- Infection & Immunity CAU GU Business Meeting – 24.08.11
- Infection & Immunity CAU GU Business Meeting – 26.01.11
- Infection & Immunity CAU GU Business Meeting – 22.06.11
- Infection & Immunity CAU GU Business Meeting – 22.06.11
- Infection & Immunity CAU GU Business Meeting – 23.11.11
- Infection & Immunity CAU GU Business Meeting – 26.10.11
- Infection & Immunity CAU GU Business Meeting – 22.02.12

Section 10

- Minutes from the Haven Sub Communications Meeting 14.04.10
- Haven 3 Year Business Plan
- London Haven Strategic Board – Terms of Reference
- Haven's Financial Bid Template
- Discussion Paper on Havens Communication Strategy for 2011-12
- Haven Paddington Evening Clinic Evaluation
- Haven Strategic Board Agenda – 01.03.12
- London Sexual Violence Needs Assessment – Draft 22.2.12
- Management Summary Report: April 2011- Jan 2012
- Management Summary Report: April 2011 – Jan 2012
- Haven Strategic Board – 01.03.12
- London Haven Board Meeting – 01.03.12
- Haven Strategic Board Meeting – 14.12.10
- Haven Strategic Board Meeting – 22.03.11

- Haven Strategic Board Meeting – 22.09.11
- Haven Strategic Board Meeting – 23.09.10
- Haven Strategic Board Meeting – 24.06.10
- Haven Strategic Board Meeting – 30.06.11

File 2

Section 1

- The Haven Business Meeting 27.01.10
- The Haven Business Meeting 03.03.10
- The Haven Business Meeting 24.03.10
- The Haven Business Meeting 26.05.10
- The Haven Business Meeting 23.06.10
- The Haven Business Meeting 28.07.10
- The Haven Business Meeting 25.08.10
- The Haven Business Meeting 03.11.10
- The Haven Business Meeting 19.01.10
- The Haven Business Meeting 16.02.10
- Joint Operational Meeting 16.03.10
- Operational Meeting (2 weekly meetings commencing 28.01.2010-30.12.2010)
- Clinical Psychology and Counselling Service Meeting 21.04.10
- Business Meeting Minutes – 26.01.2011 – 23.11.2011
- Operational Meeting – 14.01.2011 – 10.11.2011
- Results from Clinic Time Questionnaire
- Business Meeting Minutes 25.01.2012 – 04.04.2012
- Operational Meeting 05.01.201 – 09.03.2012
- Minutes from clinic meeting – 02.03.12
- Business Meeting – Terms of Reference
- Haven Staff Focus Group – Terms of Reference
- Operational Meeting – Terms of Reference
- Psychosocial Meeting Protocol
- Psychosocial Meeting Terms of Reference

Section 2

- Summary of key findings from London Sexual Violence needs assessment and Havens Review Process – 06.02.12

Section 3

- Minutes, Clinical and Research (Training) Group Minutes – 13.09.11
- Minutes, Clinical and Research (Training) Group Minutes – 15.02.11

- Minutes, Clinical and Research (Training) Group Minutes – 05.05.11
- Minutes, Clinical and Research (Training) Group Minutes – 29.11.11
- Minutes, Clinical and Research (Training) Group Minutes – 02.02.12
- Minutes, Clinical and Research (Training) Group Minutes – 21.09.10
- Clinical and Training Group – Proposed Membership & Terms of Reference
- Haven Management Group – 07.07.11
- Operations Group – 06.09.11
- Central London Training Centre – 04.11.11
- Havens Management Group – Membership & Terms of Reference
- Haven Management Group – 09.09.10
- Haven Management Group – 16..07.10
- Needs Assessment Information and Data
- Havens Adult Operational Policy – 25.01.12
- Havens Management Group – Membership Terms of Reference
- Central London Training Centre – 04.11.11
- Central London Training Centre – 04.11.11
- Operations Group – 03.02.12

Section 4

- Pan London Paediatric Meeting – 8.04.11
- Pan London Paediatric Meeting – 16.04.11
- Pan London Paediatric Meeting – 29.10.10

Section 5

- Visit to the Haven on 09.03.2009
- Haven Workplan 2011-2012
- Emails
- Service Delivery Plan

Section 6

- National Support Team for Response to Sexual Violence
- Needs Assessment, Information and Data

Section 7

- Emails
- Haven Governance Structure Overview
- Project Plan – Moving the Havens into Specialist Commissioning – 02.12.10
- Clinical Services Organisational Structure

- Structure Chart – April 2012

Section 8

- Data 01-04-10 – 30-03-11
- Management Summary Report 2010-11
- Annual Report 2010 – 11
- Data 01-01-10 – 31-12-10
- Data 02-04-10 – 29-03-11
- Management Summary Report April 2011 – January 2012
- Performance Dashboard 2011/2012
- Outreach
- Data 01-01-11 – 30-12-11

File 3 – Policies

Section 1

- Updated Local Policies
- Mental Capacity Assessment
- Domestic Violence Screening Guidelines for Haven Paddington non police referrals
- Facilities Reporting
- Debriefing Protocol for Distressing Incidents/Experiences
- Haven Follow-up Clinic Guidelines for Doctors
- Responsibility for ensuring work is fully shut down and secure before going home
- How to report a fault with the telephone
- Self referral protocol for non police referrals
- Main Priorities when there is one person on reception
- Management and Storage of patient Information
- Instructions for using the Mediscan Colposcope
- Notes Scanning Protocol
- Patient's Referral Assault Summary
- Roles and Responsibilities of Doctors
- Step by step guide to handling telephone referral.
- Telephone enquiry policy
- Trust Corporate Policy – Safeguarding Children Policy
- Witness Statement Process

Section Two

- Haven Adult Operational Policy
- Clinical Psychology and Counselling Services
- Pan-London Haven Training Matrices 2011
- Domestic Violence screening guidelines for Haven Paddington non-police referrals – Version 3 February 2012-09-17

- Labelling Forensic Samples
- Information Management Policy for London Havens
- Quality Monitoring Visit
- The London Havens – guidance for follow up
- Collection of Anonymous Police Samples
- Havens Children and Young People Operational Policy
- Havens Cross Referral Guidance
- Early Evidence Kit (EEK)
- Sealing Clothing Exhibits
- Information Policy for London Havens – Version 3 2007
- Pan London – Management and Storage of Self Referral Samples
- Haven Off Site Protocol
- Recommendations for the Collection of Forensic Specimens from Complainants and Suspects
- Management of Adult Clients with Severe Mental Health Problems: Procedures and Responsibilities
- Partner Notification and Proforma Guidelines
- Forensic Pathway for Adults

Section 3

- BLT Safeguarding Children Supervision Contract Group Supervision
- BLT Child Protection Supervision Agreement (Group)
- Trust Corporate Policy – Protection of Adults at Risk of Harm (Safeguarding)
- Trust Corporate Policy – Safeguarding Children Policy

File 4

Section 10

- Care of the acutely sexually assaulted Young Person
- Emergency Contraception
- Initial Assessment
- Why do we ask for certain information on the registration form
- Initial Assessment
- Interagency Referral Form
- PEPSA PROFORMA – young people and adults – 13 years
- Pharmacy Record Sheet
- Asian Development Worker Referral Form
- Risk Identification – RI1
- Telephone Enquiries

Section 11

- Briefing Note – Quality of Service – The Havens
- SCD2 Sapphire Instruction for dealing Quality Service Reports to and from the London Havens
- QSR received by the Haven Whitechapel
- 2010 Quality of Service Report
- 2011 Quality of service Reports
- 2012 Quality of Service Reports

Section 12

- Age Distribution
- Infection and Immunity

Section 13

- ? incident audit/risk/complaint

Section 14 – Job Descriptions

- Administrator/PA x 2
- Data Entry Coordinator/Receptionist
- Haven Service Manager
- Service Specification – Data Entry Coordinator
- Principle Clinical Psychologist
- Specialist support
- Asian Development Worker role in brief
- Young Person's Worker
- Clinical Fellow
- Paediatrician
- Paediatrician – Out of Hours on call
- Roles and Responsibilities of Junior Doctors
- Speciality Doctor – Forensic Gynaecology/Genitourinary Medicine
- Locum Trust Grade Doctor – Forensic Gynaecology/Genitourinary Medicine
- Clinical Nurse Specialist, Forensic Service – Medical and Emergency Directorate
- Clinical Nurse Specialist, Forensic Service – Infection and Immunity Specially Group
- Crisis Worker
- Sexual Offences Nurse Examiner
- Registered Nurse
- Sister/Charge Nurse
- Roles of Nurses in Absence of the CNS
- Roles and Responsibility of daytime staff 2008 – Medical Staffing

Staff Training Forms

- Pan-London Haven Training Matrices 2011
- Training Logs
- Certificates of Training
- Statutory and Mandatory Training Policy
- Mandatory Training Reference Guide

File 4/5

Section 15

- Safeguarding Records Review Meetings – Terms of Reference
  14 June 2012
  7 May 2012
  15 June 2012
  29 May 2012

- Haven Meeting
  5 April 2012
  6 June 2012
  8 May 2012
  13 June 2012
  16 May 2012
  23 May 2012
  30 May 2012

- Barts Health NHS Trust – Summary Communications Plan
- Proposal of Delayed Results to Haven Whitechapel (HW) Patients May 2012
- Operation Liberty Data Protection Principles
- Haven – S1 Follow Up Meeting – 13 March

- Notes of Incident Review Meeting

  29 May 2012
  29 February 2012
  16 February 2012
  09 February 2012

- Adult – Police Case Exhibits Found
- Property Vouchers Found
- Suspected Serious Incident Proformo
- Comprehensive Investigation report
- Legal Advice for Haven SUI

Section 16

- Judge Visit emails
- Sexual Health – 01.08.2011 – 02.11.2011
- Psychology Client Satisfaction Survey
- Haven Service User Feedback Summary –April 2012-March2011
- Haven Service User Feedback Summary -2011/12

Section 17

- Emails-Tavistock Institute
- Executive Coaching – Tavistock Institute

File 6

Section 18

- The Haven – Sexual Assault Centre, Review of Safeguarding Practice – Mary Clark

Section 19

- Needs Assessment to Inform the Review of the London Havens Sexual Assault Referral Centres

Safeguarding Review Findings Appendix Two

Operational Infrastructure to provide day to day operational support to The Haven staff on safeguarding children's and adults issues.

Lack of consistent systematic process for documenting safeguarding concerns, actions and follow up.

Access and uptake of Safeguarding supervision by staff working in The Haven.

Lack of direct access to information of safeguarding processes held in the Group supervision folder give cause for concern particularly for new staff.

Lack of systematic/documented process for on-going safeguarding supervision for Young Persons Advisor and senior clinicians.

Lack of clarity as to who has completed a Merlin and whether onward referrals have been made to Social Services.

Absence of a local centralised mechanism for recording, monitoring the uptake of Safeguarding Children and Adults training by staff working in The Haven.

Organisational wide safeguarding adult and children training attended by staff working in The Haven is generic and may not meet the needs of this specialist service.

Lack of Safeguarding adults' supervision for all staff based at The Haven. Staff at The Haven have access to Safeguarding Children supervision but there appears to be no process in place for staff to access safeguarding adults supervision other than through clinical supervision or using Psychosocial meetings.
Potential for high risk practice relating to the confidentiality and disclosure of information.
Lack of consistent approach to local Induction of staff to the service – Whilst staff who join the organisation attend corporate induction there does not seem to be a systematic process of local induction for staff at all levels. There is a process for inducting doctors into the service but not for other staff groups.

There is a heavy reliance on the use of electronic access to procedural documentation which supports the operational process at The Haven and the wider organisation, however there is clear evidence that staff do not access information on policies/procedures due to the time consuming nature.

There are a number of meetings held at The Haven Whitechapel for which some staff are unclear about the purpose, whether they should be attending or not. This causes some confusion and potentially means staff are not receiving communication about changes within the service and wider organisation.

Lack of day to day management of the service resulting in reduced management capacity to address the service issues and actions as they arise.

Lack of space within the service resulting in staff having to hot desk and in some cases not having a desk to work from.

Staff feeling sidelined with regards to their involvement with commissioners. Staff have some lack of understanding of the Commissioning cycle and process for reviewing service/developing the service specification with commissioners.

Inconsistency of grading for staff doing the same roles working at The Haven Whitechapel and staff working in The Havens at Camberwell and Paddington.

Poor record keeping.

Complexity of records and number of proforma's used in the service.

Number of records held in the service for clients.

Inconsistency of order of documents held in records which results in misfiling of information.

Lack of process for follow up and documentation of referrals.

Lack of clarity regarding the responsible individual for making onward referrals to other agencies.

Lack of referrals to other community services.

Lack of adherence to the process for the receipt and acknowledgment of referrals.

Lack of information on referral forms resulting in recipient not having the full medical/social history to be able to assess the validity of the referral.

Outstanding review of The Havens (London) Information Management Policy.

Lack of standardised process for ensuring that clients who DNA appointments at the service are followed up in a timely way.
Lack of process for systematically tracking records within the service.

Lack of clarity regarding the boundaries for The Haven with clients i.e. when does the responsibility for The Haven stop and where the responsibility for another service/professional begin.

Lack of clear process/timescales for the review and sign off of clinic records by senior clinicians within the service.

The request for blood tests and STI screening tests is lacking in some cases resulting in delay in getting blood tested and results to clients and consequently follow up treatment if required.

Lack of systematic process for checking that staff are adhering to the policy for the request and release of records.

Telephone enquiries sometimes do not become clients of The Haven dependant on the enquiry and as such there is no clear pathway for agreeing if there are any concerns regarding the client whose responsibility it is to follow the queries/concerns up.

Mixture of telephone enquiries and initial assessments documentation contained in the telephone enquiries folder. It is clear that all telephone enquiries are recorded using the telephone enquiry performa however there seems to be a lack of clarity with staff who on occasion use the initial assessment from.

Some clients are given a unique reference number and some are not which may result in difficulties tracking calls and marrying up client records if they then go onto access the service at The Haven.

The nature of the service provided by The Haven has the potential to impact greatly on staff. In managing staffs psychological well being, there was evidence that staff deal with the work that they do in very different ways. There was little evidence of a systematic process for providing all staff with the psychological support they need. Some staff were able to access support through other channels but there is no global offer available to staff.