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**Serious Incident ACTION LOG**

| **Incident summary** | Death caused by person in receipt of community treatment |
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| **Immediate actions** | **Action Required** | **Date To be completed by** | **Lead & Level of Responsibility** | **How are Actions to be audited?** | | **Evidence (of completion)** | **Current Status**  **as at (date)** |
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| Recommendation 1.  Commissioners should consider developing pathways of care that identify young people at risk of mental health problems in custody, and co-ordinates their care across primary and secondary mental healthcare, and youth justice teams. | The PCLD service is an ageless service who assess YP placed detained in custody where the police identify a possible MH concern.  There is also a CAMHS specific part time PCLDS worker in East who is also linked in with the East Sussex YOS. | Completed | Jaquie Batchelor | Monitored through regular police and SPT meetings | | Meeting minutes | Completed |
| Recommendation 2.  The Trust should ensure that serious incident investigations are of the requisite quality standard and are sufficiently rigorous and robust to enable proper organisational learning. | 1. All level 2 serious incidents are now subject to a panel review of senior clinicians. 2. Serious Incident report template has been updated to ensure all key areas are identified and reviewed 3. All serious incidents are subject to ‘sign off’ by Clinical Director, Service Director and Director of Nursing standards & safety 4. All level 3 reports and action plans are shared and reviewed by the trust suicide and homicide review group. | Complete  Completed  Completed | 1. Managing Directors 2. Director of Nursing Standards & Safety   3.Director of Nursing Standards & Safety  4.Dr Tim Ojo – Medical Director | Annual serious audit | | SI Polcy  (See above)  Minutes of Homicide & suicide review group | Complete  Complete  Completed  Completed |
| Recommendation 3.  The Trust should ensure that staff undertaking serious incident investigations are suitably trained, prepared and supported. | Only staff trained in RCA | Completed | Director of Nursing Standards & safety | Annual review | | The RCA presentation was sent separately due to the size of the file. | Complete |
| Recommendation 4.  The Trust should ensure that the clinical risk assessment and management and active engagement policies are consistently implemented. | This is now a requirement for all staff and is set as a standard in appraisal and monitored through supervision session. | On going | Local Service managers | Staff induction  Core training  Regular audits | | Supervision notes and appraisal | Complete |
| Recommendation 5.  The final outcome of contact with secondary mental health services should always be communicated to the service users’ GP. The CCG and Trust should agree the routes of  communication between secondary mental health services and GPs, and embed these into practice. | Performance requirements with CCGs and commissioners are now embedded within the community services. Requirement of 5 day response to GPs. | On going | Local Service managers | Performance reports | | Performance reports | Complete |
| Recommendation 6.  Following a serious incident such as a homicide, the Trust should incorporate best practice guidance available, including the Memorandum of Understanding that exists between the Department of Health, the Association of Chief Police officers and the Health and Safety Executive. This would ensure that timely contacting with victim and perpetrator’s families to agree how they would like to be engaged would be established in practice and policy. The resources of Police liaison and homicide teams, victim support or other available advocacy or support services should be used to support the process. | Full compliance with Duty of candour regulations | Complete | Director of Nursing standards and safety | | Monitored daily by Director of Nursing Standards and Safety  Quarterly report provided to board | Quality and safety report | Complete |
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| **Name of Lead Contact** |  | **Date:** |  |