Standard	Source	Initial Report	After Action Review	Internal independent Investigation
2.5 Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	NPSA, NQB	As above. No further detail provided.	As above.	As above.
2.6 A summary of the patient's relevant history and the process of care should be included.	NPSA	The patient's history is briefly outlined.	Yes.	Yes.
2.7 A chronology or tabular timeline of the event is included.	NPSA	No.	Yes.	Yes.
2.8 The report describes how RCA tools have been used to arrive at the findings.	NPSA	No.	Not applicable.	The report indicates that RCA methodology was used, however, the report does not explicitly refer to RCA tools.
2.9 Care and Service Delivery problems are identified (including whether what were identified were actually Care Delivery Problems (CDPs) or Service Delivery Problems (SDPs).	NPSA	No.	The review identifies key learning points rather than SDPs or CDPs.	The report sets out findings under themed headings rather than identifying SDPs or CDPs.
2.10 Contributory factors are identified (including whether they were contributory factors,	NPSA	No.	No.	No, however, the report findings would appear to be contributory factors. Use of the classification index is not apparent.

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
use of classification frameworks, examination of human factors).				
2.11 Root cause or root causes are described.	NPSA	No.	No.	Yes, diagnosis and engagement. No medication issues: however, these are patient related root causes rather than systems issues and we do not believe these are appropriate.
2.12 Lessons learned are described.	NPSA	No.	The review contains a section on core learning which details: the importance of post discharge recommendations being completed or a rationale for them not being completed being documented; the recording and management on electronic records of patient disclosure (drawing) and the subsequent escalation and handover of concerns within [name] ward; the engagement of service user A following a significant period of disengagement (he had	Lessons learned are described as gaps identified in a recommendations table. The report contains a section on arrangements for shared learning and lessons from the first internal investigation.

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
			not been seen for six months prior to the incident); lack of contemporaneous storage of clinical information is an avoidable risk in relation to having a full chronology of information available to inform care and treatment in addition to ensuring full compliance to formal police disclosure requests. No significant key actions were identified by those attending the AAR. Any additional key actions will be identified post AAR following completion of the root cause analysis exercise by the investigation team.	
2.13 There should be no obvious areas of incongruence.	NPSA	The report is not detailed enough to assess this.	No.	No.
2.14 The way the terms of reference have been met is described, including any areas	NPSA	The terms of reference are not specified.	Not applicable.	The terms of reference have not been met in terms of specifically identifying contributory factors, care and service delivery problems and producing

Standard	Source	Initial Report	After Action Review	Internal independent Investigation
that have not been explored.				recommendations that are outcome focussed.
Theme 3: Lead to a change in practice - impact				
3.1 The terms of reference covered the right issues.	NHSE SIF	The terms of reference are not specified.	Not applicable.	Yes.
3.2 The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	NPSA, NHSE-SIF, NQB	No.	The review examined core learning and key actions.	Yes.
3.3 Recommendations relate to the findings and those that led to a change in practice are set out.	NPSA	There are no recommendations.	There are no recommendations.	There are 28 findings detailed in the report which are then themed into four areas of risk: care and treatment, record keeping and communication, organisational systems and processes. However, they are not outcome focussed.
3.4 Recommendations are written in full, so they can be read alone.	NPSA	Not applicable.	Not applicable.	Recommendations are expressed as a description of the issue followed by actions identified. They can be read alone; however, they are not outcome focussed.
3.5 Recommendations are measurable, and outcome focussed.	NPSA	Not applicable.	Not applicable.	The recommendations do not all include measures or outcomes, however, the report indicates the recommendations are to be carried forward into an action plan.

APPENDIX D – Summary of Niche scores

The summary of the internal and independent investigations identified gaps, Trust actions and Niche scores are as follows:

Number	Internal independent investigation findings	Internal independent investigation recommendations	Niche Score
1	The patient disengaged from service contact and as a result was not seen for a period of 148 days before the incident. As a result, there was no contemporary understanding of his mental health status.	The EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back the learning to the Clinical Business Unit and the South Quality Standards Group.	3
2	There are occasions, such as when non-engagement became apparent, where changes of risk warranted the creation of a new or updated FACE risk assessment and this did not occur.	The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based FACE risk assessment tool at points where changes of risk warrant this using supervision and the IT audit report.	4
3	The needs of the mother had been considered within service contact, however there was no evidence that she had been offered a carers assessment.	The EIP service should review within three months, how to ensure that a carers needs assessment is offered and facilitated and include in audit of the Getting to Know You documentation.	2
4	Transition between CAMHS and Adult ADHD Services was not timely or effective. In instances where a child with a diagnosis of ADHD is in hospital for reasons other than their ADHD and they are being transferred to Adult services, ADHD care and treatment should be integrated into the overall approach to transition with immediate effect.	The revised arrangements for transition between CAMHS and adult ADHD Services should be audited within three months to ensure they are timely and effective.	3
5	Referral between forensic CAMHS and adult forensic services needs to be streamlined.	To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17 April 2019	1

6	Student nurse entries in the clinical record were not always validated, therefore there was no evidence demonstrating appropriate accountability by registered practitioners.	[name] Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.	2
7	The process of Care Coordination was influenced by the perceived wellness of the patient. An approach to the ongoing assessment, care and treatment pathway was therefore limited.	The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the CC [care coordination] process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. An update is required on the Trust wide implementation of the Trust supervision process and policy.	3
8	The victim was a random member of the public unknown to the patient. There is limited guidance on the approach towards involvement and information sharing with the victim's family.	Senior Trust officers should discuss and agree future Trust Policy in relation to involvement/information sharing with the family of a victim when the victim is not known to mental health services in these circumstances. In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family. A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting. The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from the service user A's RC regarding any feedback or otherwise to the patient regarding the review of his care and treatment.	1

APPENDIX E – List of abbreviations used in the report

‘A’	Service user referred to ‘A’ in this report
ADHD	Attention Deficit Disorder
AAR	After Action Review
BDG	Business Delivery Group
CAMHS	Child & Adolescent Mental Health Services
CBU	Clinical Business Unit
CCO	Care coordinator
CCG	Clinical Commissioning Group
CDP	Care Delivery Problem
CQC	Care Quality Commission
CPA	Care Programme Approach
CYPS	Children and Young People’s Services
DoC	Duty of Candour
EIP	Early Intervention in Psychosis
FACE	Functional Analysis of Care Environment
FCMHT	Forensic Community Mental Health Team
FCT	Forensic Community Team
LD	Learning Disabilities
MHA	Mental Health Act
NHSE	National Health Service England
NIAF	Niche Assurance Review Framework
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NQB	National Quality Board
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
PGN	Practice Guidance Note
RC	Responsible Clinician
RCA	Root Cause Analysis
SDP	Service Delivery Problems
SI	Serious Incident
SIU	Serious Untoward Incident
SIF	Serious Incident Framework
SMART	Specific, Measurable, Achievable, Relevant, and Time-specific