## ACTION PLAN POST INDEPENDENT INVESTIGATION – PUBLISHED ON WEBSITE

| Patient ID/Other | Date of Incident | Service | STEIS Number (if applicable) |
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| Mr B | 15 September 2013 | Sunderland Adult Community Treatment Team | 2013/27673 |
| Summary of Incident: Male patient killed another man and was convicted of murder. | | | |

| Recommendations Following Independent Investigation | Actions Undertaken / Planned | Lead / Timescale / Date Completed |
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| Community teams should seek specialist advice as required in relation to treatment strategies when managing patients with a history of drug and/or alcohol abuse who do not engage with the service. | The trust has embedded dual diagnosis expertise within its community teams. This resource is available to support engagement in treatment plans. There are also specialist addiction drug and alcohol services which can provide advice and guidance as required. In the locality where this incident occurred the Community Clinical Leads are dual diagnosis trained.<br><br>**Action:** Request an update on current position from Service Managers across the Trust on relationship with local drug and alcohol services and how these can help to support staff when they are dealing with a dual diagnosis patient who may be difficult to engage. | Service Managers Community and Addictions<br>April 2016 |
| The clinicians should ensure they comply with the information sharing requirements of the trust Care Co-ordination policy. | Engagement, sharing information and communication with other agencies is covered in the Trust Care Co-ordination policy NTW(C)20.<br><br>**Action:** The issues relating to this incident will be taken though the newly developing lessons learnt groups for Trust wide Community Services. This area will | Acting Group Nurse Director |

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| | be monitored though the Serious Incident Review Panel process to explore if it becomes a theme which requires additional action. | March 2016 |
| The trust should ensure that a record is made of any information shared by family members / carers with clinical staff so that the information can be taken into account in planning treatment and care. | Covered within the Trust records management policy NTW(0)09, practice guidance note 02 – record keeping standards.<br>Covered within the Trust Care Co-ordination policy NTW(C)20.<br><br>This is integral to the work the Trust has undertaken around commitment to carers. Further consideration to be given with regard to the most appropriate forum to communicate this message to all staff groups. | Acting Group Nurse Director March 2016 |
| The trust did not meet the requirements of the NPSA being open policy or the duty of candour statutory guidance. The trust should have a clear process in place to locate and engage the families of any victims so they have the opportunity to be supported and involved in the trust internal investigation.<br>As a minimum the trust should ensure that the victim's family:<br><br>• Are provided with and consulted on the terms of reference of the trust internal investigation;<br>• Know how they will be able to contribute to the process of investigation;<br>• Are informed of the findings of the trust | The duty of candour statutory guidance was not in place at the time this incident occurred in September 2013 (statutory guidance was implemented November 2014).<br><br>**Action:** The Trust is reviewing its 'Being Open' guidance that sits within the trust's incident policy NTW(O)05, to include responsibilities around duty of candour to all affected by serious incidents. All independent investigations will include within their terms of reference contact with the perpetrator, the family of the perpetrator and the victim's family as appropriate / possible to seek to answer any questions that they may have around the incident and if appropriate the care and treatment provided by the trust prior to the incident, to fully comply with this recommendation.<br><br>However the Trust feels that this approach should be supported by clear guidance from NHS England available to all statutory bodies to ensure consistency of approach and the trust awaits the further guidance relating to this matter that is listed on page 38 of the Serious Incident Framework dated March 2015. As agreed within this document, the trust will contact NHS England on a case by case basis. | Head of Clinical Risk and Investigations January 2016 |

| investigation. | | |
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| The trust should provide assurance that the systematic changes being made deliver the required service improvements. | Listed below are the five areas which were identified and addressed in the Trust's internal action plan where assurance is required that changes made are embedded to bring about the required improvements:<br><br>• Section 117 aftercare<br><br><br>• Assessment and management of risk<br>• Safeguarding children<br>• Carers' assessments and 'Getting to Know You Process'<br>• Incident Reporting<br><br>**Action:** Assurance required from relevant service managers. | <br><br><br>Directorate Manager<br><br><br>Service Managers March 2016 |

**Footnote: With reference to the above actions, where we have indicated that an action is completed, this reflects a position statement as of that date. However the Trust strives to continually develop and improve in all these areas.**