Livewell Southwest

Serious Incidents Requiring Investigation (SIRI) Policy

Version No 2.4

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent and procedural version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Clinical Risk Advisor**

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Reader Information

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Associated documentation	Risk Management Strategy Health & Safety Policy Incident Reporting & Investigation Policy and Procedure Complaints (Handling & Resolution of) Policy Absent Without Leave (AWOL) & Missing Inpatients Adult Protection / Safeguarding Adults Multi-Agency Policy & Procedures Alert of Missing Families, Children & Young People Protocol Clinical Policies Bomb Threats Protocol Disclosure of Health Records, Giving Statements, Reports,

	Inquests and Court Proceedings Policy Clinical Risk Assessment & Management Best Practice Guidance Information Governance Policy Major Incident Plan Medicines Management Policy Safeguarding Children & Southwest Child Protection Procedures Violence & Aggression Management Policy Care of the deceased Patient. This list is not exhaustive; please refer to policies listed on Intranet
Supersedes document	All previous versions
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0:1	Full review	November 2011	Clinical Risk Advisor	Comprehensive review to reflect current arrangements, national changes and to conform to corporate standards.
1	Ratified	February 2012	Policy Ratification Group.	
1.1	Extended	March 2013	Clinical Risk Advisor	Extended no changes
2	Reviewed.	May 2014	Clinical Risk Advisor	Comprehensive review to reflect current arrangements, national changes and to conform to corporate standards.
2.1	Updated	July 2014	Clinical Risk Advisor	Minor amends to Appendix A and B.
2.2	Updated	September 2014	Clinical Risk Advisor	Addition of Appendix L
2.3	Updated	October 2015	Clinical Risk Advisor	Major changes
2.4	Amendment	April 2016	Clinical Risk Advisor	Minor amendment

Serious Incidents Requiring Investigation (SIRI) Policy

1 Introduction

1.1 This policy sets out the framework for the management of Serious Incidents Requiring Investigation (SIRI) (formerly known as Serious Untoward Incidents (SUI)) within Livewell Southwest in accordance with best practice, and in line with the expectations of the National Patient Safety Agency, the NHS Litigation Authority, the Care Quality Commission and Commissioners. This document compliments, but does not replace, the Incident Reporting & Investigation Policy and Procedure system already in place.

1.2 This policy will enable Livewell Southwest to:

- Monitor the nature and frequency of SIRIs;
- Provide a supportive environment to staff involved in SIRIs and their subsequent investigation;
- Make recommendations for appropriate action with the aim of improving patient care;
- Provide feedback and learning to staff across the organisation in a structured manner, this will include areas of good practice identified during the investigation as well as learning points where improvements could be made.

1.3 The view of Livewell Southwest is that disciplinary action should not form part of a response to an incident, except in cases where one or more of the following applies:

- Where the action causing the incident is negligent, deemed gross misconduct or far removed from acceptable practice or professional standards; or

- Where there is failure to report an incident in which a member of staff was either involved or aware.

1.4 Any disciplinary issue raised in relation to the above will be investigated separately in accordance with the organisation's Disciplinary Procedure.

2 Purpose

2.1 The purpose of the policy is to formally endorse the National Patient Safety Agency's National Framework for Reporting and Learning from Serious Incidents Requiring Investigations, be clear of roles and responsibilities and timescales for completing Serious Investigations and to define the additional requirements for serious incident reporting to agencies such as Commissioners, Clinical Commissioning Group (CCG) & the Local Area Team.

2.2 Adherence to this policy ensures that, in responding to SIRIs Livewell Southwest makes situations safe, keeps stakeholders informed, takes steps to fully understand the incident and its causes, and learns the lessons to minimise the chances of a repeat. Adherence with the policy supports Livewell Southwest

pursue continuous improvement, whilst being person-centred and acting openly, fairly and proportionately.

3 Duties

3.1 The **Chief Executive** has overall accountability to the Board for ensuring the implementation of this policy.

3.2 The **Director of Professional Practice Quality &Safety** is responsible for the implementation of the SIRI process.

3.3 The **Director of Operations and Medical Director** are required to assist the Chief Executive in delivering this policy by adhering to the underpinning principles and ensuring its implementation within their services across all localities.

3.4 **Locality Managers** are responsible for the day-to-day compliance with this policy. In particular they will, in conjunction with ward and department managers, ensure staff are supported throughout the process for serious incidents requiring investigation.

3.5 All **staff** are required to comply with this policy.

3.6 The **Serious Incident Requiring Investigation Review Panel** will regularly examine each SIRI, agree and oversee implementation of any action plans and receive evidence of completion, prior to being closed by the Commissioner.

4 Definitions

4.1 A **serious incident requiring investigation** is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

a) The unexpected or avoidable death of one or more client, staff, visitors or members of the public;

b) Serious harm to one or more clients, staff, visitors or members of the public, or where the outcome requires life-saving intervention, permanent harm or major surgical/medical intervention, or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm (Seven Steps to Patient Safety Page 6 of 38, 2004);

c) A scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;

d) All falls resulting in fractured neck of femur.

e) An acquired grade 3 and 4 pressure ulcer which developed whilst the patient was receiving care from Livewell Southwest staff.
Acquired if the pressure ulcer develops:

(a) 72 hours after admission to the caseload (Community).
(b) 6 hours after admission to the ward (Inpatient units)

Inherited if the pressure ulcer is present on:
(a) Admission to the caseload (Community) or identified within 72 hours of admission to the caseload.
(b) Admission to the ward (Inpatient units) or identified within 6 hours of admission to the ward.
Then it is deemed not attributed to the provider organisation.

f) Allegations of abuse;

g) Adverse media coverage or public concern for the organisation or the wider NHS;

h) One of the core set of "Never Events" as updated on an annual basis.

i) Information Governance, major breaches and loss of personal data.

This includes those in receipt of care within the last 6 months but this is a guide and each case should be considered individually - it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.

4.2 An **unexpected death** which occurs that is not thought to be from natural causes is treated as a serious incident requiring investigation. If suspicious circumstances, the Police must be called and the area preserved as a potential crime scene.

4.3 **Permanent Harm** - harm directly related to the incident and not to the natural course of the patient's illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.

4.4 **Prolonged Pain and/or Prolonged Psychological Harm** - pain or harm that a service user has experienced, or is likely to experience, for a continuous period of 28 days.

4.5 **Severe Harm** - any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care.

4.6 **Major Surgery** - a surgical operation within or upon the contents of the abdominal or pelvic, cranial or thoracic cavities, or a procedure which, given the locality, condition of patient, level of difficulty, or length of time to perform, constitutes a hazard to life or function of an organ, or tissue (if an extensive orthopaedic procedure is involved, the surgery is considered 'major').

4.7 **Abuse** – a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological; it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent.

Abuse can occur in any relationship and may result in significant harm, or exploitation, of the person subjected to it.

4.8 A **near miss** may be defined as **"An incident that did not lead to harm, loss or damage but had serious potential to do so and where lessons can be learnt from changes in procedures, processes and systems."** It is expected that near misses are reported as this enables learning from these incidents to be implemented before harm occurs.

4.9 A **hazard** may be defined as **"Something with the potential to cause harm, or a situation / factor that may cause an incident or make it more likely to happen."**

4.10 **STEIS** - Strategic Executive Information System is the CCG database for reported SIRIs in the Southwest.

5 Reporting a Serious Incident Requiring Investigation (SIRI)

5.1 Internal Reporting

5.1.1 Following a possible SIRI, an Immediate Notification of Serious Incident Requiring Investigation Form & 72 Hour Report is required to be completed (Appendix A). This form is a comprehensive document that will enable a decision to be taken as to the level of investigation required.

5.1.2 This form will be completed by a senior clinician/manager involved in the persons care within one working day of the incident.

5.1.3 The completed form will be emailed to Serious-Untoward-Incident@nhs.net (**this is how it is displayed on the Global Address List**) within one working day of the incident becoming known. **To type in the address manually it is**: Livewell SouthwestCIC.Serious-Untoward-Incident@nhs.net. Upon receipt, the incident will be triaged and if it meets the criteria for an SIRI the CCG will be notified (via STEIS) and recorded on the locally held Risk Management Team's database.

5.2 External Reporting

5.2.1 Livewell Southwest are required to complete an initial 72-hour management report to the CCG and Local Area Team (Specialist Commissioning Group where relevant). Livewell Southwest will forward the completed Immediate Notification of Serious Incident Requiring Investigation Form & 72 Hour Report (Appendix A) which will include the following:

a) Date and location of Incident and STEIS identification number;
b) Initials, gender and date of birth of client;
c) Incident type; i.e. a Never Event;
d) Brief details leading up to the incident to include care and treatment;
e) Immediate actions taken.

6 Security of Notes (Non Electronic)

6.1 Both the Clinical Record and the SIRI Record need to be created, used, stored, retained and destroyed in line with the Livewell Southwest Clinical and Corporate Record Policy and in line with the Records Management: NHS Code of Practice Part 1 and 2 https://www.gov.uk/government/publications/records-management-nhs-code-of-practice

6.2 Patient/client records will be secured by the Team Manager and their location entered onto the electronic records system and noted in the Immediate Notification of Serious Incident Requiring Investigation Form & 72 Hour Report (Appendix A). For SIRI's that do not involve the death of a patient / client the location of notes should be noted so as access can be assured. Upon receipt, the incident will be triaged and if it meets the criteria for an SIRI the CCG will be notified (via STEIS) and recorded on the locally held Incident Reporting System.

6.3 Staff may access notes as part of the investigation by requesting from the Team Manager and returning after use; local records showing the location of the records should be kept by the manager.

6.4 Please note that under normal circumstances notes should not be disclosed to either the Police or Coroner without the Risk Management Team being notified, which must be in accordance with the Disclosure of Health Records Policy & Procedure for Adults and Children not subject to Safeguarding Concerns, on Intranet. However, in some circumstances the police will seize notes. If at all possible take a copy prior to this (please see the records management code of practice).

7 SIRI Process

7.1 The overriding emphasis of incident reporting and investigation is to learn from incidents and reviews, not to attribute individual blame or to punish. This approach will enable Livewell Southwest to focus on learning and improving systems and processes to manage risks more effectively.

7.2 Following receipt of an Immediate Notification of Serious Incident Requiring Investigation Form & 72 Hour Report (Appendix A). The Deputy Director of Professional Practice, Quality and Safety and the Risk Management Team in conjunction with the professional leads and other relevant staff will decide on the type of investigation / review required. A triage process will determine the options.

7.3 The triage process is held on receiving an Appendix A, at least 2 people from the Governance department review the case and determine if it meets the criteria for a SIRI, if not a form is sent back to the reporting area stating that it does not constitute a SIRI and any other action that may be required.

7.4 The review options are:

a) An internal review to be undertaken by the team.
b) SIRI investigation undertaken by investigators within Livewell Southwest.
c) Independent external investigation.

7.4.1 **SIRI investigation**

Step 1 This will require a detailed chronology to be produced by the investigating team, who has previously attended Root Cause Analysis training, and also gather any other information surrounding the incident. Information may be obtained from the patient family and may be involved in the review at any time during the review. (Refer to Appendix L for Guidance).

Step 2 Once completed, the chronology together with other RCA Tools that are used by the investigating team, identified by the Clinical Risk Advisor, Governance Team or Locality Managers, to analyse and review the incident.

Step 3 Once the investigation is complete the final report will be presented to the SIRI Review Panel who will agree recommendations and actions. (See Appendix B for Terms of Reference).

Step 4 After completion and review at the SIRI Panel the completed report and action plan is sent by the Clinical Risk Advisor to the CCG for closure.

Step 5 The SIRI Review Panel will continue to monitor these actions until complete. In addition, the panel will agree the best method to take forward any learning from the incident.

7.5 **Independent External Investigation**

7.5.1 The Clinical Commissioning Group (CCG) or the National Health Service Specialist Commissioning Group (SCG) are responsible for commissioning independent investigations and, consequently, the reports generated are the property of the CCG or SCG. Commissioning in this context refers to determining when an independent investigation is necessary, appointing an Independent Investigation Team, agreeing terms of reference, publishing and distributing the resultant report and ensuring a process for subsequent action to address issues raised.

7.5.2 Membership and arrangements to be agreed by the Chief Executive with the CCG or SCG.

7.5.3 An independent investigation should be undertaken in the following circumstances: This will be commissioned by the NHS England area team.

i) When a homicide has been committed by a person who is or has been under the care (i.e. subject to standard care or the care programme approach (CPA)) of specialist mental health services in the six months prior to the event (also see Appendix H);

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the Next-of-Kin to an appropriate extent;

iii) Where the CCG determines that a SIRI warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

7.6 Duty of Candour

7.6.1 Involving and supporting people following an incident is an important part of the investigation process. The Livewell Southwest principle is that communication with healthcare teams, staff, patients, their relatives and carers must be as open as possible. Following a death or serious untoward incident, it is the responsibility of the Staff to offer an explanation, a sincere apology, condolences and support; and provides them with the opportunity to raise any concerns and views so that these can be reflected as part of the investigation.

7.6.2 It is important that the views and concerns of patients and/ or their family/ carers are gained early in the investigation process to ensure these are properly addressed, excepting restrictions on disclosure such as the following:

Best interests – clinical opinion indicates that disclosure would adversely affect the patient's current health; Any written instructions from the patient regarding the disclosure of any information to others; Circumstances whereby there are serious concerns relating to a safeguarding adult/ child issue; and Circumstances whereby there are serious concerns that the patient's representative (e.g. relatives / family / carers / advocate) is not acting in their best interests.

7.7 Special considerations in respect of safeguarding incidents

7.7.1 For incidents where there are concerns around safeguarding, staff will identify these incidents within the Hospital Incident Reporting System. These incidents are reviewed by the Safeguarding team on at least a weekly basis to ensure appropriate safeguarding procedures have been followed. The decision to report a safeguarding incident as an SIRI and report this on to StEIS must be taken by the executive lead for safeguarding or nominated deputy. This must also be reported to the Care Quality Commission without delay.

7.7.2 The Executive lead will also inform the relevant commissioners and the relevant local safeguarding children/adult board. Where there is a multi-agency serious case review (SCR) the organisation may be asked to do an Individual Management Review (IMR) as part of this multi-agency investigation.

7.7.3 The learning from SCRs is shared throughout the organisation via the Safeguarding Adults /and Children's Committees.

7.8 Content of Review

7.8.1 All reviews must include:

a) Description of incident.
b) Details of patient(s) affected by incidents (name-age-diagnosis).
c) Details of staff involved and where based.
d) Short history of patient/client.

e) Chronology of events of incident, including lead up and consequence.
f) Analysis of incident using root cause analysis tools and techniques.
g) View of staff involved (this is also the opportunity to debrief the staff when the incident is reported after the event for example the death of a client in the community).
h) Possible concerns for service area.
i) Areas of identified good practice.
j) Action plan and recommendations.

7.9 **Timescale for Reviews**

7.9.1

i) Internal review should be completed within 60 working days from the date of the incident;

ii) where an independent investigation is commissioned this should be completed within 6 Months from the date of commissioning;

7.9.2 On rare occasions, extensions to the above timescales can be agreed. The circumstances for an extension must be those that are outside the normal working arrangement, such as witnesses being unable to be interviewed due to absence. Extensions must be agreed with the CCG and with the Specialist Commissioning Group where relevant. The reason for the extension must be included in the "further information" section of STEIS.

7.10 **Homicides** (also see Appendix H) - all homicides should follow the guidance that replaced paragraphs 33 –36 in HSG (94) 27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services. Follow link for Good Practice Guidance.
http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156

7.11 **Closure of SIRI – Process and Assurance -** SIRIs can only be closed on STEIS by the Commissioners following the receipt of a robust investigation report that has been generated, following review.

8 Support for Those Involved

8.1 Throughout the SIRI process, consideration should be given to the provision of immediate and/or independent support and counselling for those involved. This will include not only the staff, but also any family members or carer(s) of the patient/client affected, or to those exceptional others to whom the incident had a direct negative impact.

8.2 Support should be given by Line Managers, other team members and Unions if required. In most cases supervision will meet an individual's needs, however if required a referral to staff health and wellbeing service may be completed.

8.3 Additionally, staff can access counselling via Occupational Health on 01752 437212 or Options on 0845 155 8069.

8.4 Following a SIRI it may be necessary to provide ongoing support to a member of staff. This may be provided internally or externally as detailed above. It is the

responsibility of the Locality Manager of the service concerned to ensure this happens. Human Resource Advisors and Occupational Health Advice should be sought at this stage.

8.5 At times staff may be called as a witness for either an internal review or a court / inquest appearance. For internal reviews the member of staff will be supported as described above however, if required to attend court or inquest, additional support should be provided by the Locality Manager/Governance of the service concerned and/or legal support can be sought from Livewell Southwest Legal Services Providers through the Risk Management Team if deemed appropriate.

8.6 Where an individual or team has been exposed to a traumatic event, Livewell Southwest has developed a Trauma Debrief Template (See Appendix K) for managers to complete with staff. Once complete, this document should be attached to the corresponding electronic incident report form.

9 Feedback of Learning

9.1 The Locality Manager / Deputy will agree the best method to take forward actions and learning from any incident.

9.2 The SIRI review panel will provide a final report following completed investigations. This report will be based on the best practice document published and launched by the NPSA in 2009. The Locality Manager will monitor any actions resulting from investigation and liaise with the SIRI team when actions are completed. All completed actions will require evidence prior to being closed.

9.3 A copy of the final report will be sent to:

a) The manager of the team involved in the incident.

b) An annual report of all incidents involving suicide will be fed into the Suicide Audit. Planned education and training will be specifically designed and tailored to facilitate learning outcomes from the SIRI process.

c) The annual report will be reported to the Board, Safety and Quality Committee, and IPAM.

10 Communications

10.1 At all stages of the investigation, from the time the SIRI is first reported to the final report, consideration should be given to the communications process, both internal and external. The Chief Executive and Directors assisted by the Communications Manager, Locality Managers and the Investigation Team will agree on the level of information to be communicated, the recipients and the method of conveyance.

11 Links with Complaints and Litigation Department

11.1 During the investigation of any SIRI, regular contact should be maintained with the Complaints and Litigation Department as often, following a SIRI, the person involved (or member of family/carer) would instigate a complaint. It is good practice to ensure both the Investigation Team and the Complaints and Litigation Manager are fully apprised of any developments.

12 Information to Patients and Public

12.1 The Director of Professional Practice, Quality & Safety will need to decide, in conjunction with the Chief Executive and Communications Team, the level of information that may be made available to patients, relatives and the public who, in turn, will be briefed by the Chief Executive, Director of Professional Practice, Safety & Quality, and the Communications Lead.

13 Approaches from the Media

13.1 Patients or relatives and staff should, if possible, be briefed before the media. Any direct approaches from the media should be dealt with courteously along the following lines:

"I am sorry I am not in a position to comment at the present time but if you would like further information please contact the Communications Team".

13.2 Out-of-hours - advise the media they should contact the On-Call Director via Mount Gould switchboard telephone number 01752- 268011, out of hours this is redirected to Derriford Hospital. The On-Call Director will decide if it is appropriate to contact the on-call Livewell Southwest media support lead for advice.

14 Other Agencies

Consideration should be given to other agencies that may need to be involved in any investigation e.g. Safeguarding, Social Services, Police, other healthcare providers. Ensure that other agencies have been informed and agree arrangements for the management of the SIRI review. There should not be duplication of investigations and action planning within the health care provider where external bodies i.e. safeguarding are carrying out investigations.

15 Incidents Involving Personal Identifiable Data

15.1 The CCG will be responsible for notifying the Department of Health of any category 3-5 incidents reported. The Information Commissioner should also be informed of all category 3-5 incidents. Consideration should also be given to informing patients when personal identifiable information about them has been lost or inappropriately placed in the public domain.

15.2 The checklist for reporting, managing and investigating information governance SIRIs V 1-0 sets out guidance on the reporting of Information Governance SIRIs and assessing severity. Risk assessment categorises incidents and the likely consequences (see overleaf).

Grade:					
0	**1**	**2**	**3**	**4**	**5**
No Significant reflection on any individual or body. Media Interest very unlikely	Damage to an individual's reputation. Possible media interest i.e. celebrity involved	Damage to a team's reputation. Some local media interest that may not go public	Damage to a services reputation/ Low key local media coverage	Damage to an organisations reputation/ Local media coverage	Damage to NHS reputation/ National media coverage
Minor breach of confidentiality. Only a single individual affected	Potentially serious breach. Less than 5 people affected or risk assessed as low i.e. files were encrypted	Serious potential breach and risk assessed high i.e. unencrypted clinical records lost. Up to 20 people affected	Serious breach of confidentiality i.e. up to 100 people affected	Serious breach with either particular sensitivity i.e. sexual health, or up to 1000 people affected	Serious breach with potential for ID theft of over 1000 people affected

16 Inquest

16.1 Attendance at inquest can be a stressful time for staff, to support staff through this process the procedure for attendance at inquest flowchart should be followed Appendix C. In addition, please refer to the **Disclosure of Health Records, Giving Statements, Reports, Inquests and Court Proceedings Policy.** This guidance covers inquests, police and coroner statements, claims against the organisation, children's proceedings private / public law, fraud and any investigations by Inland Revenue or other agencies, Employment Tribunals, protection of vulnerable adults and any serious incidents requiring investigation.

16.2 All Staff attending an inquest will be supported by the SIRI team and legal representative will be provided if appropriate.

17 Training

17.1 Risk management information is provided to all levels of staff on mandatory corporate induction, including being open and honest, complaints, incident reporting and SIRI reporting, investigation and learning the lessons.

17.2 A one-day workshop for managers is available as Core Management Training for Health, Safety and Risk Management, which includes incidents and SIRIs.

17.3 Health, Safety and Risk Assessor training is available annually, valid for two years before attending refresher training. This is available for all levels of staff, with specific sessions for managers focussing on their more strategic issues.

17.4 Mandatory training is monitored by Professional Practice Quality and Safety Directorate, including “did not attend” follow-up. Locality and line management are individually responsible to ensuring all staff attend mandatory training, together with identified essential training pertinent to staff roles. Mandatory pressure ulcer training requires attendees to undertake two written exam papers. They require a 90% pass mark (2nd test) and there is a process in place for staff who fail to meet the required pass mark.

17.5 Ongoing support is available for all staff by contacting the Risk Management Team.

17.6 Root Cause Analysis (RCA) training is available approximately 5 times a year, co-ordinated via the Risk Management Team, aimed towards managers and senior clinicians. This training includes root cause analysis, action planning and learning the lessons. Once trained, these staff are then placed on the list of available staff to undertake SIRI reviews.

17.7 With the introduction of the Duty of Candour it is a requirement and good practice to offer to meet with the patient or family. This can be a difficult meeting for families and staff, it is important to provide debriefing and training for staff to support them during this process.

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18 Monitoring Compliance

18.1 Case-by-Case

18.1.1 Compliance with this policy will be monitored on a case-by-case basis via the SIRI Panel. Livewell Southwest has two SIRI panels - one for Pressure Ulcers and one for all other SIRIs. The panels meet monthly and every SIRI will be monitored to ensure the processes described in this policy are followed.

18.1.2 Any omissions / deviations from the processes described in this policy will be addressed by the chair of the panel with the Locality Manager of the service involved in the incident.

18.1.3 In all cases, Livewell Southwest has a formal reporting mechanism in the Safety and Quality Committee accountable to the board that has responsibility for monitoring the management and follow up of SIRI, implementation of action plans and identification of themes and trends.

Notification of Serious Incident Requiring Investigation (SIRI)

Notification Forms (Appendix A) are available on the Livewell Southwest Website under documents-Templates - Incident Forms or click on the Link Below:

http://Livewell Southwestnet.derriford.phnt.swest.nhs.uk/Documents/FormsTemplates.aspx

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Professional Practice Safety & Quality

Date: 5th February 2016

Immediate Notification of Serious Incident & 72 Hour Report

Please complete in as much detail as possible. This document should then be e-mailed to: **Serious Incidents** Livewell SouthwestCIC.serious-untoward-incident@nhs.net **within 1 working day of the incident. NB.** Please ensure that the form is completed in full and also the safeguarding questions

Date and Time of incident:	
SIRI Ref No: (to be completed by Risk Management Team)	
Name:	**Designation:**
Date and Time completed:	**Base:**

Staff or Patient incident:		
Patient / Staff Name:		
Date of Birth (if known):		
Gender:	**Male** ❑ **Female** ❑ **Not Stated** ❑	
Ethnicity:		
Occupation:		
Job Title: (if member of staff involved)		
District/Locality/Area/Ward		
Inpatient / Community:		
GP Practice:		
Consultant :		
Named nurse:		
Care Coordinator / Lead Professional (Mental Health Only)		
Informal/Detained:		
Patient Hosp & NHS number:		
Standard Care or CPA (if MH Community Patient)		
Diagnosis(Must be completed) Including if relevant:- Dual diagnosis and/or known drug and/or alcohol problems)		

Date, time and exact place of incident:	
Details of incident : Please describe and include any injuries sustained, and details of the event, that are known.	
What led to the incident **(If applicable)**	
Immediate action taken:	
Are there any immediate concerns regarding care?	
Is there anything about this incident that at this early stage, leads you to think that it arose due to any form of abuse being experienced by the service user (including bullying and cyber-bullying). If so, please describe that.	
Is there anything about the care that has been provided that at this early stage, leads you to think that this incident arose because there has been a failure on behalf of professionals and care givers to provide the appropriate care. If so, please describe that.	
Are you aware of any child or adult safeguarding concerns that are ongoing for the service user. If so, what are they?	
Name of Person initially informed of incident:	

Staff involved (if applicable):	
Other involved : (relatives/carers/clients)	
Equipment Involved:	
Date of Care Plan:	
Date of Risk assessment:	
Date of last CPA review: (Mental Health only)	
If on CPA does the care Plan include Crisis Contingency Plans and Relapse Plans? (Mental Health only)	
Date of last discharge from mental health in patient care: (Mental Health only)	
Are there any issues regarding Safeguarding Adults / Children?	
When Informed and by whom?	
Police involvement: (include name/number of officer and contact number)	
Main contact person regarding this incident: Please state telephone number.	
When did staff make contact with family/relatives/carers?	
Has the duty of candour been applied? **If YES please Include evidence. If NO please describe rationale.**	**YES / NO**
Was support and information offered to relatives/carers? By whom? Please describe:	

Who undertook to support staff, and were they offered the opportunity to discuss the incident?	
If no support offered to anyone please specify why?	
Date and venue of support meetings:	
Are there any follow up arrangements?	
Have arrangements been made to support staff not on duty at time of incident?	
Records have been secured and are being held at:	
Team Manager to record where records are on record tracking system (i.e. PiMS)**:**	
If this was a maternal death up to one year post-natal. Have the PHNT been Informed.	**Yes/No** **Details:**
Update of information:	

Acquired Pressure Ulcer Grade 3-4
Immediate Notification of Serious Incident - 72 Hour Report

Definition of Acquired/ Inherited Pressure Ulcer

An ACQUIRED pressure ulcer occurs whilst a patient is receiving care from Livewell Southwest in either of the following circumstances;

- **In-patient wards ; 6 hours after admission onto an inpatient ward**
- **In the community; 72 hours after admission onto the caseload.**

An INHERITED pressure damage is defined as:

- **When a new patient is transferred or admitted with a pressure ulcer into inpatient or community services within Livewell Southwest.**
- **Either as an in-patient; within 6 hours admission onto an inpatient ward or**
- **In the Community; within 72 hours after admission onto the caseload.**

You do not need to complete this form for an inherited pressure ulcer

This document should then be e-mailed to: **Serious Incidents** Livewell SouthwestCIC.Serious-Untoward-Incident@nhs.net **within 1 working day of the incident.**

Date and Time of incident:	
SIRI Ref No: (to be completed by Risk Management Team)	
Name:	**Designation:**
Date and Time completed:	**Base:**

Staff or Patient incident:	**Patient Pressure ulcer**
Patient Name	
Date of Birth (if known):	
Gender:	**Male ❑ Female ❑**
Ethnicity:	
Occupation:	
District/Locality/Area/Ward	
Inpatient / Community:	
GP Practice:	
Consultant :	

Named nurse:		
Care Coordinator / Lead Professional		
Patient Hosp & NHS number:		
Details of pressure ulcer incident :		
Immediate action taken:		
Are there any immediate concerns regarding care?		
Is there anything about the care that has been provided that at this early stage, leads you to think that the pressure ulcer has developed because there has been a failure on behalf of the involved professionals and care givers to provide the appropriate care? If so, please describe that.		
Are you aware of any child or adult safeguarding concerns that are ongoing for the service user? If so, what are they?		
Are you aware of any existing known safeguarding concerns within this care setting? If so, what are they?		
Name of Person initially informed of incident:		
Staff involved (if applicable):		
Other involved : (relatives/carers/clients/outside agencies)		
Equipment Involved:		
Date of Care Plan:		

Date of Risk; Waterlow Assessment:	
Main contact person regarding this incident: Please state telephone number.	
When did staff make contact with family/relatives/carers?	
Has the Duty of Candour been applied? YES / NO **If YES please include evidence. If NO please describe rationale.**	**YES**
	NO
Was support and information offered to relatives/carers? **By whom?** **Please describe:**	
Update of information:	

Pressure Ulcer Details		
Pressure Ulcer	**Where did the pressure(s) ulcer occur?**	
	Patients home	
	Hospital and ward name	
	Residential care (Name)	
	Nursing care (Name)	
	St Luke's Hospice	
	GP Surgery	
	Clinic (Name)	
	If Other please state	
	Could this be a moisture lesion? Yes/No	
	Could this be a diabetic ulcer? Yes/No	
	Is this a deterioration of an existing pressure ulcer? Yes/No	
Is this pressure ulcer acquired? Yes		**SEND APPENDIX A**
Is this pressure ulcer inherited? Yes		**STOP! DO NOT SEND APPENDIX A**
State Origin Of Pressure Ulcer		
Area Of Body Affected	**Grade 3**	Sacrum
		Left Heel
		Right Heel
		Left Buttock
		Right Buttock
		Left Hip

		Right Hip
		Other
		Please State:
	Grade 4	Sacrum
		Left Heel
		Right Heel
		Left Buttock
		Right Buttock
		Left Hip
		Right Hip
		Other
		Please State:
	Unstageable	Sacrum
		Left Heel
		Right Heel
		Left Buttock
		Right Buttock
		Left Hip
		Right Hip
		Other
		Please State:

Patient advice on pressure area care given;	**Yes/No**	**Comments/ Date**
Carer advice on pressure area care given;	**Yes/No**	**Comments/ Date**
Type of pressure relieving equipment used?		
Repositioning plan;	**Yes/No**	**Comments/ Date**
Has the appropriate equipment been installed? • **This needs to be followed up with visit to check to see if it's being used correctly.**	**Yes/No**	**Comments/ Date**
Other Aids;	**Yes/No**	**Comments/ Date**
Nutritional Assessment;	**Yes/ No**	**Comments/ Date**

Waterlow / Risk Assessment;	**Yes/ No**	**Comments/ Date**
Wound Assessment;	**Yes/ No**	**Comments/ Date**
Skin Assessment;	**Yes/ No**	**Comments/ Date**
Skin Care;	**Yes/No**	**Comments/ Date**
Date of Care Plan reviewed;	**Yes/ No**	**Comments/ Date**
Is a current care package in place?	**Yes/ No**	**Comments/ Date**
If yes; does it meet the patient's needs?		**Comments/ Date**
If no; does a care package need implementing?		**Comments/ Date**
Type of care package;		**Comments/ Date**
Any additional action please detail;	**Yes/No**	**Comments/ Date**
Has a referral to the Tissue Viability Service been made for Grade 3-4 Pressure Ulcer;	**Yes/No**	**Comments/ Date**

Appendix C

Serious Incidents Requiring Investigation Review Panel

1 Terms of Reference

1.1 The Serious Incidents Requiring Investigation (SIRI) Review Panel will meet monthly to review all incidents occurring within Livewell Southwest (Livewell Southwest) in accordance with the Serious Incidents Requiring Investigation Policy, and demonstrate adherence to the SIRI policy

1.2 The members of the SIRI Panel will review in detail SIRI reports, when the investigation is complete and presented by the investigation team, as appropriate.

1.3 The SIRI Panel will produce a report summarising serious incidents requiring investigation, together with comments and recommendations.

1.4 Recommendations from the SIRI investigation will be sent to the Locality Manager who is responsible for the action plan.

1.5 The SIRI panel will seek independent and outside advice, as appropriate.

1.6 The SIRI Panel will disseminate any learning from investigations, together publication of a quarterly SIRI Newsletter.

1.7 The SIRI Panel will review SIRIs across Livewell Southwest to identify any trends/learning.

1.8 The panel will provide a report to Safety and Quality Committee and the CCG

2 Membership

- Consultant Psychiatrists
- Clinical Risk Advisor
- Deputy Director of Governance Professional Practice(Chair)
- Locality Managers
- Secretary
- Professional Leads
- Consultant Psychologist
- Team Managers

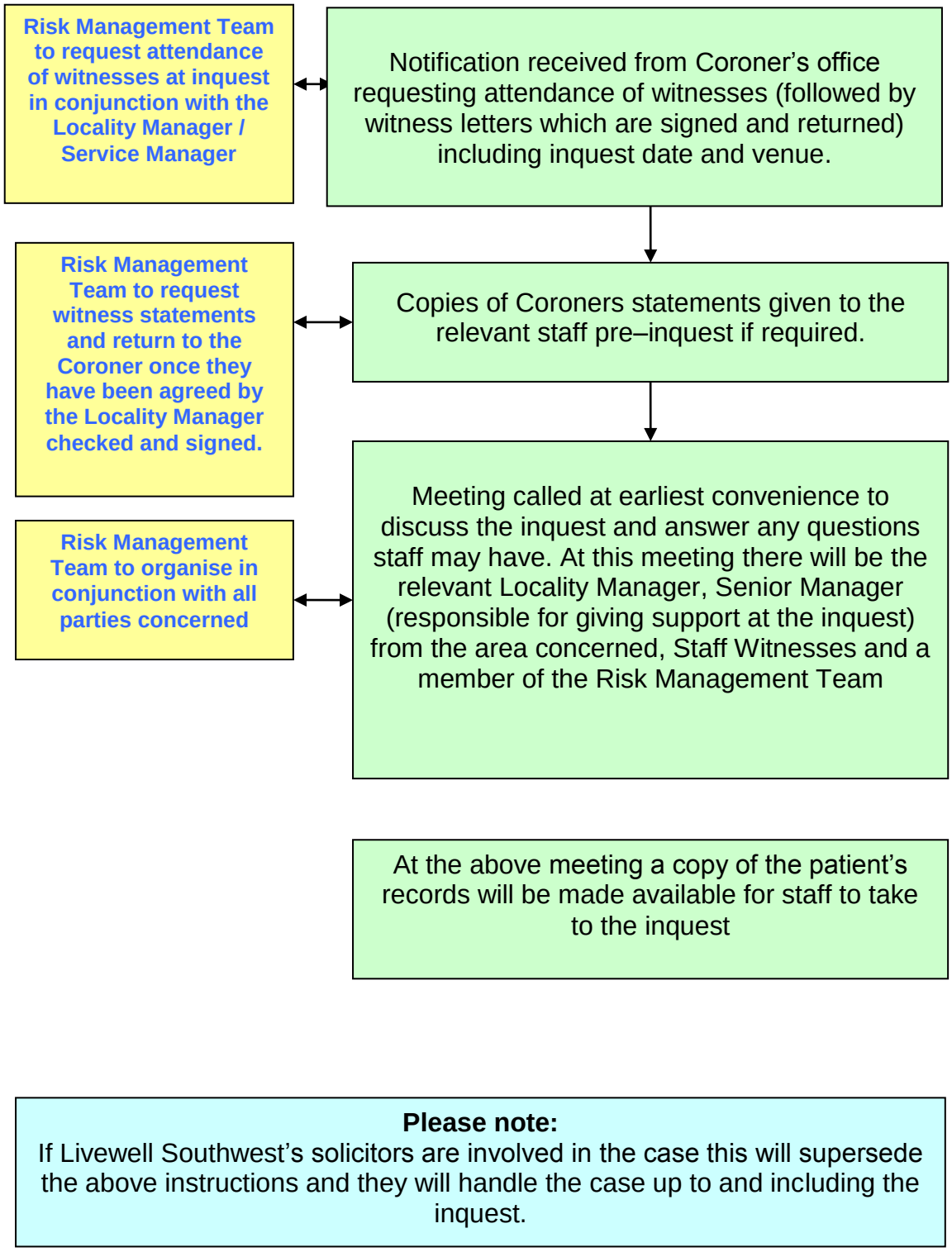
3 Quorum

Five members of the Committee including at least four clinicians who must be appropriate to the events under discussion.

4 Frequency

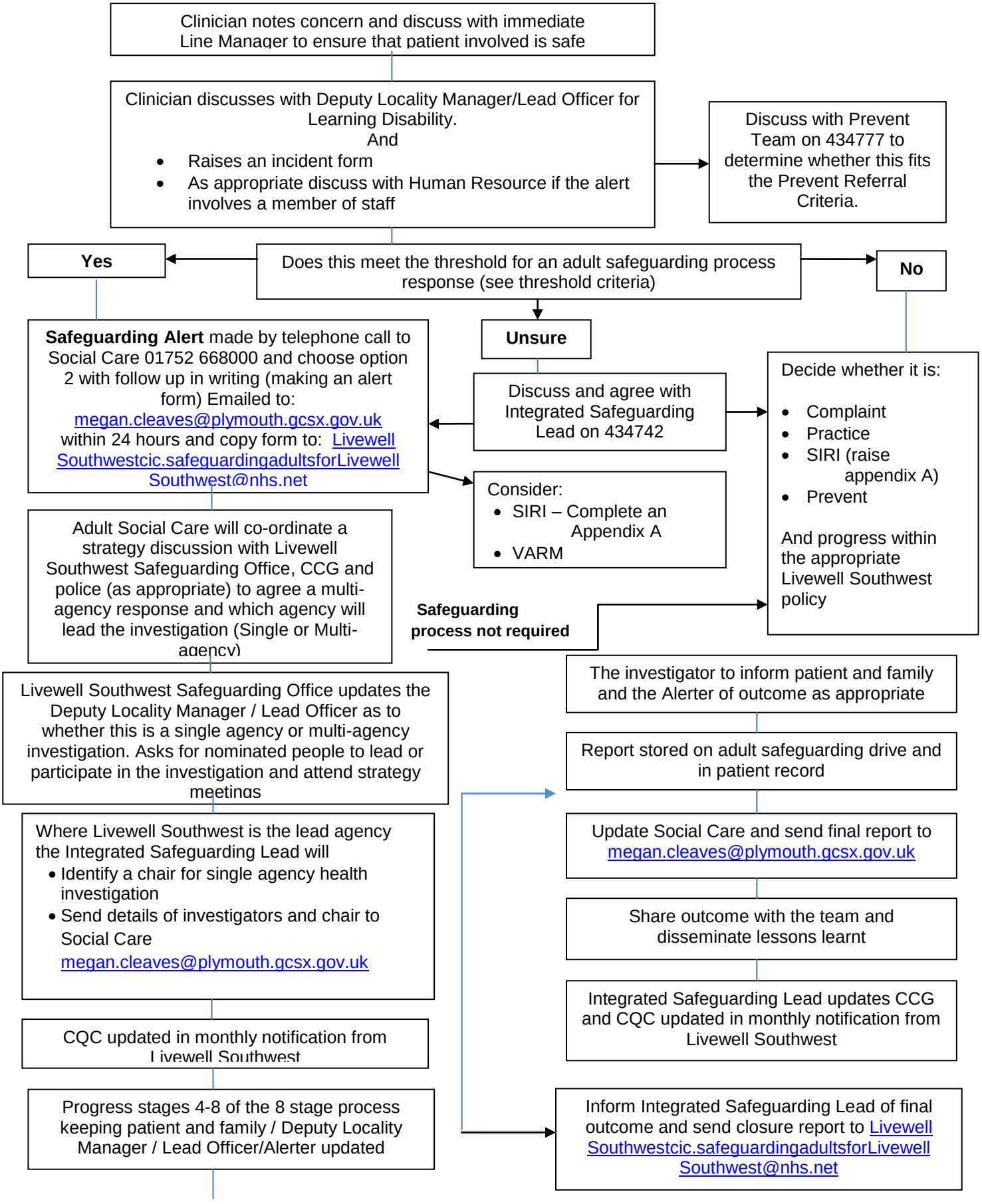
Monthly for 2 hours.

Staff Attendance at Coroners / Inquest



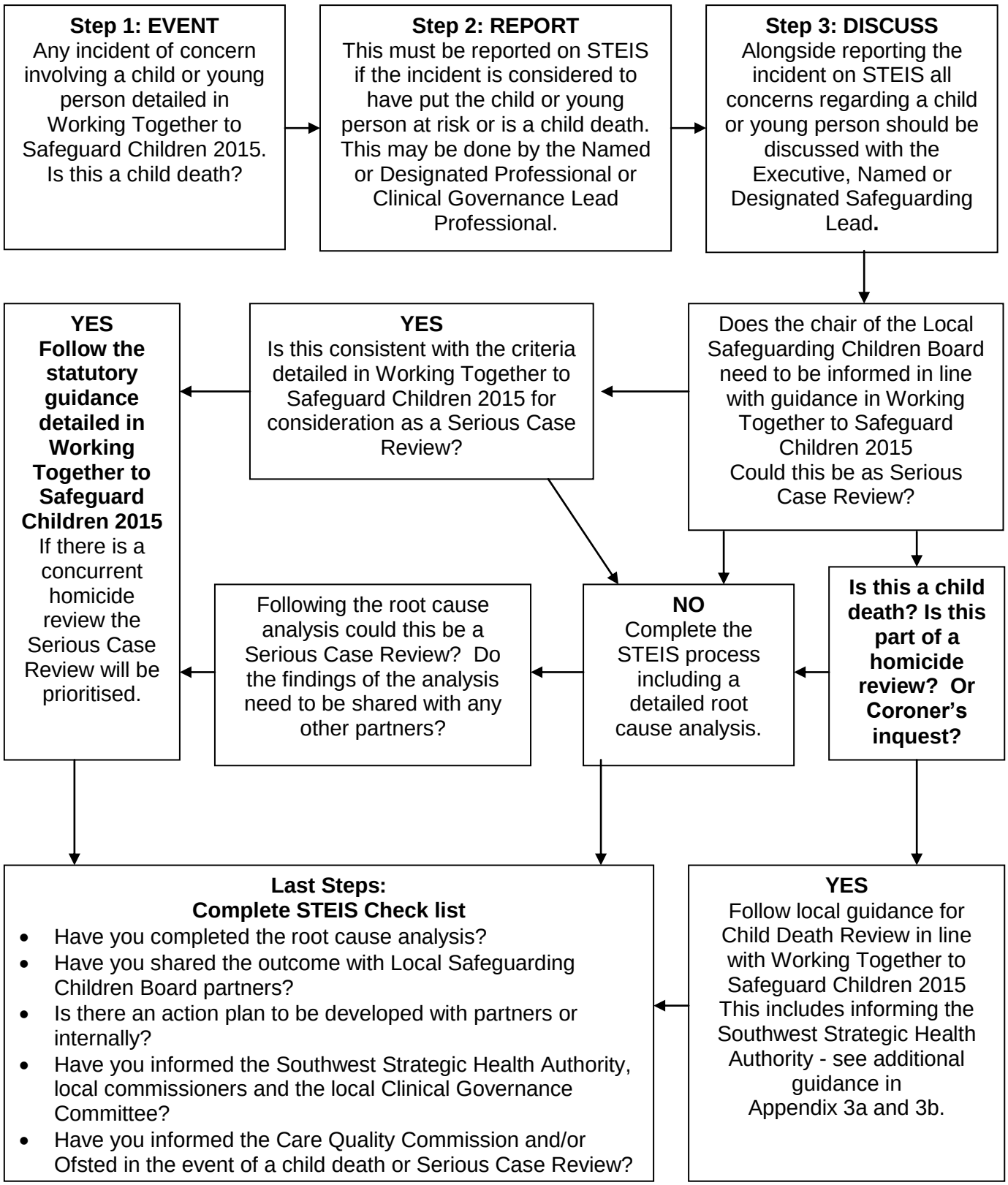
Please note:
If Livewell Southwest's solicitors are involved in the case this will supersede the above instructions and they will handle the case up to and including the inquest.

Adult Safeguarding Alert and Investigation Flowchart.



Appendix F

Working Together to Safeguard Children
Flow Diagram of Incident Reporting



Safeguarding Children - Unexpected Child Death or Episode of Serious Abuse

Inform immediately: Duty Managers-NHS Trust, Livewell Southwest, Children Young People Services, Police, Named and/or designated professionals

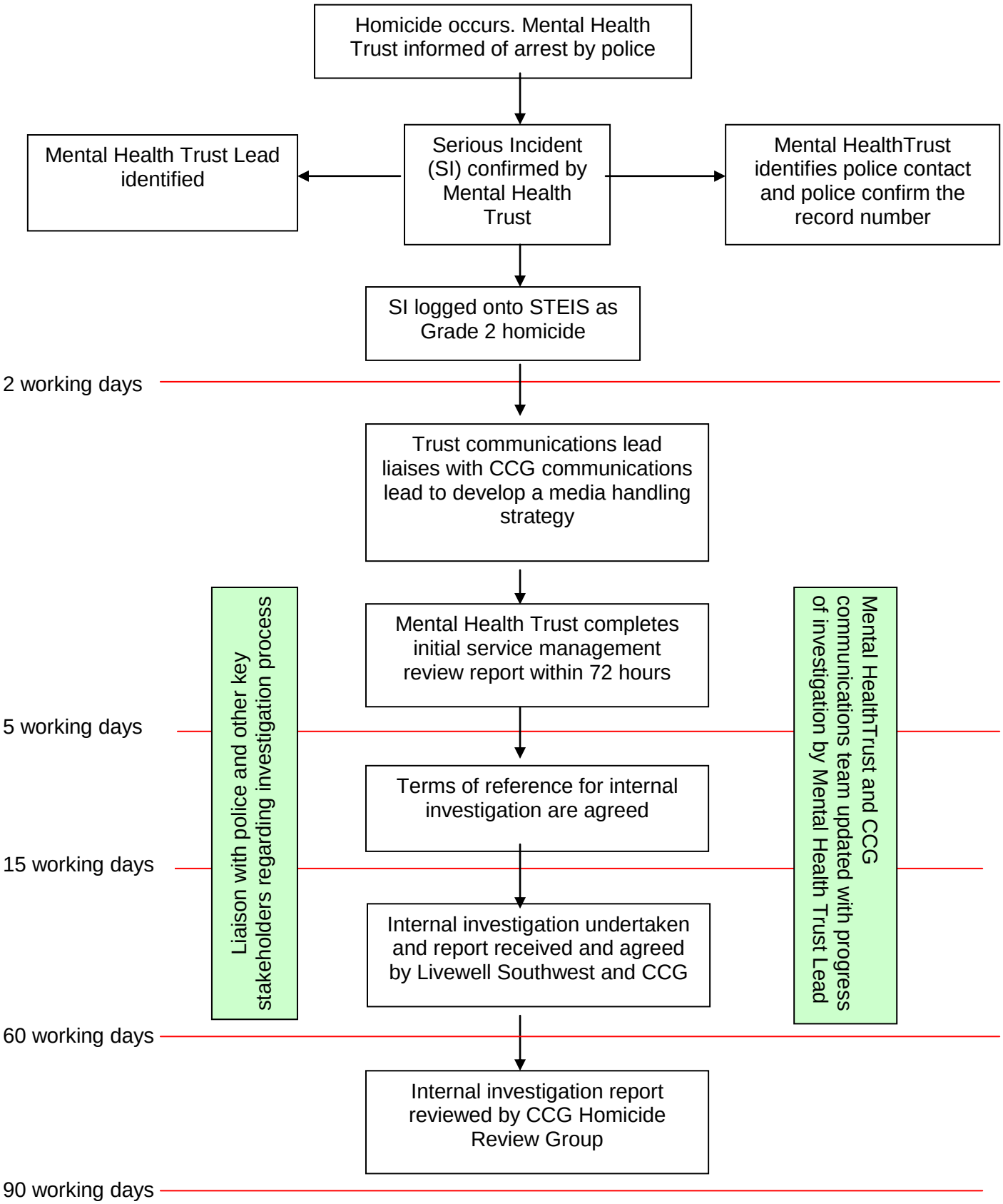
Secure records: Hospital, community, public health nursing, midwives, therapists, GP

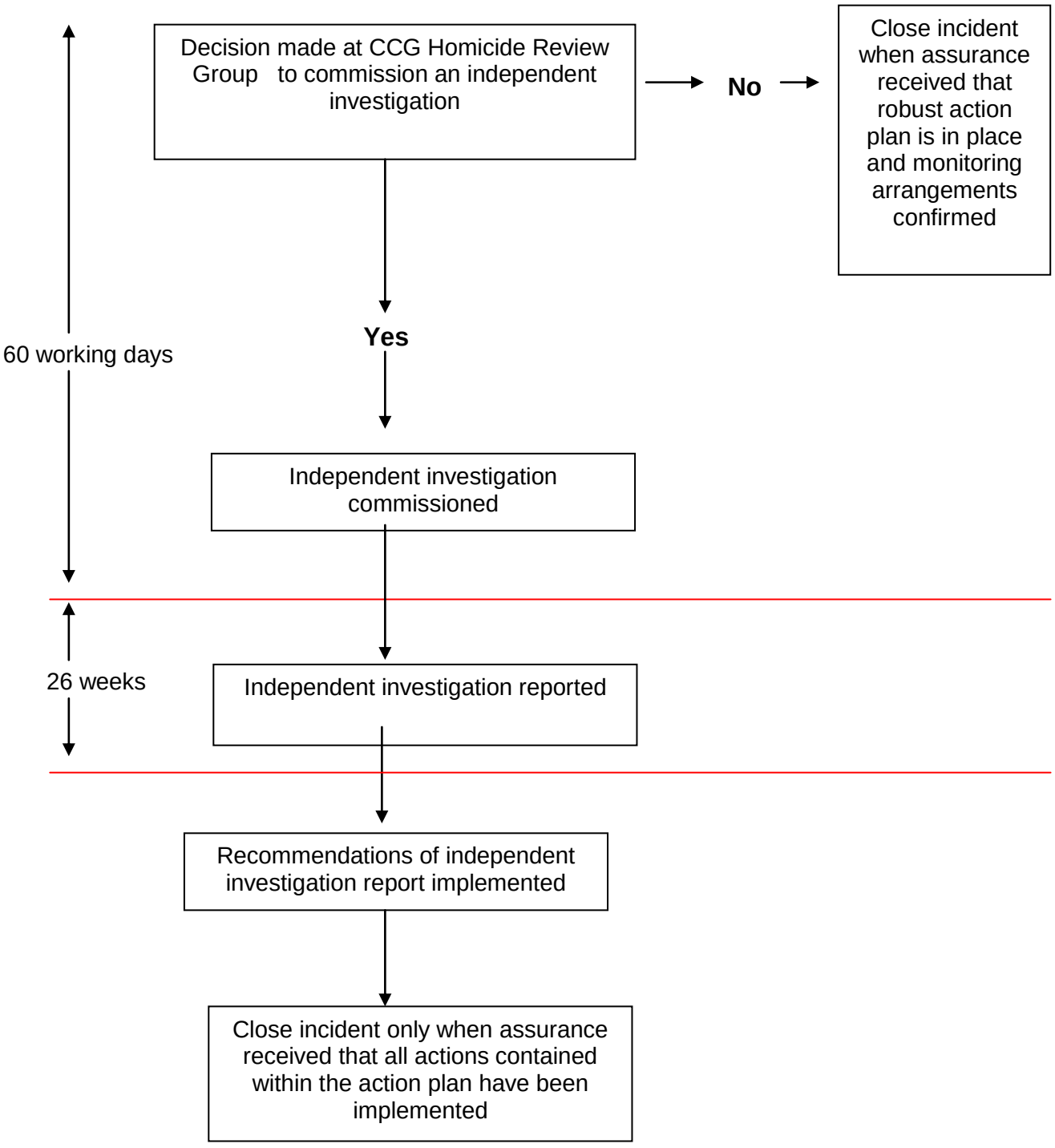
All Deaths	Serious Incident	Serious Case Review
• All deaths, expected and unexpected: telephone call then Form A notification to Child Death Overview Panel office • Completion of Form B's on request by CDOP office (Form B does not inform SIRI process) • Paper exercise if SCR in progress. • For unexpected deaths: local multi-agency case review/discussion held after final autopsy report with feedback to parents. Not necessarily held if it is a police led investigation or if child protection led, then local case conference will be held after strategy meeting. • All deaths including unexpected, anonymised data to CDOP with feedback to LSCB's	• Deaths and untoward instances. • May include Road Traffic Accidents. • Internal to NHS organisation. • If a Serious Case Review is initiated then any disciplinary action or other review may be undertaken concurrently. Agree locally how the SUI investigation co-ordinates with the SCR (paragraph 8.20 "Working Together"). • Need to keep record updated and SHA informed. • Requirement for feedback to clinicians.	• Follow Chapter 8 of Working Together • Individual Management Reports (IMR's) completed by agencies • Interviews with key workers • Direct links between IMR writers and Trust management • Internal recommendations from IMR's • Reporting to Local Safeguarding Children's Board SCR sub group • Overview report, action plan and executive summary to LSCB and to Ofsted

These parallel processes draw on the same data, but each has a different purpose and outcome. There will be some duplication and concurrent working involved but this is unavoidable. The cases will involve sensitive information, as well as different timescales for action, and it is vital that practitioners communicate effectively with each other in negotiating who does what and when. This is also reflected in paragraph 8.20 of Working Together to Safeguard Children which states that "Arrangements should be agreed locally on how an NHS Serious Incident (SI) investigation into the provision of healthcare should be co-ordinated with a Serious Case Review."

Flowchart Following Grade 2 SIRI – Homicide Defined by HSG 94 (27)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4113575




Decision made at CCG Homicide Review Group to commission an independent investigation
No
Close incident when assurance received that robust action plan is in place and monitoring arrangements confirmed
Yes
60 working days
Independent investigation commissioned
26 weeks
Independent investigation reported
Recommendations of independent investigation report implemented
Close incident only when assurance received that all actions contained within the action plan have been implemented

Appendix I

Livewell Southwest CIC
[Please Insert Address}
www.livewellsouthwest.co.uk

Dear
I am writing to you in my capacity as *(insert title)* on behalf of Livewell Southwest (Livewell Southwest) regarding the incident involving *[insert name].* I would like to offer my sincere apologies for any distress caused as a result of the incident and I would like to apologise for intruding at this difficult time.

I have been asked to conduct an internal review into the incident and the purpose of my letter is to make you aware of the process I will follow.

An essential part of our review, commissioned by the Livewell Southwest Serious Incident Panel will be an investigation into aspects of care provided around the time of the incident and the remit of the review team is as follows:

- Establish the facts of what happened to you *(Insert name if applicable).*
- Establish if failings occurred in care and /or treatment.
- Look for learning points and improvements.
- Establish how recurrence may be reduced or eliminated.
- Formulate realistic recommendations which address root causes and learning points to improve systems and services.
- Present the key findings in a report as a record of the investigation process.
- Provide a consistent means of sharing learning from the incident.
- Highlight areas of notable practice.

As part of this review, I would like to ask if you and / or your family would like to meet with me and *[insert name and title]* who is jointly investigating the incident with me. If you would like to meet please contact me using the details below. You are welcome to bring someone with you for support.

I would also ask that if there is anything you would like to be considered as part of the investigation, to please let *[insert name]* know. Finally please be assured that this review does not prevent you from accessing the formal complaint process should you so wish and I have copied the Customer Services Department into this letter to make them aware of our contact.

I look forward to hearing from you in due course, however if you have any questions or queries in the meantime please do not hesitate to contact me.

Yours Sincerely

(Insert name and title).

Enclosure: Duplicate letter

CC: Customer Services Department

References:

1. World Health Organisation (2009). The Conceptual Framework for the International Classification for Patient Safety. Version 1.1. http://www.who.int/ /taxonomy/en/patientsafety

2. National Patient Safety Agency (2009). Data Quality Standards. Guidance for organisations reporting to the reporting and learning system. http://www.nrls.npsa.nhs.uk/

3. National Patient Safety Agency (2004). Seven Steps to Patient Safety. Your guide to safer patient care. http://www.nrls.npsa.nhs.uk/

4. Care Quality Commission (2009). Essential Standards of Quality and Safety. The care quality Registration Regulations. Will be effective from 1st April 2010

5. McGraw Hill Concise Dictionary of Modern Medicine (2002). The McGraw-Hill Companies Inc

6. Department of Health and Home Office (2000). No Secrets. Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=publications+policy+and+guidance

7. H.M Government (2006). Working together to Safeguard Children. http://www.dcsf.gov.uk/

8. Department of Health. National NHS Advisory group (2010) - No secrets. Clinical Governance and adult Safeguarding. "An Integrated process" http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112361

9. NHS Security Management Service (NHS SMS) (2010). The Security Incident Reporting System (SIRS) http://www.nhsbsa.nhs.uk/SecurityManagement.aspx

10. Department of Health (2010) Checklist for reporting, managing and investigating Information Governance Serious Untoward Incidents http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm

11. National Screening Committee, NHS Cancer Screening Programmes (2010). Managing Serious Incidents in National Screening Programmes. http://www.screening.nhs.uk/

Appendix K

DEBRIEF CHECKLIST FOLLOWING A SERIOUS INCIDENT

As soon as practically possible following a serious incident (including the use of physical intervention techniques), the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. It is envisaged that this meeting will take no longer that 60 minutes, any significant points raised can be documented and discussed with the relevant manager / advisor.

The aim of the debrief and subsequent review is to learn lessons and support staff and service users.

If possible someone that is not directly involved in the incident should facilitate the session and the following checklist should act as a prompt in order to ensure all the relevant information has been gathered and advice given.

All persons involved in physical intervention incidents must be offered a debrief and this must include any service user(s) involved.

FACILITATOR DETAILS: DATE AND TIME OF INCIDENT: DATE AND TIME OF DEBRIEF: INCIDENT REPORT REFERENCE NUMBER: PEOPLE INVOLVED IN THE INCIDENT: PEOPLE PRESENT AT DEBRIEF:
What happened during the incident?
Were there any trigger factors?

What was each person's role in the incident?
How did the individuals feel at the time of the incident, how do they feel now and how do they think they will feel in the future?

For further information please refer to the following Policies:

Physical Intervention Policy
Violence and Aggression Policy
Incident Reporting and Investigation Policy
Serious Incidents Requiring Investigation Policy

Consider the events, what went well and what didn't go so well?
Physical Intervention Incidents: Did the team feel safe? If not why? Did you feel confident and competent to safely manage the situation / incident? If not, why not?
Any further comments or concerns?
What can be done to address any concerns raised?

Appendix L

Guidance for Serious Incidents Requiring Investigation (SIRI) Investigators

Livewell Southwest has 2 SIRI panels.

The first panel oversees all grade 3 and 4 Acquired Pressure ulcers. The panel consists of Professional Lead, Tissue Viability, Nurse Specialist, Deputy Locality managers, Allied Health Professionals, District Nurses, Locality Managers and other health professionals.

The second panel oversees all other SIRI's. These generally come from within the Mental Health Services but can arise from other services within Livewell Southwest. The panel consists of the Deputy Director of Professional Practice, Professional Lead, Locality Managers, Deputy Locality Managers, Consultant Psychiatrist, Consultant Psychologist, CMHT manager and the Safeguarding Lead.

SIRI Process
A SIRI is an incident that is classed as a significant incident .The National Patient Safety Agency (NPSA) gives guidance on what is considered a SIRI. The risk department will use this guidance to determine whether the incident is a SIRI .If it does not meet the SIRI threshold it will be triaged and teams may be requested to undertake an internal RCA.
The timescale for completion of investigations are 60 working Days or 6 Months for an independent review

Why do we conduct SIRI'S?
Serious incidents provide essential opportunities for learning, both at the organisational level and for individual clinicians. The review of such incidents forms one of the core components of governance in healthcare.
Reviews are conducted in order to identify good practice and areas from which the organisation need to learn. The purpose is not to attribute blame for incidents, but may involve asking challenging questions about the care which was provided.an appropriate balance must be in place between support and challenge; however those who have conducted reviews find that the role of investigator provides an excellent opportunity for professional development and reflection on their own clinical practice.

SIRI Process
A SIRI is alerted to the risk department via an Appendix A form. This form should be placed onto STEISS within two working days by the Risk department (STEISS is a reporting system for all SIRI's).An anonymous copy is sent to the Clinical Commissioning Group (CCG) as a 72 hour report
The SIRI policy can be found within the policy page on the Intranet.

Process for allocation
Each SIRI will have investigators allocated to investigate. The investigators are generally allocated by the Locality Manager or the Risk Department. Inexperienced investigators are matched with staff who have experience of undertaking SIRIs .However it has proved beneficial to have a mix of speciality whilst undertaking the SIRI, providing there is one investigator who has the clinical knowledge of the service user group. For Mental Health SIRIs a Consultant Psychiatrist is also allocated to review the case.

Role of the Investigators.

1. To contact the other investigator to plan process for investigation, confirm timescales for investigation and dates for presenting at panel. All templates and information will be forwarded to the investigators by Graham Burton.
2. To request any medical/Nursing notes, both paper and electronic.
3. To identify the staff that will be required to be interviewed. This may include other providers who were involved. Experience from staff that have been involved in SIRI report that being interviewed as a team is more supportive. However, it may be that there are practice issues for individuals which might make meeting as a group more difficult. This requires the judgement of the investigators.
4. The Duty of Candour (DoC) was introduced following the Francis Report. This requires us to contact the service user and/or their family to apologise for the distress that has occurred due to the incident and to inform them of the SIRI process. At this stage we would not offer apologies for the incident as the investigation is not complete.
   The decision to contact the family, particularly if there has been a death is a difficult one; investigators should be guided by information from the team and clinical judgement as to the approach to the service user or family. Some families are keen to meet investigators to enable them to input into the investigation. There is a sample Duty of candour letter that can be used to make initial contact (see attached). Investigators can also contact Graham Burton, Clinical Risk Advisor or Dawn Slater, Deputy Director of Professional Practice, Safety and Quality, if they require assistance in how to implement the duty of candour
5. The reporting template for SIRI must be completed including recommendations. These recommendations should be measurable, achievable and related to the SIRI. The report must be sent to Graham Burton by a minimum of 5 workings days prior to the panel at which the report is presented. Investigators may find it helpful to seek advice from the Risk Management team during their review.
6. The report should be taken to the SIRI panel by the investigators. Good examples of reports include the investigators identifying what good practice would look like. Examples and advice of good reports can be obtained from Graham Burton Normally the investigators will be given a defined time slot on the agenda to present the report.
7. The team managers will be invited to the panel to receive the report.
8. Upon presenting the report the investigators will be required to summarise the incident, Root Cause Analysis (RCA) and other contributing factors. The investigators will be required to discuss the recommendations and rationale. The

panel will have the opportunity to question, ask for clarification and in some cases challenge the report in a respectful and constructive manner.

9. Once the report has been agreed by the panel, the report is sent to the relevant Locality Manager for them to develop the action plan and to implement actions.
10. The action plan may contain recommendation in relation to other teams or services .however the action plan and all recommendations will need to be monitored by the Locality manager and fed back to Graham Burton to allow the action to be closed.
11. The investigators are required to feedback the report and the recommendations to the clinical team and to the service user / family. There may be occasions when it is not appropriate to implement the DOC, but this should be discussed in the first instance, with Graham Burton, Clinical Risk Advisor or Dawn Slater, Deputy Director of Professional Practice.
    Any requests from the service user / family for the SIRI report must be forwarded to Graham Burton, Clinical Risk Advisor.

If, during the investigation, there are concerns regarding clinical practice of individual staff or concerns of service user safety, please contact Dawn Slater, Deputy Director of Professional Practice, Safety and Quality, Professional Leads or your line manager.

Safeguarding Adults

1. There are occasions when the incident that has led to the raising of an Appendix A will also be raised as an adult safeguarding alert.

2. If this is the case and investigation for both processes is required the SIRI acts as a single investigation and record for both. This is jointly agreed between the risk office and the safeguarding office. One of the outcomes of this investigation will be to present information in such a way that an adult safeguarding case conference can determine whether significant harm has occurred.

3. In this circumstance, in addition to the RCA training, one of the allocated investigators should have completed the safeguarding adult investigation training that is delivered by Plymouth City Council or, be experienced at leading safeguarding investigations and familiar with the Plymouth process. If there are multi-agency components to the alert an investigator from another agency may be allocated to work alongside the Livewell Southwest investigator. This will most often occur when investigations are looking at the development of pressure ulcers.

4. Prior to presentation at SIRI panel, any SIRI investigation will be presented at an adult safeguarding case conference chaired by either the Safeguarding Adults Officer from NEW-Devon CCG or Plymouth City Council. The relevant Deputy Locality Manager attends this meeting to hear the outcome and to be part of the action planning that is taken to SIRI panel. This adult safeguarding case conference is coordinated from the Livewell Southwest Safeguarding Adults Office.

5. This means that the SIRI can be presented at SIRI panel with an agreed safeguarding outcome of not substantiated, substantiated or not conclusive and with an action plan for the safeguarding issues already agreed with the Case Conference Chair.

6. Feedback to staff involved and their managers cannot happen until the case conference has taken place and an outcome agreed.

7. Advice throughout this process can be sought from the Livewell Southwest Integrated Lead for Safeguarding Adults and Children.

Children

1. Any SIRI that has a safeguarding children element will be a single agency investigation for Livewell Southwest and does not extend to an investigation of the input of any other agency involved with the child.

2. Unlike SIRI's relating to safeguarding adults, the SIRI does not act as an investigation to determine whether significant harm has occurred. This always takes place within the Plymouth Child Protection Process led by Plymouth Children's Social Care and where applicable, the Police.

3. If a multi-agency review or serious case review is deemed necessary by the Plymouth Safeguarding Children Board, the Livewell Southwest SIRI can be called to inform that process.

4. Any staff member investigating SIRI's where there is a safeguarding children element should be experienced at working in children services and have attended Level 3 Safeguarding Children training.

5. Advice throughout this process can be sought from the Livewell Southwest Integrated Lead for Safeguarding Adults and Children or the Named Nurse/Named Doctor for Child Protection.

Root cause analysis training

RCA training is provided by Graham Burton, Clinical Risk Advisor & Alison Wadley, Risk Management Advisor. The training is undertaken approximately 4 times a year to a maximum of 20 delegates. The training consists of theory underpinning the Root Cause Analysis Process, interspersed with practical work on the use of tools and a case study. Once trained the delegate's names will be entered onto a list of potential reviewers, and will be supervised by an experienced person when they undertake their first SIRI review.

Thank you for your support with the SIRI process and if you have any queries please contact: Graham Burton, Clinical Risk Advisor or Dawn Slater, Deputy Director of Professional Practice, Safety and Quality.