

8. When the report has been agreed by the service, a 'learning event' occurs. This is when the report and any action plans are developed and shared with the team and senior managers.
9. The report is then sent to the Trust's medical director and the director of nursing and quality to review and approve the report on behalf of the Trust.
10. The final report is then submitted to the relevant commissioning group for external review. It is also sent to the coroner if appropriate.
11. You will be offered a 'supported reading' of the report which is given by the lead investigator. A copy of the report is also offered to you.

The Trust will share learning from the incident within the team and other similar teams across the Trust. We will also consider where else this should be shared.

Where can I get more help and support?

You can find more information and support about losing a loved one on the Support After Suicide website:

www.supportaftersuicide.org.uk/help-is-at-hand

www.facingthefuturegroups.org/

Your lead investigator is.....

Contact number.....

Email.....

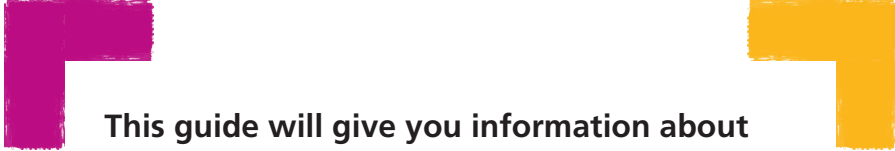
Your feedback is welcome

We invite you to share any comments, compliments, concerns or complaints you have about the Trust. Please speak to a member of staff or contact our customer services team on 0800 587 2108 who can also provide help in understanding this information.

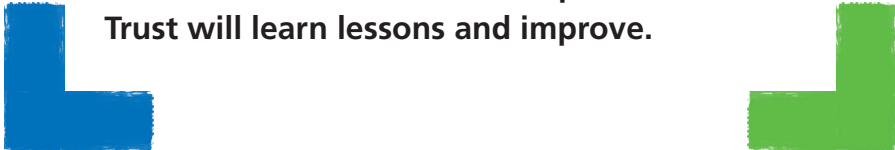


A guide to serious incidents

Information for service users, families and carers



This guide will give you information about South West Yorkshire Partnership NHS Foundation Trust's serious incident process. It has been designed to help you, your family and friends understand what happens after a serious incident. It will also explain how the Trust will learn lessons and improve.



What is a serious incident?

Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that further investigations are necessary to create a detailed report.



What happens when a serious incident is reported?

Following a serious incident, the Trust has to complete a serious incident investigation and submit a report to the local commissioning group. We aim to complete this within 60 working days of the incident being allocated to an investigator. If this is not possible we will keep you informed.



When something is reported as a serious incident, the Trust takes the following steps:

1. The incident is reported and recorded on the Trust's electronic incident management system, which is called Datix.
2. An investigation team is appointed and includes a lead investigator and a medical investigator. The investigators are not involved in services where the incident took place.
3. The lead investigator will contact you. They will be able to:
 - direct you to where you can get support
 - listen to any comments you might have about the care given by the Trust and agree with you what will be looked at as part of the investigation
 - become the main point of contact for the duration of the investigation
 - agree with you how often and what method of communication you would prefer to keep updated about the investigation
4. The investigators hold an initial investigation set up meeting where staff who provided care to the person are invited to attend, as well as the person's GP and any other appropriate agencies. This meeting gives the investigation team the opportunity to ask questions to staff and seek clarity on any issues. Staff can also ask questions about the process. This generally takes place within two weeks of the date of the incident being assigned to the investigators.
5. Trust records are reviewed that relate to the care provided. GP records are also requested, if required, subject to consent.
6. During the process, the investigation team may interview staff and or speak with other agencies involved in the person's care to examine the care provided by the Trust.
7. A report is drafted which includes the findings of the investigation.

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