Kent and Medway
NHS and Social Care Partnership Trust

Management and Investigation of Serious Incidents

Document Reference No.	KMPT.CorG.020.08
Replacing document	KMPT.CorG.020.07
Target audience	Trust-wide
Author	Head of Patient Safety
Group responsible for development of this policy	Trust-wide Patient Safety and Mortality Review Group
Status	Authorised
Version No	8.0
Authorised/Ratified By	Trust Wide Patient Safety and Mortality Review Group
Authorised/Ratified On	January 2023
Date of Implementation	January 2023
Review Date	April 2024
Distribution date	February 2023
Number of Pages	12
Contact Point for Queries	kmpt.policies@nhs.net
Copyright	Kent and Medway NHS and Social Care Partnership Trust 2023

DOCUMENT TRACKING SHEET

Management and Investigation of Serious Incidents

Version	Status	Date	Issued to/approved by	Comments
V0.1	Draft	11th October 2007	Risk Management Group	
V1.0	Approved	11th October 2007	Risk Management Group	
V2.0	Approved	October 2009	Health & Safety and Risk Committee	
V3.0	Approved	October 2011	Health & Safety and Risk Committee	
V3.1	Draft	March 2016	Patient Safety Group	Absorbed into Management of SI policy but felt to be too large, so separated out again
V4.0	Approved	January 2017	Trust Wide Health Safety and Risk Group	Updated flow charts on p10 and 11. Ratified
V4.1	Approved	February 2018	Policy Manager	Separated Equality Impact Assessment from document. Amended 'service line' to 'care group' throughout the document.
V5.0	Draft	April 2019		Updated Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy
V6.1	Draft	April 2022	Head of Patient Safety	Policy reviewed and agreed – changes throughout. Appendices added. Reviewed by Patient Safety Leads and ratified on that basis at Trust-wide Patient Safety and Mortality Review Group.
V7.0	Final	April 2022	Trust Wide Patient Safety and Mortality Review Group	Approved Assurance to be given to Quality Committee
V7.1	Draft	January 2023	Head of Patient Safety	Added section 9 and appendix 13 investigation template relating to the Use of Force Act 2018.
V8.0	Final	January 2023	Trust Wide Patient Safety and Mortality Review Group	Approved Assurance to be given to Quality Committee

Serious Incident Framework 2015 (NHS England)
Never Events policy and framework – revised January 2018 and Never Events List 2018 (NHS Improvement)
National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, March 2017)
Regulation 20: Duty of candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (Care Quality Commission 2014)
A just culture guide (NHS Improvement, 2018)
NHS Records Management Code of Practice 2021
Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England, and police forces in England and Wales (published Dec 2021 by Department of Health & Social Care)

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Complaints Handling Policy and Procedure	KMPT.CorG.019
Whistleblowing Policy	KMPT.HR.002
Claims Management Policy and Process	KMPT.CorG.014
Health and Safety Policy	KMPT.CorG.005
Duty of Candour – Being Open Policy	KMPT.CorG.018.05
Risk Management Strategy	KMPT.CorG.012
Disciplinary Procedure	KMPT.HR.007
Learning from Experience Policy	KMPT.CorG.011

SUMMARY OF CHANGES

Date	**Author**	**Page**	**Changes (brief summary)**
18/06/2019	Head of patient Safety		The policy was updated to include national policy, framework and regulations. There was also the addition of: • Use of RCA meetings • Just Culture Guide • Retention of records • Appendices added • Definitions updated and added • Evidence table updated and additional information included
26/04/2022	Head of Patient Safety		Changes have been made throughout policy and new appendices added.
09/12/2022	Head of Patient Safety		Added appendix 13 and section 9.

CONTENTS

1 INTRODUCTION

1.1 When a Serious Incident or potential Serious Incident occurs, there must be systematic measures in place to respond to them. These measures must protect patients, staff and visitors and ensure that robust investigations are carried out. This in turn must result in the organisation learning from Serious Incidents and putting actions in place to minimise the risk of the incident happening again.

1.2 Adherence with the policy supports KMPT in its objective to pursue continuous improvement in the delivery of its services, whilst being person-centred, acting openly, fairly and proportionately within just culture.

2 PURPOSE

2.1 The purpose of this policy is to ensure that risks associated with Serious Incidents are identified and managed in accordance with best practice and in line with the expectations of the Care Quality Commission, NHS England and NHS Improvement, Clinical Commissioning Groups and the public.

2.2 This policy formally endorses the NHS England Serious Incident Framework, 2015 to be clear of roles and responsibilities, timescales for completing serious incident investigations and to define the additional requirements for Serious Incident reporting to all relevant external bodies as identified above. It is recognised that the new NHSE/I Patient Safety Incident Response Framework (PSIRF) is due to released in June/July 2022 and that this policy will be expected to be amended by April 2023 in line with that. Policy updates will take place over that timeframe.

3 DEFINITIONS

3.1 *STEIS

3.1.1 STEIS is an acronym for Strategic Executive Information System. This is a system on which NHS and other providers are required to report cases meeting the criteria of Serious Incident (as described below). It is recognised that this is expected to change in 2022/23 and the policy will be updated when this occurs.

3.2 Serious Incident (this is a case reported on *STEIS)

3.2.1 The Serious Incident Framework of 2015 (NHSE) advises that, in broad terms, Serious Incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

3.3 Serious Incidents in the NHS include:

3.3.1 Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes
    - suicide/self-inflicted death; and

- homicide by a person in receipt of mental health care within the recent past;

- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
- Actual or alleged abuse: sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
  - where abuse occurred during the provision of NHS-funded care. This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident;
- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death (see appendix 1);
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
  - Property damage;
  - Security breach/concern;
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency). Please refer to the KMPT Major Incident Plan. All major incidents are reported as SI.
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3.3.2 The term Serious Incident must only be used for cases reported on STEIS. All other cases are incidents or potential Serious Incidents until determined whether to report on STEIS or downgrade to incident level.

3.3.3 The list above is not exhaustive. There are times when cases are also reported on STEIS for transparency or significant learning.

3.4 Never Event

3.4.1 Never events are defined by the Department of Health. The list of never-events is reviewed annually. Please refer to Appendix 1 for an up to date list.

3.5 Root cause analysis (RCA)

3.5.1 RCA is a structured investigation that aims to identify the true causes of a problem and the actions necessary to eliminate it by reviewing the whole system within which a problem, error or incident has occurred, including human factors.

3.5.2 The investigation must be conducted using a recognised systems-based investigation methodology that identifies:

- The problems (the what?);
- The contributory factors that led to the problems (the how?) taking into account the environmental and human factors and
- The fundamental issues/root cause (the why?) that need to be addressed.

3.5.3 The investigation must be undertaken by those with appropriate skills, training and capacity.

4 DUTIES

4.1 KMPT Board

4.1.1 The KMPT Board is responsible for ensuring systems and processes are in place to undertake suitable and sufficient investigations so learning and implementation can be demonstrated. They will receive assurance from the Quality Committee through Summary and Exception reporting. They will demonstrate leadership in underpinning a learning and open culture by supporting staff in taking forward the Management and Investigation of Serious Incidents and Duty of Candour Policy, and by ensuring KMPT continues to demonstrate improvements in service delivery and safety.

4.1.2 It is KMPT Board's responsibility to ensure staff feel safe to report issues and the information they share will be treated with respect and acted upon appropriately for the improvement of the safety and quality of KMPT services. They will support Just Culture.

4.1.3 The KMPT Board will ensure that there are systems and processes in place to evidence learning from Serious Incidents. They will support the PSIRF model when released.

4.1.4 Board members may be required to attend Immediate Management Reviews.

4.2 The Quality Committee

4.2.1 The Quality Committee, on behalf of the KMPT Board, will review the Quality Digest They will receive assurance that underpins that change has been/is being embedded throughout KMPT where it is appropriate to the learning. They will provide leadership and support to Care Group Heads of Service in undertaking their programme in continuous learning, review, implementing and sustaining change and then evaluating the outcomes.

4.3 The Trust Wide Patient Safety and Mortality Review Group

4.3.1 The Trust Wide Patient Safety and Mortality Review Group Chaired by the Chief Nurse is responsible for ensuring evidence is available to demonstrate that learning is taken forward across the Trust. Additionally, the Group will monitor exception reporting of delayed actions from SIs. . It will also review Trust-wide action plans developed from Serious Incidents except those reported direct to other groups such as the physical health action plan.

4.3.2 The group will ensure learning is disseminated across KMPT and actively support the continuous publication of best practice and examples of learning from Serious Incidents via the learning from experience group to ensure all staff have access to information and that there is a continuous re-evaluation of risk reduction measures undertaken in a systematic and sustained process.

4.3.3 4.3.3 The group will ensure that the organisation has adequate methods to ensure evidence of learning is captured.

4.3.4 4.3.4 The final completed action plan from homicide serious incidents will be reviewed and approved for closure at this meeting.

4.4 Trust Wide Serious Incident and Mortality Panel

4.4.1 The Trust Wide Serious Incident and Mortality panel is chaired by the Head of Patient Safety or their deputy and sits twice a week on Mondays and Wednesdays.

4.4.2 The purpose of the panel is to review all incidents reported on Datix where the level of harm is moderate to death and make decisions about the level of investigation required (see appendix 3), based on the 72 hour management report and further review where necessary, such as from experts or additional review by the corporate patient safety team. This may include a structured judgement review.

4.4.3 When it is unclear if a case is to be reported on STEIS, the Panel is to seek advice from Executive Directors.

4.4.4 Decisions will, be made in line with national guidance and KMPT decision making flow charts (appendix 4).

4.4.5 The Panel must identify a panel member to escalate to executive staff and to the communications team when cases are identified which are likely to attract publicity or have been/may be in social media, or which may require their consideration and escalation.

4.4.6 The Panel will agree responsibility (in conjunction with the executive lead if required) for informing the patient, family and/or carers if the case is likely to attract publicity through media forms.

4.4.7 The Panel will receive information from care groups about initial learning from all Serious Incidents to be reported on STEIS. When no initial learning has been identified, care group leads attending the Panel will be responsible for escalating to care group leads to ensure initial learning is put in place.

4.4.8 The Panel will devise terms of reference for root cause analysis investigations. Expert opinion must be sought if decisions on STEIS making cannot be made.

4.5 Expert Groups

4.5.1 Expert groups within the Trust, such as the Medication Review Group, and physical health group will routinely monitor the number and types of incidents arising from their specialty and ensure appropriate actions are taken and reported externally as required (see appendix 3).

4.6 Care Group Governance/Risk Management Groups/Care Group Leads

4.6.1 Care group leads are responsible for ensuring 48 hour reports are completed for any possible Serious Incident within 48 hours.

4.6.2 Care group patient safety leads are responsible for ensuring that 48 hour reports are completed to a good quality, are available for the Serious Incident and Mortality Panel and include information that enables the Panel to make a reasonable decision on whether to report on STEIS.

4.6.3 Care group leads must ensure initial learning is identified for STEIS reported cases, and implemented. The Care Groups will retain responsibility for implementing local action plans and ensuring there is a system of evaluation and evidence of learning. They will provide evidence on service changes and improvements and evidence of the implementation of best practice. They will review and monitor their Serious Incidents and ensure adequate SMART (specific, measurable, achievable, relevant and time-based) actions are put in place.

4.6.4 Care Group Groups will utilise the information gained from the analysis of reports and ensure risk management and risk reduction strategies are put in place. Escalation and dissemination of urgent issues should take place through care group processes.

4.6.5 Care Groups will be responsible for ensuring actions from Serious Incidents are completed within the given timeframe when related to their services.

4.6.6 The care group patient safety teams must review incidents on a daily basis to ensure any cases that require escalation to the Serious Incident and Mortality Panel are escalated in a timely manner.

4.6.7 The Care Group leads will sign off root cause investigations in line with appendix 8.

4.6.8 Care group patient safety leads and appropriate care group leads will attend Immediate Management Reviews, and be responsible for ensuring appropriate attendance at these meetings.

4.6.9 Care group leads will ensure staff participate in root cause analysis investigations.

4.6.10 Care group leads will ensure that Duty of Candour is completed within legal framework timeframes.

4.6.11 Care group leads will ensure support is provided to all staff involved in Serious Incidents, including staff that have been caring for the individual patients. This will include on-going support as well as initial support. This relates to all staff, including NHSP staff, agency staff, locums and students and any other staff involved including support staff.

4.6.12 Care group patient safety leads and care group leads will be responsible for ensuring appropriate attendance at the Serious Incident root cause analysis action plan meeting.

4.1 Chief Executive

4.1.1 The Chief Executive has overall responsibility for ensuring investigations are appropriate and effective and learning is identified and disseminated across the organisation. The Chief Executive is committed to KMPT demonstrating sustainable effective change based on learning from Serious Incidents.

4.2 Chief Nurse (Designated Board Member Lead for Patient Safety)

4.2.1 The Chief Nurse takes responsibility for ensuring all serious incidents are managed and investigated appropriately according to KMPT Policy and meet all external requirements. The Chief Nurse takes responsibility for sharing lessons learnt, ensures that the Chief Executive and Trust Board are appraised of incidents that are reportable to the Care Quality Commission, NHSE/I, Clinical Commissioning Groups and other external Stakeholders.

4.2.2 Ensures learning is demonstrable and evidenced and good practice is shared across the organisation.

4.2.3 Takes responsibility for alerting the Chief Executive of high-profile cases or those that risk organisational reputation.

4.8.4 The Chief Nurse will Chair, or appoint a deputy, for all Immediate Management Reviews (IMRs).

4.9 Head of Patient Safety

4.9.1 The Head of Patient Safety will Chair the Serious Incident and Mortality Panel or ensure a deputy is available.

4.9.2 The Head of Patient Safety will quality check all root cause analysis investigations as outlined in appendix 8 or ensure a deputy is appointed when not available.

4.9.3 The Head of Patient Safety is responsible for ensuring appropriate escalation of all Serious Incidents takes place and for appropriate escalation for any areas of particular concern such as homicide and reputational concerns.

4.9.4 The Head of Patient Safety will attend IMRs, be responsible for setting up meetings and ensure appropriate attendance from the corporate Patient Safety Team and ensure notes are taken and distributed within one working day of the meeting.

4.9.5 The Head of Patient Safety or Serious Incident and Complaints Investigation Lead is responsible for ensuring downgrade requests of Serious Incidents is appropriate.

4.10 Central Investigation Team (CIT)

4.10.1 The CIT will ensure all root cause analysis Serious Incident investigations are completed in line with national timeframes (see appendix 8).

4.10.2 The CIT will be responsible for seeking appropriate expert advice (internally or externally) for all root cause analysis Serious Incident investigations (except information governance investigations).

4.10.3 The CIT will ensure involvement of patients/families/carers in investigations throughout the investigation, and in line with Duty of Candour.

4.10.4 The CIT will lead and diarise the root cause analysis investigation action plan meetings in a timely manner.

4.10.5 The CIT will ensure cases are reported on STEIS in accordance with the Serious Incident framework.

4.10.6 The CIT will investigate in line with the Just Culture guide.

4.10.7 The CIT is expected to identify key staff involved and ensure that they are aware of the investigation process, reiterating that the investigation is a learning process.

4.10.8 The CIT lead investigator will share the findings, and usually the investigation report with the patient/family, except in exceptional circumstances such as at police request, where doing this may increase the risk to the patient (e.g. in some safeguarding or domestic violence cases).

4.10.9 All investigators of root cause analysis investigations must be trained in the process.

4.11 Patient Safety and Complaints Facilitator and Mortality Review Manager

4.11.1 The Patient Safety Facilitator and Mortality Review Manager are responsible for ensuring completion of 72 hour reports in line with appendix 9.

4.12 Role of Clinicians/Specialist Advisors

4.12.1 Clinicians and specialist advisors will provide expert opinion and support to the investigation process.

4.12.2 This will be determined at the onset of the investigation process by the Serious Incident and Mortality Panel. However, it is sometimes only recognised that expert involvement will be required as the investigation proceeds and experts may be included later in the investigation on occasions. CIT will identify this additional expertise.

4.12.3 Where there is insufficient expertise within the organisation, KMPT will consider identifying an external Consultant who will support the CIT.

4.13 Communication Team

4.13.1 Communications are a vital element of supporting and delivering effective management of serious incidents. The Trust ensures that robust communication and media management arrangements are in place for both internal and external communication. In some cases, serious incidents may lead to media attention which can be prolonged. The Trust will make every effort to ensure that staff are informed and supported prior to any media involvement (see corporate communication strategy).

4.14 All Staff

4.14.1 All staff have a responsibility to highlight and report any incidents or risk issues on Datix that would warrant further review or investigation.

4.14.2 KMPT will expect them to contribute fully to the investigation process in an open and honest manner.

4.15 Patient Safety Specialists

4.15.1 Patient Safety Specialists have been appointed by KMPT and they are responsible for attending update meetings from NHSE/I, developing the Patient Safety Strategy for KMPT and embedding this by April 2023, updating KMPT, and ensuring that investigation processes are embedded into KMPT.

4.15.2 They are also responsible for ensuring that adequate support is provided to the investigation process.

4.15.3 They are responsible for ensuring that staff are trained in line with the patient safety syllabus.

4.16 Initial Management Review (IMR) Panel

4.16.1 The Panel is required to determine actions for high profile cases, possible high-profile cases, homicides and child deaths. It will be led by the Chief Nurse or deputy and will follow the format in appendix 2.

4.16.2 Panel members are expected to prioritise attendance when requested and convened, or to appoint a deputy to attend.

4.16.3 The Panel will make decisions regarding immediate actions required and appropriate liaison and escalation as appropriate.

4.16.4 The IMR note taker will ensure notes of meetings are sent within one working day of the meeting to enable timely actions.

5 KEY ISSUES, INVESTIGATION, ROOT CAUSE ANALYSIS, AND SUPPORT FOR ALL INVOLVED (STAFF, PATIENTS AND FAMILIES)

5.1 Investigations, whether they be through root cause analysis, or trend and themed analysis, are completed to ensure that repeated incidents do not occur, allows patients and families to understand why the incident happened, and also provide assurance of good practice.

5.2 In most cases a serious incident does not result from one single event, but is more likely to have involved cumulative triggers which, in isolation may have no effect, but when they occur in an event chain can be serious or even catastrophic. Almost all investigations will determine systems errors that have led to the incident occurring, even when it appears to have been due to an individual making an error.

5.3 When investigating a serious incident, it is important to concentrate on the facts, with a retrospective review of events to establish the underlying causes. Analysis will then identify areas for change, looking at long-term solutions, improving standards and improving patient safety and to minimise reoccurrence in the future or to reduce the level of harm.

5.4 The process for root cause analysis investigations is documented in appendix 4.

5.5 Determining a Serious Incident and who will investigate (including independent investigations)

5.5.1 Decision making as to whether to STEIS report will usually be made by the Serious Incident and Mortality Panel. In line with appendix 4 and the NHSE Serious Incident Framework 2015. On occasions, the Panel may seek

Executive opinion if a decision cannot be made. Additionally, a structured judgement review or care group investigation may take place to seek further assurance, or when a case does not meet STEIS criteria.

5.5.2 Occasionally, an independent investigation may be considered where the integrity of the organisation is likely to be challenged or where it would be difficult for an organisation to conduct an objective investigation. In these situations, the investigation team must all be independent of the Trust. Should this be required, an Executive decision will be made.

5.5.3 The Serious Incident and Mortality Panel will determine initial terms of reference for the investigation.

5.6 Investigating

5.6.1 The key features of a good investigation are:

- Clear terms of reference (these may be added to during the course of the investigation by the investigator, care group or others) and parameters (scope);
- Involvement of patients, their families and carers, and witnesses, using a collaborative approach as far as possible and in line with Duty of Candour. The Trust believes that patients and their families/carers are a critical part in learning from serious incidents. The level of patient/family/carer involvement depends on the nature of the incident, the patient and the patient's consent for their family to be involved. Access to language and sign interpreters will be provided, as required. It is expected that patients and/or families/carers will be invited to include terms of reference to the investigation;
- Involvement of staff involved including leaders of those involved and beyond, and openness and transparency of those who have been involved in the incident, and objectivity by investigators and peer review of investigations;
- Involvement of experts in the investigation;
- A timely and responsive investigation, to ensure that no other patients are involved in similar incidents;
- A proportionate investigation;
- A thorough identification and analysis of events with clear rationale, with a system thinking approach;
- A clear and concise report;
- SMART actions put in place to prevent repeat incidents, including how the actions can be measured. These are to be developed by a facilitated action plan meeting, if required, and include appropriate staff as determined by the care group in line with appendix 8.

5.6.2 It is important to also note that learning occurs equally from good practice as well as practice that requires improvement.

5.6.3 Summaries of learning to share safety lessons and best practice will be publicised in Trust Wide and local learning bulletins.

5.6.4 If the need to communicate to all staff is urgent this will be done through the Communications Team.

5.6.5 The Serious Incident and Mortality Panel or IMR or the investigator during the course of the investigation will identify when there is a need to involve external agencies following a Serious Incident. This may include police, other provider organisations or organisations involved in supporting the patient, and commissioners of services. The investigation will be escalated to experts within the organisation for learning and any external reporting required. It is usual that if a police investigation is occurring that the lead investigator will liaise with police to check when KMPT can carry out their investigation.

5.6.6 It is recognised learning can take place in many ways other than root cause analysis, but can be included in root cause analysis investigations. Learning from patient safety should be embedded across the organisation.

5.6.7 Researched approaches and methods known to be effective for learning from patient safety are shown below and should also be embraced by all members of the organisation.

.

- Psychological safety - An environment where staff feel safe to raise concerns, have the freedom to speak up, with an expectation that staff can openly discuss errors and be free from punishment or blame for the disclosure.

- Staff involvement - An environment where staff involvement is prioritised and staff have time to talk about patient safety in order to learn from patient safety incidents.

- Storytelling - An environment where staff are encouraged and are able to share stories relating to errors or mistakes in order for other individuals or teams to learn.

5.6.8 There are times when a themed analysis approach may be made in regards to areas of concern which may be a risk to patient safety. This will also follow the STEIS reporting process and be investigated by the CIT if the risk is great. This must be determined by the Serious Incident and Mortality Panel.

5.6.9 The care groups must have methods of ensuring evidence gathering for learning is in place and completed.

5.6.10 The first step in conducting an RCA is to commence a tabular timeline of events based on the scope and terms of reference provided by the Serious Incident and Mortality Panel, and also terms of reference as requested by the patient/family/carers. Investigators are asked to identify any good practice, problems in care, and acts or omissions within the timeline. It is important that timelines are not made up of just healthcare records. Evidence should be gleaned from multiple sources. This process will help to identify who may need to be invited to meet with investigators as part of the investigation. Evidence considerations can be found in the 5P approach in appendix 5. It is noted that there may be times when the investigation may précis another investigation, such as a human resources investigation of safeguarding investigation. In these cases the Précised RCA template should be used as the report (see appendix 12).

5.6.11 The CIT lead investigator will identify people to be included in the RCA meeting or to have meetings with the investigator, with the former being the preferred approach (recognising this is not always possible).

5.6.12 It may be useful to advise staff/patients/families/carers or visitors to keep their own record of the incident and events leading up to it. This is for their own personal use. Very occasionally staff will be asked to write a statement if there will be a court case, however this would normally not be required for root cause analysis investigations.

5.6.13 It is recognised that other organisations may take the lead on the investigation process and KMPT may contribute.

5.7 RCA meetings

5.7.1 Ideally the investigation team and staff involved will meet to review the timeline and analyse what has occurred. This will lead to the team involved to help determine potential SMART actions to prevent further incidents occurring.

5.8 Conducting meetings with staff involved

5.8.1 At all stages sensitivity and tact will be practised with appropriate support available for anyone providing information into the investigation process.

5.8.2 All those identified for to meet with the investigators will be contacted by the lead investigator from CIT who will explain the process and purpose of the investigation, to include:

- To find out what happened,
- To identify areas of good practice,
- Areas where systems did not work and
- Commence implementation of safety improvements.

5.8.3 All staff involved must have access to confidential support and counselling if required during a potentially stressful period and that they can bring a staff side representative or workplace colleague with them at any interview.

5.8.4 All investigations to be conducted in a manner:

- That is demonstrably supportive, and with active listening;
- In a just culture atmosphere;
- For learning and improving

- Those involved will be given information on progress as appropriate.

5.8.5 On occasions, at the end stage during an investigation, it may be deemed that a managerial investigation may also be required. When this occurs the Just Culture Guide must be used. See section 7 and appendix 6.

5.9 Conducting meetings with patients/families/carers (see Duty of Candour/Being Open policy)

5.9.1 Patients/families/carers may wish to have a friend or relative with them or wish to bring an advocate. Patients/families/carers and visitors will be offered further support and signposted to counselling if required.

5.9.2 All meetings will be held in a sensitive and supportive manner.

5.9.3 Patients are too unwell for meetings on occasions, and if it has been identified that a representative of the patient can be liaised with, this should also take place.

5.9.4 The patient or representative should be kept informed throughout the investigation.

5.10 Support for the investigating team

5.10.1 The Serious Incident and Complaints Investigation Lead and the Head of Patient Safety are to be available to anyone undertaking an investigation who requires support or the opportunity to discuss process and progress or who just wants the opportunity to reflect on the investigation so far.

5.10.2 Each week, investigators will have an opportunity to discuss cases in a peer review meeting. This will be led by the Serious Incident and Complaints Investigation Lead.

5.11 Completing the RCA report

5.11.1 The report of the investigation should be prepared using the appropriate root cause analysis template (see appendices 10, 11 and 12.

5.11.2 It will include the development of a SMART action plan in line with the CIT SOP (see appendix 8):

SPECIFIC	Specific: say exactly what you mean.
MEASURABLE	Measurable: it can be evidenced that the action is completed.
ACHIEVABLE	Achievable: they can be completed in a reasonable timeframe
REALISTIC	Realistic: Actions that can be achieved
TIME-RELATED	Time-related: they have realistic deadlines.

5.11.3 The report will be quality checked and returned to investigators, if necessary, for amendments. Once complete the report will be scrutinised by the Head of Patient Safety or appointed deputy if unavailable, care group leads and the Chief Nurse or appointed deputy. The final report must be submitted to the relevant Clinical Commissioning Group within 60 working days. There are

some circumstances in which the deadline can be extended, for example to allow for Police investigations.

5.11.4 A copy of the report is shared with the patient, family and/or carers, the team and others, as relevant, including staff involved in a manner agreed with them, and other organisations.

5.12 Timescales for feedback to interested parties

5.12.1 The timescale for completion of the investigation is usually 60 working days, although this may be extended where there are exceptional circumstances and investigators should discuss this in good time with the Serious Incident and Complaints Investigation Lead to allow for an extension request to be made to the CCG. Feedback will be the responsibility of the Lead Investigator. Patients and families should be advised of extensions during the course of the investigation.

5.12.2 Patients/families and carers should be given feedback from the investigation in line with Duty of Candour i.e. within ten days of completion of the investigation, when signed off by the Chief Nurse or appointed deputy.

5.13 Evidence of action completion

5.13.1 Following completion of the investigation, actions and action plan owners will be added to Datix by the appropriate care group. Care groups will ensure that evidence for closure is appropriate.

6 HIGH PROFILE SERIOUS INCIDENTS/NEVER EVENTS IMMEDIATE MANAGEMENT REVIEW (IMR)

6.1 When the serious incident is a homicide, inpatient suicide, child death, Never Event or likely to attract significant public interest, the case must be escalated to the Head of Patient Safety or Deputy Director Quality and Safety as soon as it is known, who will then alert the Chief Nurse.

6.2 An initial review will be carried out by a member of the patient safety team as appointed by the Head of Patient Safety or Serious Incident and Complaints Investigation Lead in conjunction with the appropriate care group patient safety lead. This must be completed as soon as possible after the incident has been recognised and no later than one working day from recognition of the incident. That person must be available for the IMR.

6.3 An initial IMR meeting will be arranged by the Head of Patient Safety or deputy, inviting all staff considered to be required. This will be determined in collaboration with the Deputy Director of Quality and Safety. A representative of the communications team must be included. This should be held within one working day of the incident being recognised if required.

6.4 The Lead Serious Incident and Complaints Investigator will appoint a member of CIT as a potential lead investigator for if the case is reported on STEIS, and to be available to attend the IMR.

6.5 The IMR will be chaired by the Chief Nurse or deputy and a note taker will be appointed by the Head of Patient Safety. Notes will be sent to the attendees within one working day to allow for actions to be undertaken in a timely manner.

6.6 The meeting will follow the format in appendix 2.

6.7 The IMR will determine the investigation team. It may be necessary to appoint an external investigator to support the internal investigating team. This will be approved by the Chief Nurse.

6.8 Information will be provided to the panellists of high-profile cases as per appendix 7

6.9 The CIT support officer will take notes at high profile investigation meetings.

6.10 The Chief Nurse or deputy will be responsible for escalating cases to the CQC, NHSE/I and CCG as required.

6.11 For mental health related homicide investigations, see appendix 13.

7 JUST CULTURE GUIDE

7.1 Most Serious Incidents, when investigated well will determine system errors rather than individual errors. The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. The Just Culture Guide was developed as a tool in promoting cultural change. This must be used in investigations if considered that there may be a managerial investigation.

7.2 The guide was developed by NHS Improvement in March 2018 and is used to support a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

7.3 It asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive. It also helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly.

7.4 The guide should not be used routinely. It should only be used when there is already suspicion that a member of staff requires some support or management to work safely, or as part of an individual practitioner performance/case investigation. The guide does not replace the need for patient safety investigations as the aim of RCA investigations is system learning and improvement.

7.5 A just culture guide can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available. It does not replace HR advice and should be used in conjunction with organisational policy. The guide can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

8 COVID-19 STEIS CASES

8.1 In March 2022, following new guidance on COVID-19 and STEIS reporting from NHSE/I (Learning from hospital-onset COVID-19), it was agreed that KMPT would report severe harm or death from COVID-19 on STEIS, or outbreaks on wards where learning was initially identified by the Infection Control team or the ward involved. The

COVID-19 RCA template will be used for outbreaks (see appendix 11) and the RCA template will be used for all individual patient cases (see appendix 10).

9 USE OF FORCE ACT INVESTIGATIONS

9.1 When a patient has been severely harmed or when death has occurred following use of force, specific requirements are required for the completion of investigations under the Use of Force Act 2018: statutory guidance for NHS organisations in England, and police forces in England and Wales. The requirements are found in appendix 13.

10 RETENTION OF RECORDS

10.1 The NHS Records Management Code of Practice 2021 advices on how incident records should be maintained and notes this to be a minimal period which can be extended by up to 20 years:

Record type	Retention start	Retention period	Action at end of retention period	Comments
Serious Incidents	Date of Incident	20 Years	Review and consider transfer to a place of deposit.	Retention begins from the date of the incident not the incident reported date.
Incidents (not serious)	Date of Incident	10 Years	Review and if no longer needed destroy	Retention begins from the date of the incident not the incident reported date.

10.2 All information relating to Serious Incidents will be retained on Datix. This includes the RCA report and any draft reports, any statements if required, analysis records, notes from the investigation and any further information used in the investigation.

11 LINKS WITH OTHER PROCEDURES

11.1 This procedure does not stand alone. It must, where appropriate be read with the following:

- Learning from Experience Policy
- Duty of Candour Policy
- Safeguarding Policy
- Complaints Policy
- Safeguarding, the Disciplinary Policy

12 TRAINING

12.1 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

12.2 The aim of the training is to ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

13 TRAINING NEEDS ANALYSIS

Staff Group	Policy Awareness/Roles & Responsibilities Team Briefings, Local Induction	Root Cause Analysis Training	Level one of Patient Safety Syllabus
Medical Staff/Inpatient Adult Community/Consultants	✓	CIT staff. Further consideration will be given to training once the Patient Safety Syllabus and national Patient Safety Strategy is further determined.	All staff by end of 2022.
Junior Doctor	✓		
Locums	✓		
Clinical Staff Based in Adult Wards/Learning Disability Units/Specialist Units Registered Nurses/ HCA's/ OT's/Psychologists	✓		
Clinical Staff Based Older Adult Units Registered Nurses/HCA's/OT's	✓		
Clinical Staff Based in Rehab. Services Registered Nurses/HCA's/ OT's, Psychologists	✓		
Clinical Staff Based in Forensic Services Registered Nurses/HCA's/ OT's/Psychologists	✓		
Community Team Staff Adult/Older Adults/ Registered Nurses/OT's/ Psychologists/Art/Drama Therapists/Speech & Language Therapists/.STR Workers/Technical Instructors	✓		
Social Workers	✓		
Administration/Reception Staff	✓		
Porters	✓		
Domestics	✓		
Catering Staff	✓		
Non-clinical, not Admin. Including Managers/Directors	✓		

14 EQUALITY IMPACT ASSESSMENT

14.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

15 HUMAN RIGHTS

15.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds.

16 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in the event of non-compliance
Completeness of information on 72 hour management reports as reported via the Datix system	Patient Safety Facilitator or Mortality Manager will review the 72 hour reports to ensure completeness for STEIS cases.	Serious Incident and Mortality Panel.	All forms on receipt that are required to be reviewed at the Serious Incident and Mortality Panel	Trends will be raised with The Head of Patient Safety and taken to the Learning from Experience meeting.	The managers of Datix 72 hour report will be contacted by the care group patient safety leads in the first instance and thereafter using the escalation process to Head of Service.
Reporting of STEIS cases	Care group meetings Trust-wide Patient Safety and Mortality Review Meeting. Quality Committee.	Heads of service Medical Director Chief Nurse	Monthly Monthly Bi-monthly	Reports Minutes of meetings	Chief Nurse
Demonstration of learning from serious incidents and evidence of change	Trust-wide Patient Safety and Mortality Review Meeting. QPR meetings Learning from experience group.	Chief Nurse	In line with meetings timetable	Minutes of meetings	Follow up with Care group Heads of Service.
Reporting within the timescales for Serious Incidents	Trust Wide Patient Safety and Mortality Review Group	Deputy director of Quality and Safety.	Bi-monthly Board reports	Minutes of meetings and reports	Care Group Leads on the panel will take action

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in the event of non-compliance
					through the Care Groups to ensure compliance
Monitoring of timely completion of investigations for Serious Incidents	In Quality Digest	Quality Committee	Bi-monthly	Minutes	To escalate to Chief Nurse
Sharing of investigations within national timeframe with patients/families/ carers	Duty of Candour Panel Duty of Candour audit	Head of Patient Safety Quality Committee	Weekly Annually	Notes from meeting Audit report	Escalation by care group to care group leads. Escalation to Chief Nurse. To be determined by Quality Committee

16.1 There are no exceptions to this Policy.

APPENDIX 1 NEVER EVENTS LIST 2018

Full details can be found at:
https://improvement.nhs.uk/documents/2899/Never_Events_list_2018_FINAL_v7.pdf

Those in bold particularly could relate to mental health services

Surgical

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post procedure

Medication

4. Mis-selection of a strong potassium solution
2. Administration of medication by the wrong route
3. **Overdose of insulin due to abbreviations or incorrect device**
4. Overdose of methotrexate for non-cancer treatment
5. Mis-selection of high strength midazolam during conscious sedation

Mental Health

9. Failure to install functional collapsible shower or curtain rails
Involves either:

- **failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide**
- **failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails.**

General

10. Falls from poorly restricted windows
A patient falling from a poorly restricted window. This applies to:

- **windows 'within reach' of patients; this means windows (including the window sills) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to climb out of the window**
- **windows located in facilities/areas where healthcare is provided and that patients can and do access**
- **where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall**
- **where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the 'key' provided.**

11. Chest or neck entrapment in bed rails
Entrapment of a patient's chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.

Setting: All settings providing NHS-funded care including care homes, and patients' own homes where equipment for their use has been provided by the NHS.

12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes

14. Scalding of patients
Patient scalded by water used for washing/bathing.
Excludes:
• scalds from water being used for purposes other than washing/bathing (e.g. from kettles)

15. Unintentional connection of a patient requiring oxygen to an air flowmeter

APPENDIX 2 IMMEDIATE MANAGEMENT REVIEW PROCESS

Flowchart – Immediate Management Review

(for potential SIs likely to attract media attention or be of interest to regulators, including Never Events)

Incident reported on Datix or directly to *Head of Patient Safety (*or Deputy Director Quality and Safety in the absence of HoPS)

↓

*Head of Patient Safety informs Chief Nurse and then contacts the appropriate Patient Safety Lead for the Care Group (or appropriate specialist if it is a corporate concern) to request urgent information. Agree information to be gathered (e.g. from police, other healthcare providers, prison services, social services, safeguarding, health and safety) and who will be responsible for this.
Information to be gathered into a briefing by the corporate Patient Safety Team.

↓

*Head of Patient Safety or deputy informs senior management team (Chief Operating Officer, Chief Nurse and Medical Director) and communications team as well as other appropriate staff (e.g. safeguarding, health and safety) and includes a short briefing and this document. This will include planned actions as agreed above.

↓

*Head of Patient Safety or deputy sets up a Management Review Meeting to occur within 24 hours of incident if required (as agreed with Chief Nurse)

↓

72 hour report (template on Datix) to be completed within 24 hours (action responsibility is with Patient Safety Lead)

↓

Briefing for the Board to be completed - Chief Nurse to nominate

↓

IMR meeting takes place within 24 hours
Duty of Candour responsible person to be determined
Duty of Candour actions to be agreed if not commenced. If commenced, further actions to be agreed.
Support of staff to be agreed
Actions to be agreed
*Head of Patient Safety or deputy to document minutes and actions from this meeting and send to agreed staff following the meeting

↓

Head of Patient Safety to report incident on STEIS as agreed

↓

Notify CCG - Chief Nurse to nominate responsible person

↓

Notify NHS England - Chief Nurse to nominate responsible person

↓

Notify CQC - Chief Nurse to nominate responsible person

↓

Next Actions to be determined

Management Review meeting
Venue:
Date and time:
Datix ID:

Minutes

Attendees:

Apologies:

ITEM	
1.	**Introduction to the incident:** **Notes:** **Actions already taken:**
2.	**Family Contact**
3.	**Liaison with other appropriate groups e.g. police, safeguarding**
4.	**Records – secured and where stored.**
5.	**Communication with key stakeholders** **CQC:** **CCG:** **NHSE/I:** **Others:**
6.	**Staff Support**
7.	**Immediate Learning**

8.	**Draft ToR for comprehensive report**	
9.	**Investigation Team**	
10.	**Next Actions**	Who?

Next meeting (if required):

Actions and updates

Action	Who (initials)	Date to be completed	Update

APPENDIX 3 EXTERNAL REPORTING OF INCIDENTS

External reporting of incidents

	Incident Type	**Contact (who and how)**
NHS England Clinical Commissioners Groups Care Quality Commission Local Authorities e.g. Social Services, police	Suicide of any person on NHS premises or under the care of a specialist team in the community Homicide committed by a patient with mental health problems Serious injury or unexpected death involving a member of staff, visitor, contractor or another person to whom the organisation owes a duty of care Serious damage to NHS property, particularly resulting in injury or disruption of services e.g. through fire, flood or criminal activity. Incidents associated with infection that produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others Any other Serious Incidents that may be identified as a cluster of events that lead to something more significant including those that may attract media attention.	The Serious Incident and Mortality Panel review the management review and RiO where necessary to identify if a Serious Incident has occurred. Where it is decided that this is the case, the CIT will enter the incident on to the STEIS System within two working days. Other organisations should be notified as soon as possible to ensure appropriate engagement. Communication leads will be determined through the above panel. National Reporting & Learning System by the Datix Team within two working days.
Her Majesty's Coroner	Deaths to be reported to HM Coroner: • Death where no doctor saw the deceased during his or her last illness; • A death where, although a doctor attended the deceased during the last illness, the doctor is not able or available, for any reason, to certify the death; • Death from industrial diseases or poisoning • Death at work • Cot death and postnatal deaths	Registrars of births and deaths, doctors or police must report these types of deaths to HM Coroner. The ward doctor would contact the police to advise of a death and the police would normally inform the Coroner's Office.

	Incident Type	Contact (who and how)
	• the death was sudden and unexplained; • Death occurred during an operation or before full recovery from anaesthetic • Cause of death unknown or within 24 hours of admission • Any violent, suspicious or unnatural death or a death due to neglect • Drug related deaths • Death of anyone currently or recently detained in Police/Prison Custody or another type of state custody	
Health & Safety Executive (HSE)	Death, major injury or dangerous occurrence. Over seven day injuries Specified injuries (such as fractures, scalp injuries and some burns)	Managers have the responsibility to ensure that the HSE are informed. They should inform the Health and Safety team, who will contact, on behalf of managers, the Health & Safety Executive see Health & Safety files or Health & Safety home page (Trust Intranet) Managers have the responsibility to ensure that the HSE are informed within seven days. They should inform the Health and Safety team, who will contact the HSE, on behalf of managers, using a RIDDOR form (see Health & Safety file or go to link on the Health & Safety home page – Trust Intranet)
National Health Service Resolution	Incidents where the Trust becomes aware that litigation will result	All staff through the Legal Services Team as soon as they are aware. 01622 724100

	Incident Type	Contact (who and how)
Professional Regulatory bodies	Incidents where there appears to have been a breach of the professional code of conduct.	All staff members to escalate to managers as soon as a breach of the professional code of conduct becomes apparent in line with the disciplinary policy. Managers should escalate to Human Resources Team and the Deputy Director of Nursing.
Medicines and Healthcare Products Regulatory Agency (MHRA)	Incidents involving injury or risk of serious injury involving healthcare products and equipment	All staff, in line with the Medical Devices Policy, must report incidents /near misses relating to medical devices via Datix. The Datix Team will then report these to the Medicines and Healthcare products Regulatory Agency (MHRA) on-line reporting system. A copy of the on-line report will then be forwarded to the Medical Devices Coordinator for information and any necessary action.
Safeguarding Vulnerable Children	Any incident involving serious harm to a child	All staff immediately via Safeguarding processes on the intranet
Safeguarding Vulnerable Adults	Any serious incident involving a vulnerable adult	All staff immediately via Safeguarding processes on the intranet.
Care Quality Commissioner	All unexpected mental health related deaths including suicides and homicides or those where individuals have died in hospital of a physical illness where mental health services may have contributed. For statutory requirements, any death of any patient that is detained or liable to be detained whilst in KMPT care.	Reported by the Quality and Compliance Manager as informed by the Patient Safety and Complaints Facilitator and Mortality Review Manager and following review at the Serious Incident and Mortality Panel.

	Incident Type	**Contact (who and how)**
Environmental Health/Food Standards Agency/Public Health England	Incident involving contaminated food products resulting in illness	All staff to escalate incidents immediately to the Infection Control team and Estates as soon as identified. The former would escalate to Public Health England.
Local Community	Any incident that is likely to impact on the local community	The SI and Mortality Panel will determine other organisations e.g. KCC, other Trusts, charitable organisations, police to be contacted and who would lead the communication. This may need to be in consultation with executive staff.

APPENDIX 4 STEIS DECISION MAKING AND PROCESS

Serious Incident reporting in line with the definition of STEIS reportable cases (see paragraph 3.1.1 in policy)

IMMEDIATELY inform manager/ shift lead/service manager/on call manager → Assesses medical/other needs of people involved

↓

BEFORE END OF DAY staff member who is aware of the incident (and preferably witnessed or was involved in the incident) completes → Takes URGENT action as relevant

INCIDENT FORM (online Datix) →

- Inform the service user / relatives – tell them that the incident will be reviewed and actions taken as appropriate in line with the Duty of Candour/Being Open policy.
- Review and update healthcare records.
- Consider adult/child protection alert and/or police involvement
- Urgent learning shared
- Support to commence for staff involved
-

→ * Where staff member injured or traumatised, manager considers referral to Occupational Health
* Informs Ministry of Justice (Forensic services)
* Head of Patient Safety or Patient Safety and Risk Manager communicates with other external agencies/media (e.g. police)

↓

WITHIN 48 HOURS relevant manager completes **MANAGEMENT REPORT (on Datix) including initial actions taken**

This must include:

- To share and reflect upon current practice (actions before, during and after the incident)
- To highlight ways of improving practice (learning)
- To support staff and service users and encourage the therapeutic relationship between staff, service users and their carers
- To ensure best practice is followed
- To provide an opportunity to highlight issues with trust systems and trust/local policies, procedures and protocols.
- This report will be reviewed by the care group and Serious Incident and Mortality Panel.
- If reported on STEIS, and related to a death, 72 hour report to be reviewed by Patient Safety and Complaints Facilitator or Mortality Review Manager and provided to the Chief Nurse and to be sent to the CQC as required in line with appendix 9.
- Assurance that Duty of Candour has been commenced if the incident meets this criteria.

→ * Considers **RIDDOR**
* Where patient/staff is potentially traumatised, Clinical Team provides initial support. Manager/psychology to monitor wellbeing of staff/service user and offer access to further support / counselling if signs of trauma still evident in long term
*Consider the use of the Just Culture Guide if there is consideration of a managerial investigation (see section 7 and appendix 6).

↓

Trust Wide Serious Incident and Mortality panel reviews the 48 hour Management Report at the next meeting, to determine if a reportable incident has occurred in line with the national Serious Incident Framework (2015). In the event that a Serious Incident is declared the CIT will report this by entering on the STEIS system.

The CIT SOP (see appendix 8) is followed once the incident is declared on STEIS.

The investigation is submitted to the commissioner of the services within national timeframes.

The care group monitors the serious incident action plan until completed for local actions.
The CIT's Serious Incident and Complaints Investigation Lead monitors the Trust-wide action plans developed following Serious incidents.
The Head of Patient Safety reports on all action plan progress in the Quality Digest report on a bi-monthly basis.

APPENDIX 5 EVIDENCE TO BE CONSIDERED WHEN UNDERTAKING A ROOT CAUSE ANALYSIS INVESTIGATION

Evidence to be considered when undertaking a root cause analysis investigation	
Identified areas of evidence to consider (5 Ps)	**Involvement**
People	Those staff, patients, visitors or anyone else who was involved in the Serious Incident. Anyone who witnessed the event but was not directly involved. The wider team(s). Organisation leads. It can be helpful to ask people to make notes of the event to refresh themselves when the RCA meeting or meeting with people occurs as part of the investigation.
Place(s)	Review of the area where the incident occurred. It can be helpful to visit the area at the same time on the same day of the week that an incident occurred. This can identify areas of concern. Health and Safety Leads Staff involved NHS Accredited Security Management Specialist (ASMS)
Parts (equipment)	Any equipment that has been involved and has been considered to have participated in the Serious Incident should be retained and be checked. Medical Devices Manager – Medical devices Hoists – Moving and Handling Trainer Resuscitation Officer Health and Safety Leads
Paper	Medical records will often be a starting point to commencing a timeline in a clinical investigation, however there will be other areas that need to be reviewed: EME records and other maintenance records Duty rotas Diaries Handover records

	Policies Mental Health Act External guidance such as NICE guidance Staff involved or other experts Records Manager Information Rights Manager Caldicott Guardian
Paradigm of working.	The widely held beliefs about the normal working processes, team relationships, and adequacy of leadership in the work place (how the team works). Staff within the team Consultation group Experts Chief Nurse Deputy Director of Nursing Executive Medical Director Clinical Leads Senior Practitioners Heads of Service Another similar team External Experts/other Trusts
	This list is not exhaustive and each investigation has to be reviewed on a case to case basis

APPENDIX 6 JUST CULTURE GUIDE

APPENDIX 7 GUIDANCE FOR RCA PANEL MEMBERS IN A HIGH PROFILE ROOT CAUSE ANALYSIS INVESTIGATION

Guidance for panel members involved in a high-profile Root Cause Analysis investigation

June 2021

Serious incident reporting

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

High profile serious incident reporting

The Trust has developed a process for high profile serious incident such as homicide investigations whereby a panel will be put together to complete the investigation. At this time, the involvement of a Non-Executive Director (NED) on this panel is restricted to homicide investigations only.

IMR

The Immediate Management Review Meeting is set up following the high-profile serious incident being reported. This meeting is chaired by the Chief Nurse or her Deputy. Its purpose is to review the 72-hour report, coordinate immediate learning, establish the terms of reference for the serious incident investigation and agree an investigation panel. Meeting is attended by senior managers from teams involved in the patient's care, subject matter experts and a member from the communications team. There is an established template for the meeting and process that is followed.

Investigation panel

The investigation panel will consist of a lead investigator from the Central Investigation Team who has expert knowledge of the serious incident process and will be able to coordinate and guide the investigation. There will be a NED on the panel, a clinician – who will likely be a consultant psychiatrist or consultant clinical psychologist and any relevant specialist, such as safeguarding. On occasions, a further investigator from another mental health trust may join the panel to provide greater scrutiny. During the course of an investigation, it may be necessary to invite other experts to provide an opinion on specific areas.

Role of the NED on the panel – What to expect from the investigation process

The role of the NED, as with other members of the panel, will vary from investigation to investigation. This is due to the complex and varied nature of the investigations that are undertaken. However, it is likely that at minimum, attendance at the investigation panel meetings will be required. There will be an initial panel meeting, a progress review meeting and a review of the findings meeting. In addition, the NED will be involved in providing support to the families and attending the high-profile action plan meeting.

It may be that the NED is asked to partake in the investigative process by attending staff or family meetings along with the lead investigator. The NED can also support the investigation by reviewing evidence or by escalating to the Chief Nurse, a challenge to the investigation process.

A review meeting will allow panel members to have input into the ongoing gathering of evidence and provide expertise on relevant areas for further investigation. This might be requesting that specific areas are covered during discussions with staff or scrutinising what has been gathered.

Once all the information is gathered the panel will need to consider the findings of the investigation. It would be expected that the written report will be formulated by the lead investigator using the information agreed within the investigation panel meetings.

The NED will also have organisational expertise that the panel can draw upon. It may be that key service improvements being developed at Board level could support the learning established as a result of the investigation and vice-versa.

Once the report is completed, it will be submitted to the high-profile action plan meeting for the purpose of formulating a robust action plan to highlight any areas of learning identified. This will be attended by those in the sign off process as well as the investigation panel.

On completion of the investigation, the RCA investigation report will be shared with the patient and or their family. In addition, the victim's family will be informed of the findings of the investigation.

The involvement of the NED within this aspect of the investigation should provide assurance to the families as to the significance of this process to the Trust.

The report will be sent to the Clinical Commissioning Group for review and closure. The report may also be sent to NHS England for further scrutiny, this may result in a further investigation being commissioned by NHSE, as outlined within the national framework (Appendix 1).

What will be shared with panel members?

At the outset of the panel formation, this document will be shared with the NED which includes the following documents for reference:

- The 72 hour report
- The serious incident policy
- The national Serious Incident Framework
- Relevant KMPT policies

APPENDIX 8 CENTRAL INVESTIGATION TEAM STANDARD OPERATING PROCEDURE

http://i-connect.kmpt.nhs.uk/document-library/central-investigation-team-standard-operating-procedure/6532

APPENDIX 9 STANDARD OPERATING PROCEDURE REPORTING UNEXPECTED DEATHS, SEVERE HARM CASES AND OTHER SIGNIFICANT CASES TO THE CQC

Introduction

The CQC require the Trust to notify them of certain incidents and incident types. This is completed in two ways depending on the type of incident. These are the 72 hour report process and the monthly report to the CQC. These cases relate to incidents taken to the Serious Incident and Mortality Panel.

72 hour reports

72 hour reports are required to be completed for the following criteria and provided to the CQC:

- All unexpected deaths where KMPT care and service delivery problems potentially contributory to the death have been identified
- All in-patient deaths regardless of contributory factors
- All homicides where either the perpetrator or victim was a KMPT patient in the last year
- All other significant cases as determined by the Serious Incident and Mortality Panel

The reports are completed using the 48 hour management report held on Datix, and updated accordingly with any additional information gathered.

The 72 hour reports are completed by the corporate patient safety team and sent to the CQC via the KMPT Assurance Manager as soon as is reasonably practicable and following approval by an Executive Director or designated person. The 48 hour reports are completed by the manager or designated person from the service involved in the patient's care. It is the responsibility of the care group patient safety teams to ensure the 48 hour reports are of a good quality.

Monthly report for non-STEIS cases to the CQC

These reports will include information about all unexpected deaths, severe harm and significant incidents which do not meet criteria for 72 hour reports and have been reviewed at the Serious Incident and Mortality Panel.

The monthly report will be completed by the corporate patient safety team and sent at the end of each calendar month via the KMPT Assurance Manager.

Information to be included in the report is included in Appendix A.**Appendix A**

Mortality cases and severe harm cases reported to CQC

Reporting month: xxx

Date sent to CQC:

Introduction

This report is to inform the CQC of and mortality and severe harm cases. Cases included are non-STEIS cases which are in-patient deaths, homicides, severe harm cases or cases that may be significant. STEIS cases are sent separately in the form of 72 hour reports.

Unexpected deaths where there are no KMPT care and service delivery problems

Datix number	Incident description	Discussion and rationale of downgrade from SI and Mortality Panel	Learning and any actions if required

Other severe harm cases where there are no KMPT care and service delivery problems

Datix number	Incident description	Discussion and rationale of downgrade from SI and Mortality Panel	Learning and any actions if required

There are occasions when new information comes to light and a case is upgraded to a STEIS reportable case, e.g. when a Coroner advises of new information or a structured judgement review finds new details. When this happens the CQC will be informed via the 72 hour process.

APPENDIX 10 STANDARD RCA TEMPLATE

Root Cause Analysis Investigation Quality Improvement Report
(with thanks to EKHUFT regarding the use of the template with additional changes)

Type of incident (STEIS category as appropriate)		**Date of incident**	
Reason for reporting			
Datix reference		**Date reported on Datix**	
STEIS reference		**Date reported on STEIS**	
Clinical Commissioning Group (CCG)	(Kent and Medway CCG)	**60 day deadline date**	
Complaint reference if appropriate		**Complaint date**	
Legal/claim reference if appropriate		**Legal/claim date**	
Referred to Her Majesty's Coroner / Date	N/A / Yes / No	**Date referred to Coroner**	
Is this linked to a safeguarding alert?	N/A / Yes / No	**Date of safeguarding alert**	
Structured Judgement Review (SJR) completed?	Yes / No	**SJR date**	
Is a Safeguarding adult review (SAR) being completed?	N/A / Yes / No	**Date**	
Is a Domestic Homicide Review to take place	N/A / Yes / No		
Is the patient a veteran of UK services?	Yes / No		
Care Group and speciality			
Site and ward/department/team			
Other organisations			
Duty of candour lead			
Lead investigator			
Investigation team			

Team link worker		
Action plan lead		
Initial review by Head of Patient Safety		**Date**
Care Group sign off (Head of Service or other)		**Date**
Care group sign off (Medical)		**Date**
Patient safety sign off		**Date**
Executive approval		**Date**
Homicide or high profile sign off		**Date**

Version Control

Version number draft/final	Date	Responsible person	Additions or amendments and reasons for these
0.1 draft			
0.2 draft			

Contents

1. Summary of incident and findings

Incident:

Findings:

Root cause(s):

Recommendations:

2. Information for the patient/family and terms of reference

The Trust will adhere to the principles of serious incident investigation (NHS England, 2015). The investigation will:

- Involve the patient and their family, the staff involved and relevant experts
- Be open, transparent and without bias
- Identify what happened
- Analyse what happened and why
- Record learning and how this will be shared within and external to the Trust
- Be timely in line with NHS timeframes
- Be proportionate and be systems based

Our investigation will be objective and draw out factual conclusions. We are aware, that as a result, the language used within this report will come across as detached and analytical. The report may, at times, appear cold as a result. We would like to apologise to the patient, patient's family and/or carers if the tone of this report causes further distress. The investigation team would like to reassure the patient, patient's family and/or carers that we have not lost sight of the impact on them.

The investigation team, on carrying out a thorough analysis of events, acknowledge that this is undertaken with the benefit of hindsight. We recognise that with hindsight it is easier to see what could have been done to prevent patient harm than when the events were unfolding. The investigation team has, using the evidence gathered, sought to look beyond the actions of individual staff members to understand why mistakes were made. This means that the investigation should identify weaknesses in systems, processes and cultures that may have led to a mistake occurring. The aim is to ensure learning occurs and assurance gained that the risk of something similar occurring again in similar circumstances is reduced.

When the investigation has been completed it will be shared with the patient/family and the Commissioners in accordance with the national Serious Incident framework. On occasions, the Commissioner may ask more questions. If this happens, the information requested and provided back to the Commissioners will be shared with the patient/family when this changes the outcome of the findings, or if the patient/family want the detail of this.

Standard terms of reference

Please review if safeguarding was appropriately considered.
If children were involved, please check that actions were appropriate to ensure they were considered and safeguarded.
Please review carers' support was appropriately considered if required.

Specific questions and terms of reference

Specific questions and terms of reference requested by the patient/family.		
3. Background to patient		
Age:	Gender:	Legal status at time of incident:
Please note that background information is documented in regards to the incident and taken from healthcare records and accounts from staff. Patient, family or other background information is as supplied by the patient/family		

4. Descriptive chronology			
Source key: healthcare record (HCR), RiO (RiO – electronic patient record), Patient (P), feedback at RCA meeting (RCA), multidisciplinary meeting (MDT), meeting with staff involved (M), relative account (R), witness account (W), telephone interview (TI) or other (state e.g. CCG, GP, SECAmb etc.)			
Date, time and source Related to outcome? (Y/N)	What actually happened	What should have happened (What do local or national policies, procedures, practice standards, etc. say?)	Problem (P) (What happened that should not have, what did not happen that should have) Notable (N) (Exemplar practice)

5. Incident analysis
Problems related to the outcome
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problems unrelated to the outcome
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problem:
Why the problem occurred:
Improvement plan number/comment:
Additional analysis determined during the investigation
Problem:
Why the problem occurred:
Improvement plan number/comment:
Problem:
Why the problem occurred:
Improvement plan number/comment:

Problem:
Why the problem occurred:
Improvement plan number/comment:
Notable practice
Notable practice:
Why the notable practice occurred:
Improvement plan number/comment:

6. Risk analysis			
Previous similar incidents	**Mitigation prior to current incident**		
Risk grading	**Likelihood**	**Impact**	**Score**
Pre-investigation risk assessment			
Post-action plan implementation risk assessment			

7. Conclusion and root cause
Conclusion **Root cause(s)**

8. Investigation process record				
	Participants (initials and title)			**Date**
Narrative Accounts				
Staff discussions				
Meetings log				
Peer review (e.g. Central Investigation Team meeting or quality improvement meeting				
Investigation tools (please tick ✓)	Chronology / timeline		Multidisciplinary review	

	Health Care record		System factors	
	Five whys		Human factors	
	A Just Culture Guide	Yes/Not required	Barrier analysis	
	Reflection		Process map	
	Other(s) (state)			

9. Engagement and participation		
Duty of Candour	Date:	Person responsible:
Verbal apology, facts and contact details given		
Questions / contributions to investigation invited		
Support offered / signposted:		
Initial written notification:		
Written summary of investigation and learning:	To be shared by DoC lead within 10 days of executive sign off of the RCA.	
Additional DoC detail:		

Staff involvement (please tick ✓)			
Individual debrief		Reflection or After Action Review	
Team debrief		Support from mentor/supervisor	
Counselling offered		Support from line manager	
Narrative account		Investigation meeting	
XX			
Additional staff support detail:			

10. Challenges to the investigation

11. Improvement plan

- What can be improved (Recommendations) and How (Actions)
- Each Root Cause and SIGNIFICANT Contributory Factor must have a recommendation and associated action(s)
- Previous action plans should be built on rather than repeated as mitigation was not sufficient to reduce the likelihood of recurrence
- Evidence of actions completed prior to final report submission must be recorded on the action plan e.g. training / competence records, confirmed minutes/notes of meetings, updated policy/procedure/checklist, audit/monitoring reports, emails/letters, screenshots of intranet/SharePoint, newsletters, posters etc.
  SMART **actions – S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**ime bound

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**

Action strength guide

Strong: Architectural/physical changes, new devices with usability testing, engineering control (forcing function), simplify process, standardise equipment/process, tangible involvement by leadership	**Intermediate:** redundancy/backup systems, increase staffing/decrease workload, software enhancement/modification, eliminate/reduce distraction, simulation training with refreshers and observations of practice, checklist/cognitive aids, eliminate look-alikes and sound-alikes, standardise communication tools, enhanced/highlighted documentation communication.	**Weak:** double checks, warnings, new procedure/memorandum/policy, training

IMMEDIATE ACTIONS TAKEN POST-INCIDENT

RAG status	Recommendation - SMART	Level Team	Action - SMART	Evidence of completion for assurance	Lead	Has the lead agreed	Due date	Progress update	Date achieved

		Care group **S**ite **Tr**ust-wide				**action? Y/N (if no detail why)**			

ACTIONS RECOMMENDED FOLLOWING THE INVESTIGATION										
RAG status	**Recommendation - SMART**	**Level** Team **C**are group **S**ite **Tr**ust-wide	**Action - SMART**	**Evidence of completion for assurance**	**How will success be measured?**	**Lead**	**Has the lead agreed action? Y/N (if no detail why)**	**Due date**	**Progress update**	**Date achieved**
	Share learning within the team / division / Trust									

	Monitor completion of actions	D		Minutes of Governance meetings		Care Group Head of Nursing				

Appendix 1
Evidence base, key terminology and glossary
Team / department information

Appendix 2: A Just Culture Guide (NHS Improvement 2018)
Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action. The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:
- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here – **Q1. deliberate harm test**

1a **Was there any intention to cause harm?**

Yes

Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

FAIR TEST

No go to next question – **Q2. health test**

2a **Are there indications of substance abuse?**

Yes

Recommendation: Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier.

FAIR

2b **Are there indications of physical ill health?**

2c **Are there indications of mental ill health?**

Yes

Recommendation: Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if ill health issues could have been recognised and addressed earlier.

FAIR TEST

If **No to all** go to next question – **Q3. Foresight test**

3a **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b **Were the protocols/accepted practice workable routine use?**

3c **Did the individual knowingly depart from these protocols?**

If NO to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

FAIR TEST

If **Yes to all** go to next question – **Q4. Substitution test**

4a **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way**
4b **in similar circumstances?**

4c **Was the individual missed out when relevant training was provided to their peer group?**

Did more senior members of the team fail to provide supervision that normally should be provided?

If YES to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

FAIR JUST

If **No to all** go to next question – **Q.5 mitigating circumstances**

5a **Were there any significant mitigating circumstances?**

YES

Recommendation: Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senor HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

FAIR JUST

If **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff supervision and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

FAIR

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by: Academy of Medical Royal Colleges, avma action against medical accidents, CareQuality Commission, General Medical Council, National Guardian Freedom to Speak Up, NMC Nursing & Midwifery Council, NHS England, Royal College of Nursing

APPENDIX 11 COVID-19 OUTBREAK TEMPLATE

Root Cause Analysis Investigation Quality Improvement Report
(with thanks to EKHUFT regarding the use of the template with additional changes)

Type of incident (STEIS category as appropriate)	HCAI/Infection control incident meeting SI criteria		
Datix reference		**Date reported on Datix**	
STEIS reference		**Date reported on STEIS**	
Clinical Commissioning Group (CCG)		**60 day deadline date**	
Care Group and speciality			
Site and ward/department/team			
Other organisations			
Lead investigator			
Investigation team			
Team link worker			
Initial review by Head of Patient Safety			**Date**
Care Group sign off			**Date**
Patient safety sign off			**Date**
Executive sign off			**Date**

Version Control

Version number draft/final	Date	Responsible person	Additions or amendments and reasons for these
0.1 draft			
0.2 draft			
0.3 draft			

Contents

12. Summary of incident and findings

Incident:

Findings:

Root cause(s):

Recommendations:

13. Terms of reference

The Trust will adhere to the principles of serious incident investigation (NHS England, 2015). The investigation will:

- Be open, transparent and without bias
- Identify what happened
- Analyse what happened and why
- Record learning and how this will be shared within and external to the Trust
- Be timely in line with NHS timeframes
- Be proportionate and be systems based

Specific questions and terms of reference

- Review compliance with infection control and PPE guidelines
- Determine any gaps in COVID-19 testing of patients and staff
- Ensure all aspects as detailed below in section 4 are reviewed and analysed

14. Duty of Candour
All patients have had Duty of Candour carried out. They have been advised of the investigation and will be informed of findings on completion of the investigation.

15. Overview		
Possible points of transmission	**Y/N**	**Details**
Did any patients spend time off the ward or in the community in the 7 days leading up to the outbreak?		
Did the ward receive visitors in the 7 days leading up to the outbreak?		
Were any patients unvaccinated or part-vaccinated?		
Did staff come to work when they were displaying symptoms of COVID-19 as described on the NHS website? (Continuous cough, high temperature, loss or change in taste or smell).		
Did staff come to work with any other symptoms?		
Were there any concerns about patients not social distancing/isolating?		
Details of PPE guidance and numbers affected	**Response**	
How does the Trust keep staff updated on PPE guidance?	**http://i-connect.kmpt.nhs.uk/document-library/covid-19-standard-operating-procedures/5354**	

	KMPT has a PPE page on the trust intranet, which all staff have access to. This page provides current information, advice and guidance on PPE including clarification on how the revised PHE PPE guidance applies to our services; guidance videos on donning (putting on) and doffing (taking off) equipment along with up to date posters, resources and wearing the appropriate PPE. **Investigators – please use the link above which will take you to all current policies and procedures.**		
Number of patients affected and tested COVID-19 positive?			
Number of staff affected and tested COVID-19 positive?			
Number of wards affected			
Number of wards/areas closed to new admissions?			
Additional information regarding infection control	**Y/N (if Yes, please provide additional information and analysis)**	**Any there any further issues that require additional analysis? Y/N/N/A**	**If yes, add problem**
During the investigation, did investigators identify any concerns from ward staff or infection control team staff regarding infection control, including the use of PPE?			
Were infection control measures in place breached at any point?			
Were there any patients not appropriately swabbed?			

16. Chronology of relevant events related to the outbreak? (Patients)							
	Date of admission (if in last 28 days) or state long-term	Date of swabs in the 7 days before the outbreak?	Date of positive PCR	Did the patient comply with self-isolation when requested?	Was social distancing maintained in the 7 days prior to the outbreak and during the outbreak?	Was the patient off the ward in the 7 days prior to the outbreak and during the outbreak?	Additional comments e.g. (no) concerns regarding the patient relating to infection control/Analysis if required
Patient A							
Patient B							
Patient C							
Patient D							

17. Chronology of relevant events related to the outbreak? (Staff)							
	Did the staff member require a PCR test due to symptoms (S), because the infection control team (ICT) requested it or because of a positive lateral flow test (LFT)?	Date of symptoms (if symptomatic)?	What symptoms were described?	Date of last working day before onset of symptoms or positive lateral flow/PCR	Date of positive PCR	Did the staff member come to work with any of the three symptoms identified by the NHS (cough, temperature, loss/change of taste or smell)?	Additional comments/Analysis
Staff A							
Staff B							

Staff C							
Staff D							

18. Risk analysis			
Risk grading	**Likelihood**	**Impact**	**Score**
Pre-investigation risk assessment	5	5	25
Post-action plan implementation risk assessment	5	5	25

These risk factors are due to a global pandemic.

19. Investigation process record				
Type	**Participants (initials and title)**		**Date**	
Staff interviews / discussions				
Meetings log				
Investigation tools (please tick ✓)	Chronology / timeline	x	Multidisciplinary review	
	Health Care record		System factors	
	Five whys		Human factors	
	A Just Culture Guide	Yes/Not required	Barrier analysis	
	Reflection		Process map	
	Other(s) (state)			

20. Challenges to the investigation

21. Improvement plan

The Trust has a Trust-wide action relating to COVID and any new actions identified in this review have been added to that action plan.

RAG KEY:	
Green	Complete
Amber	Work in progress but not overdue
Red	Overdue

ACTIONS RECOMMENDED FOLLOWING THE INVESTIGATION										
RAG status	**Recommendation - SMART**	**Level** Team **C**are group **S**ite **Tr**ust-wide	**Action - SMART**	**Evidence of completion for assurance**	**Lead**	**How will success be measured?**	**Has the lead agreed action? Y/N (if no detail why)**	**Due date**	**Progress update**	**Date achieved**
	Share learning within the team / division / Trust									

	Monitor completion of actions	D		Minutes of Governance meetings	Care Group Head of Nursing					

APPENDIX 12 PRÉCIS LEARNING REPORT OF A SAFEGUARDING/HUMAN RESOURCES/SECURITY/HEALTH AND SAFETY INVESTIGATION

Précis Learning Report of a Safeguarding/Human Resources/Security/Health and Safety Investigation			
Type of incident		**Incident date**	
Datix ID reference		**Datix ID reported date**	
STEIS reference		**STEIS reported date**	
Commissioner	(Kent and Canterbury CCG)	**60 day due date**	
Complaint reference		**Complaint date**	
Legal/claim reference		**Legal/claim date**	
Referred to Coroner	Y/N	**Safeguarding**	Y/N
Structured Judgement Review	Y/N	**SJR date**	
Care Group			
Site and ward/team			
Other organisations			
Was the patient subject to the mental health act?	Y/N		
Duty of candour lead			
Lead investigator			
Investigation facilitator			
Investigation team			
Action plan lead			
Divisional Q&A approval and date			
Head of Patient Safety approval and date			
Executive approval and date			

Case summary
Incident details: **Conclusion:** **Recommendations identified:**
Terms of reference
Terms of reference or additional patient/family questions
Background
Please note that background information is documented in regards to the incident and taken from healthcare records and accounts from staff. Patient, family or other background information is as supplied by the patient/family
Description of events

Duty of Candour		
Verbal apology, explanation and contact details:	Date:	Person responsible:
Questions / contributions to investigation invited: The patient has not requested any further questions.	Date:	Person responsible:
Support offered / signposted: Contact details provided.	Date:	Person responsible:
Initial written notification	Date:	Person responsible:
Written summary of investigation and learning: Findings of the investigation will be shared with the patient / family following submission to the CCG.	Date:	Person responsible:
Additional DoC detail:		

Staff support / learning		
Date that is planned to feedback to staff	Date:	Person responsible:

	Please tick ☐
Individual debrief	
Team debrief	
Reflective write up or After Action Review (helpful for revalidation)	

Support from supervisor/mentor	
Support from line manager	
Just Culture Guide	
Counselling offered	
Support from professional body/union representative	
Notification to University for student practitioners	
Description of support offered	
Investigation	
Findings	
Conclusion: **Root cause:**	

Pre and Post Risk gradings

	A **Potential Severity (1-5)**	**B** **Likelihood of recurrence at that severity (1-5)**	**C** **Risk Rating (C = A x B)**
Pre investigation risk assessment (This must match the **risk grading** on the Datix investigation)			
Post investigation risk assessment			

17 IMPROVEMENT PLAN

- What can be improved (Recommendations) and How (Actions)
- Each Root Cause and SIGNIFICANT Contributory Factor must have a recommendation and associated action(s)
- Previous action plans should be built on rather than repeated as mitigation was not sufficient to reduce the likelihood of recurrence
- Evidence of actions completed prior to final report submission must be recorded on the action plan e.g. training / competence records, confirmed minutes/notes of meetings, updated policy/procedure/checklist, audit/monitoring reports, emails/letters, screenshots of intranet/SharePoint, newsletters, posters etc.
  SMART **actions – S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**ime bound

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**

Action strength guide

Strong: Architectural/physical changes, new devices with usability testing, engineering control (forcing function), simplify process, standardise equipment/process, tangible involvement by leadership	**Intermediate:** redundancy/backup systems, increase staffing/decrease workload, software enhancement/modification, eliminate/reduce distraction, simulation training with refreshers and observations of practice, checklist/cognitive aids, eliminate look-alikes and sound-alikes, standardise communication tools, enhanced/highlighted documentation communication.	**Weak:** double checks, warnings, new procedure/memorandum/policy, training

IMMEDIATE ACTIONS TAKEN POST-INCIDENT

RAG status	**Recommendation - SMART**	**Level** **T**eam **C**are group **S**ite **T**rust-wide	**Action - SMART**	**Evidence of completion for assurance**	**Lead**	**Due date**	**Progress update**	**Date achieved**

ACTIONS RECOMMENDED FOLLOWING THE INVESTIGATION									
RAG status	**Recommendation - SMART**	**Level Team Care group Site Trust-wide**	**Action - SMART**	**Evidence of completion for assurance**	**How will success be measured?**	**Lead**	**Due date**	**Progress update**	**Date achieved**
	Share learning within the team / division / Trust								
	Monitor completion of actions	D		Minutes of Governance meetings		Care Group Head of Nursing			

APPENDIX 13 CONCISE ROOT CAUSE ANALYSIS INVESTIGATION

Quality Improvement Report Use of Force Investigations

(with thanks to EKHUFT regarding the use of the template with additional changes)

Type of incident (STEIS category as appropriate)			
Datix reference		**Date reported on Datix**	
STEIS reference		**Date reported on STEIS**	
Clinical Commissioning Group (CCG)	(Kent & Medway ICB)	**60 day deadline date**	
Coroner informed date			
Care Group and speciality			
Site and ward/department/team			
Is a junior doctor or student involved in the incident?			
Other organisations			
Lead investigator			
Investigation team			
Team link worker			
Initial review by Head of Patient Safety			**Date**
Final patient safety review			**Date**
Care Group sign off			**Date**
Executive sign off			**Date**

Version Control

Version number draft/final	Date	Responsible person	Additions or amendments and reasons for these
0.1 draft			
0.2 draft			
0.3 draft			

Contents

22. Summary of incident and findings

Incident:

Conclusion:

Root cause(s):

Recommendations:

23. Terms of reference

The Trust will adhere to the principles of serious incident investigation (NHS England, 2015). The investigation will:

- Be open, transparent and without bias
- Identify what happened
- Analyse what happened and why
- Record learning and how this will be shared within and external to the Trust
- Be timely in line with NHS timeframes
- Be proportionate and be systems based

Specific questions and terms of reference

- Review compliance with infection control and PPE guidelines
- Determine any gaps in COVID-19 testing of patients and staff
- Ensure all aspects as detailed below in section 4 are reviewed and analysed

24. Duty of Candour

Initial conversation date Initial letter date Comments
25. Background and relevant characteristics of patient
Background ***Relevant characteristics** **For (k below) in the list above, the patient's relevant characteristics are:** the patient's age whether the patient has a disability and, if so, the nature of that disability their status regarding marriage or civil partnership whether the patient is pregnant the patient's race the patient's religion or belief the patient's gender the patient's sexual orientation gender reassignment – whether the patient identifies with a different gender to their sex registered at birth
26. Requirements under Use of force Act 2018
The information should include (this relates to m below):** the views of the patient any psychological impact details of any injuries the patient or staff involved may have suffered whether the outcome of the use of force was segregation or seclusion whether the police were called to assist and, if the police were called to assist, the following information should also be recorded: the reason they were called whether the incident was recorded by their body-worn camera and if not, why not who the relevant police contact is

27. Risk analysis			
Risk grading	**Likelihood**	**Impact**	**Score**
Pre-investigation risk assessment			
Post-action plan implementation risk assessment			

28. Investigation process record		
Type	**Participants (initials and title)**	**Date**

Staff interviews / discussions				
Meetings log				
Investigation tools (please tick ✓)	Chronology / timeline	x	Multidisciplinary review	
	Health Care record		System factors	
	Five whys		Human factors	
	A Just Culture Guide	Yes/Not required	Barrier analysis	
	Reflection		Process map	
	Other(s) (state)			
29. Challenges to the investigation				

30. Chronology of relevant events		
Date, time and source	**Describe events**	**Issues identified/ what went well. To include an understanding of why. Improvement plan number**
	These must be included: a) the reason for the use of force b) the place, date and duration of the use of force c) the types of force used on the patient d) whether the types of force used on the patient formed part of the patient's care plan e) the name of the patient on whom force was used (this is to be on Datix only please) f) a description of how force was used g) the patient's consistent identifier h) the name and job title of any member of staff who used force on the patient i) the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient j) the patient's mental disorder (if known) k) the relevant characteristics of the patient (if known) (see* above) l) whether the patient has a learning disability or autistic spectrum disorder m) a description of the outcome of the use of force (see ** above) n) whether the patient died or suffered any serious injury as a result of the use of force and injuries should be documented o) any efforts made to avoid the need for use of force on the patient (details to be included are of what led to the use of force and provide a record of the de-escalation techniques that were employed). p) whether a notification regarding the use of force was sent to the persons (if any) to be notified under the patient's care plan (this must be with the patient's consent)	When analysing, please consider: when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others? is there a reduction in the average duration when force is used? was the level of force proportionate in all cases? there an overall reduction in the use of physical restraint? is there a reduction in the use of prone and supine restraint? is there a reduction in the number of complaints from patients and families or carers following the use of force? is there a reduction in the number of injuries to patients and staff following the use of force? what steps have been taken to reduce the use of force for all patients, and in particular those sharing protected characteristics under the Equality Act 2010?

31. Improvement plan

RAG KEY:	
Green	Complete
Amber	Work in progress but not overdue
Red	Overdue

ACTIONS RECOMMENDED FOLLOWING THE INVESTIGATION										
RAG status	**Recommendation - SMART**	**Level** Team **C**are group **S**ite **Tr**ust-wide	**Action - SMART**	**Evidence of completion for assurance**	**Lead**	**How will success be measured?**	**Has the lead agreed action? Y/N (if no detail why)**	**Due date**	**Progress update**	**Date achieved**
	Share learning within the team / division / Trust									
	Monitor completion of actions	D		Minutes of Governance meetings	Care Group Head of Nursing					

Mental Health-Related Homicide

Information for Mental Health Providers

April 2019

Contents

Foreword

The impact on families, friends and staff following a mental health related homicide is traumatic and life changing.

We have developed a set of principles and activities to help Mental Health Providers support families and staff following a mental health-related homicide. These materials should be shared with relevant teams within your organisation and we hope they will support existing processes and structures to continue providing meaningful support to those affected by incidents of this kind.

It is important that there are robust systems in place to ensure learning is shared across the healthcare system and with other agencies, such as the Police and social services to reduce the likelihood of such tragic incidents.

Whilst it is essential to learn from these incidents this can, on occasion, be difficult, especially if the alleged perpetrator has had minimal contact with health and social care services. However, if there has been contact with services then this contact should be reviewed to identify learning, which could be both service improvements and sharing of good practice. As responsible bodies, there should be clear platforms to take this learning forward locally, regionally and nationally.

Families often ask investigating teams if the incident could have been prevented. Health and social care is complex and a service user may come into contact with multiple agencies and multiple services. Whilst it is often difficult to say for certain that an incident was preventable, an independent investigation will often identify gaps and omissions in care pathways and recommend actions that could improve systems. These actions are put in place to strengthen the systems that staff work in, improve care for service users and reduce the risk of reoccurrence of such incidents.

Public services must ensure that those families affected by a mental health homicide are treated in a respectful, sensitive and professional manner without discrimination. Families should be offered appropriate, compassionate support and be provided with information on how they can access available help to begin to cope and recover.

We appreciate that all situations and organisations are different, and that one size does not fit all. To help achieve a consistent approach, we have worked with families and staff to develop a set of principles and activities to support them in the aftermath of a mental health-related homicide and some information for families about what to expect. These written materials are entitled *Information for Families of Victims Following a Mental Health-Related Homicide* and *Information for Families of an Alleged Perpetrator of a Mental Health-Related Homicide.* They are accompanied by podcasts that reflect the experience of a mental health-related homicide from a range of perspectives and are are available on the NHS England website.

NHS England London has developed these materials in collaboration with the families of victims of mental health-related homicide, the families of alleged perpetrators, voluntary/charity and advocacy organisations, NHS Resolution, NHS organisations, Metropolitan Police Service and Independent Investigators.

Families and staff have been incredibly generous by sharing insights at workshops, in interviews and by contributing content. We would like to thank them for the time they have taken to help us to create these materials.

We hope the materials will help us to provide meaningful support to those affected by incidents of this kind.

England

Resolution

METROPOLITAN POLICE

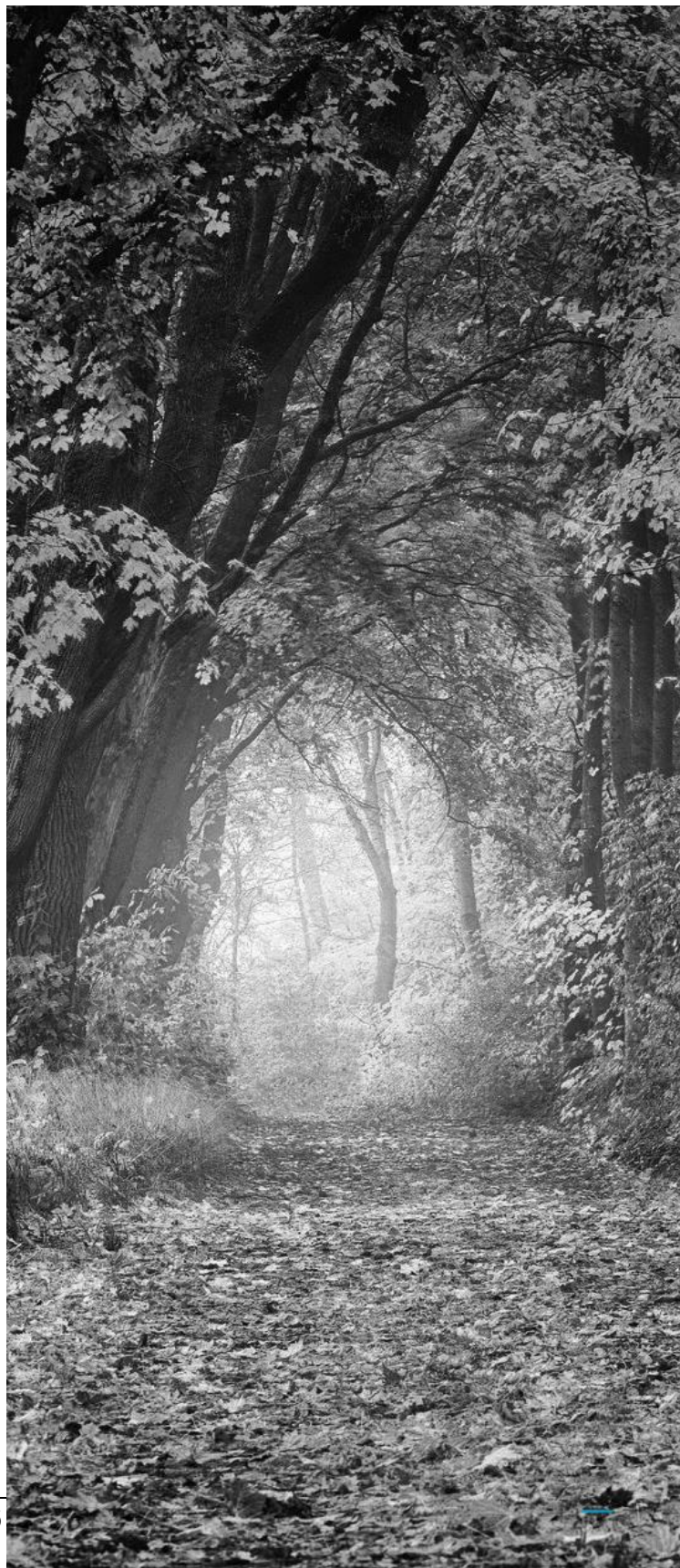
Introduction

There is no escaping the intensity of emotion for all involved in the weeks and months following a mental health-related homicide and every individual has their own way of expressing and dealing with the situation.

For those families bereaved by mental health-related homicide the devastation is unique and made worse by the suddenness of the event and knowledge of the circumstances. This emotional trauma will have a long-lasting impact on the immediate family, which can include children, and those around them including wider family and friends.

In addition to coping with pain and grief, research has shown that bereaved families often experience problems with physical health, housing, employment and the breakdown of relationships. In the case of domestic homicide, the family may be coping with additional complexities, multiple deaths and sometimes suicide.

As well as having to contend with their loss, families must deal with the immediate aftermath: the media, the Police investigation and the criminal justice process which can take years. There are long lasting consequences for families' mental and physical health and often they need support from the very system that they may perceive has failed them. They come to the NHS looking for information and answers and services need to be prepared to respond with openness,honesty and support tailored to their needs.



The family of the alleged perpetrator also suffer greatly and may experience social isolation. In addition, they will want to get information, answers and may want to contribute and be involved.

It is important to be aware that each family or individual will respond differently and, as such, the approach to supporting them will vary depending on the circumstances and how the family would like to be involved.

It is clear from the people who have helped to develop these materials that families value personal support through advocacy (often provided by the voluntary sector), together with a nominated individual within the Mental Health Provider who understands the case and can help families understand what is involved and their role in it.

Mental Health Provider staff will also need support following an incident of this kind. People who cared for the alleged perpetrator may feel anxious and be concerned about
their own part in the events that led to the incident. The impact on staff can be profound and they need care and compassion throughout the process.

The aim of the NHS internal reviews and independent investigations is to learn from these events and preventfuture ones. Over time, many families want to be given a chance to help services to change by being included in internal reviews, investigations, sharing learning and supporting development. They need to see positive changes and be confident that our system is able to learn and that their involvement can make a difference for others.

Experience has shown that there are behaviours that, if adopted by the Mental Health Providers and related agencies, can ease the process and prevent making the situation harder for those involved. It is recognised that staff are already working hard to support patients and families following an incident. These materials have been designed to support that work and to continue to help everyone provide appropriate support for families of victims, families of alleged perpetrators and staff.

Guiding Principles

We have identified Four Principles when supporting people during this time:

Communicate, Support, Involve and Learn

1. Communicate regularly and with sensitivity and clarity.
2. Provide support for both families and staff.
3. Involve families and staff in reviews, investigations and in sharing learning.
4. Commit to learning.

We have identified a number of Key Actions that underpin the principles:

- Supporting families in the first days and weeks following an incident.
- Staff support.
- Independent investigation.
- Engaging families to support continuous learning.

Existing Frameworks

NHS England, Mental Health Providers and commissioners of mental health services have a number of responsibilities and reporting obligations following a serious incident:

- NHS England Serious Incident Framework 2015[1]
- Duty of Candour[2]

In addition the NHS England and National Quality Board Learning From Deaths Guidance sets out guiding principles and ways for NHS organisations to improve how we engage with families and how we learn when things go wrong.[3]

These Mental Health-Related Homicide materials are intended to accompany and complement official frameworks, by describing some of the experiences that people have shared, practical things that have been found to help and suggestions for further resources and support.

https://improvement.nhs.uk/resources/serious-incident-framework/
The Serious Incident Framework is currently under review. The updated version will be published in 2019
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/
Note: An updated version will be available in March 2019

1. Communicate

Initial actions

When an incident occurs, it is important to immediately assign responsibility for effective communication.

Join up

Depending on the nature of the incident, it may be necessary for several organisations to make contact with those families affected. This should be clearly explained to the families and where possible, agree one point of contact/an identified person.

Say Sorry

Families have told us that organisations do not always say sorry or they do it in a way that does not resonate or seem well-intended at the time. It is important to continue to acknowledge our empathy throughout the often long process. For additional guidance on saying sorry see NHS Resolution (resolution.nhs.uk).

Adopt the right style

Families affected by a mental health-related homicide must be treated in a respectful, sensitive and professional manner, without discrimination.

Enable Choice

The quality and accuracy of the internal review and independent investigation is likely to be significantly enhanced by the involvement of family and friends. Some families will decline/defer communication from the Mental Health Provider when it is offered, and this is their right. Record this choice but try re-establishing communication at a later date when the family may be ready to engage.

Ensure Timeliness

It is important to identify and open communication channels with families as
early possible, to maintain communication throughout and to commit and keep to the next communication each time contact is made. Stay in contact as planned, even if you do not have any new information to share. Always keep families informed on progress including reasons that may result in delays to the agreed schedule.

"We were assigned a person. There was a diary reminder every month. This makes a difference to the family: a process, something to hold them account to, a structure."

Victim Family Member

2. Provide Support

Commit for the long-term

The sudden loss and trauma that families experience following a mental health-related homicide cannot be underestimated. Families have to re-live the painful memories, with court attendances and organisations investigating their own service's contacts. The process can take years and this impacts on everyone involved: families of the victim and those of the alleged perpetrator who are both facing new challenges every day.

Signpost with support

The incident can impact on the family in many ways (eg: finances, housing and childcare). There are information, support and advocacy services available. Let people know what they can access and support them to do so.

Offer Psychological/Counselling Support

Families should be offered appropriate, compassionate support and be provided with information on how they can access available help to begin to cope and recover. The families may not wish to receive this support from where the alleged perpetrator had received care and treatment. You may need to organise a reciprocal support system with a neighbouring/their local trust.

Keep the door open for support

Families may change their mind about the support they need or want. This experience will impact everyone differently and they might find that they need support at different times. This support should be available for the wider family also. Consider how the local processes (including waiting times) might impact and how they can be avoided.

Communicate regularly with staff

Staff need to know what the process will involve, their role and the need for the organisation to learn. An early de-brief as a group, with opportunities for other informal and individual de-briefs is important.

Support Staff

These incidents are rare and so it is unlikely that staff will have experienced this before. They will need support to understand the impact on them both professionally and personally.

Support those providing the family with support

In addition, those assigned to supporting the families will need on-going support, supervision and opportunities to de-brief.

3. Involve Families & Staff

Involve families at the earliest opportunity

The quality and accuracy of any internal review/ independent investigation is likely to be significantly enhanced by the involvement of family and friends. Families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation. If families do wish to be involved, agree on and abide by their preferred timelines and points of contact.

Appreciate that all families are different

It is important to be mindful of the family dynamic and that different family members might want to meet separately with the internal review and independent investigation teams. The internal review/investigation team might also need to meet with friends and other members of the public affected by the incident.

Involve Staff

Mental Health Provider staff may wish to engage in different ways and need a choice of support – as a team or individually. Even though it is often a significant period of time afterwards, it is important to make sure that there is a reflective session around the time of the final report, in addition to the sharing learning sessions.

Work in partnership

It is good practice to work in partnership with the other agencies involved and the other investigations taking place. Activities outside of the Mental Health Provider do sometimes take priority, such as the criminal investigation.

"Ask the family. They're the ones that know the patient."

Mother of perpetrator

4. Commit to Learning

Organisational culture

Consider how the learning from this event will interact with on-going quality improvement programmes and be meaningful to teams. Find ways to share the learning early and often and evidence the changes and improvements that are made as a result.

Work in partnership

It is important that there are robust networks and systems in place to ensure learning across the health system and other agencies, such as Police, social services and the wider social economy to reduce the likelihood of such tragic incidents.

Build family and staff experience into learning

For organisational culture to change and improve it is vital that the experience of care, from all perspectives is fully understood.
It is important to share the findings of the investigation with those involved.

Engage Leadership

It is imperative that the leadership within the Mental Health Provider, commissioners and relevant stakeholders understand and own the changes that are needed at wider system and organisational level. Patient Safety teams need to work with the leadership within the Mental Health Provider and commissioners, during and following a mental health-related homicide investigation, to support them to fully understand and own the changes that are needed at wider system and organisational level.

Engage staff

The investigation process, reporting and action planning can sanitise the information to a certain extent and it is therefore important to find ways to gather and share family and patient stories in a way that engages people in the required improvements at all levels – team, executive, board and wider system.

> *"We are here to help illuminate the past, to make the future safer."*
>
> **Frank Mullane, AAFDA**

Key Actions

In order to support families and staff an awareness of the whole process is required. The family and staff experience the mental health service reviews and investigations in the context of everything else that they are involved in: the Coroner's inquest, funeral, Police investigation and criminal proceedings.

There is a need for flexibility and responsiveness, the ability to enable access to a variety of support methods, an understanding of the complex nature of the grieving process and a close working relationship with investigators.

Families may not necessarily be familiar with either the NHS or other services and how they operate. It is highly unlikely that they are familiar with mental health-related homicide and any of the processes and procedures that will follow.

Every stage will need to be clearly described and explained.

> *"You are left shunned and isolated, as if you are in your own prison cell."*
>
> **Family of perpetrator**

Following a mental health-related homicide the family of the victim have a range of agencies who get in contact and a number of activities that take place that they are required to be involved in. We have listed some of the activities here. This can take place over a number of months and years.

General

- Victim(s) identified (by the family)
- Media interest
- Coroner's Inquest
- Post Mortem
- Funeral arrangements
- Dealing with the estate and will
- Welfare/Bereavement Benefit payments

Police

- Some personal possessions may be held by Police as evidence
- The home may be a crime scene
- Police Family Liaison Officer allocated to victim family
- There may be a criminal trial
- There may be an appeals process
- In some situations, no charges are brought

NHS Internal Investigations

- Early family contact should be made in agreement with the Police Senior Investigating Officers' strategy
- Provide information on internal review process and possible independent investigation.

Learning

- Should be agreed system/channels for using learning within the MH Provider
- Board ownership of learning
- Action plans will be developed and the Providers held to account for implementing
- Family involved in monitoring of change
- Sharing – nationally – not just local – families appreciate seeing change
- Continued support for the family

NHS England Independent Investigation

- Following internal review, Independent Investigation may be commissioned by NHS England London
- Family involved.
- Final report and sharing findings
  - Flexible support needed as family timeframe unpredictable
  - MH Provider Internal Investigation is conducted alongside the criminal proceedings
  - Family involved in terms of reference, mid-point review and final report

Investigations and reviews

- A number of organisations may carry out investigations, depending on the circumstances (Police, NHS, Domestic Homicide Review)

16

- A range of agencies may be involved. Such as: Healthcare Service Ombudsman, Health & Safety Executive, Independent Office for Police Conduct, Nursing Midwifery Council, General Medical Council, Crown Prosecution Service, Prison Ombudsman

The first days and weeks following an incident

Co-ordinate with other agencies

- Work in partnership with the other agencies involved (other health providers, Coroner, Police, voluntary sector) and ensure that communication is joined up.
- Initial contact with both victim's family and alleged perpetrator's family must be agreed beforehand by the Police Senior Investigating Officer.
- Nominate a single point of contact within the Mental Health Provider to liaise with the Police Family Liaison Officer (FLO) and the families.
- Where an alleged perpetrator was cared for by more than one organisation a Lead Mental Health Provider will be identified.

Offer support to access advocacy services

- There are sources of support and advocacy available, including media advice, but families will need help to access them.
- Families should have access to the help of specialist advocate homicide support agencies and independent advocates experienced in bereavement and sudden loss.
- Check with the Police FLO what agencies/ support has been provided to the family to prevent saturation of information.
- Please see Help and Support section for further information.

First communication

After a mental health related homicide, families often describe being in a state of shock, bewilderment and a sense of disbelief. They need and want information from Mental Health Providers and have reported that, in the past, this has been very difficult to access.

It is important to acknowledge that, on occasion, providing support and information can be difficult if the alleged perpetrator has had minimal contact with health and social care services.

The first communication with the families of both the victim and the alleged perpetrator is important to demonstrate a commitment to openness, honesty and support:

- The Mental Health Provider(s) should send condolences to the family within seven days of becoming aware of the death.
- Say sorry. Saying sorry is not an admission of legal liability; it is the right thing to do.[5]
- Treat families with empathy and respect.
- Communication should be sensitive, clear, inclusive, in plain English, free of jargon and any technical terms should be explained.
- Be sensitive to any cultural needs.

5 https://resolution.nhs.uk/saying-sorry-leaflet/

- Offer interpreters and information in other languages if required.
- Ensure that any contact is sensitive to specific dates, for example birthdays, anniversaries, funeral etc.
- Identify one point of contact within the Mental Health Provider. This person should have the skills and experience to support the family throughout the process and will be independent of the teams that cared for the alleged perpetrator.
- Ideally, use generic contact details in the event that the nominated staff member leaves or is on a period of absence.

We have developed some booklets for families that describe what they can expect from the NHS. These are entitled *Information for Families of Victims Following a Mental Health-Related Homicide* and I*nformation for Families of an Alleged Perpetrator of a Mental Health-Related Homicide.* This information is intended to support your conversations with families.

18

Meeting the family

- Ensure that the Mental Health Provider's nominated point of contact is available to meet with the families.
- If multiple agencies are involved, consider having one multi-agency meeting with the family to prevent duplication of information.
- Enable the family to decide on the location and timing of meetings.
- Consider who should join this meeting –should the family liaison (NHS and Police) services be present?
- Help staff to prepare, including how to start and end the meeting.
- These meetings will be difficult for all, it is therefore advisable that those assigned to managing such a meeting are appropriately senior and knowledgeable, as to confidently be able to support and answer any queries raised by the family.
- Manage expectations of first meeting:
  - Establishing how much involvement family want in the process.
  - Establishing one point of contact within the family.
  - Explanation of internal review and investigation process.
  - Offer additional meetings at key points during the process.

Offering Psychological and Counselling Support

- The meeting is an opportunity to identify the psychological support/counselling needs of family, including any children.
- Waiting times and processes, such as referral criteria, can be a major barrier – consider how this might be flexed due to exceptional circumstances.
- Grief and the ways that people express their feelings is individual and everyone reacts in their own way. Responses can also change over time.
- A review of the research into the impact of homicide[6] found that bereaved families following a homicide reported repetitive thoughts, being on-guard, detachment, depression and sleep disturbance. Some also reported alcohol and drug dependence. The studies also indicate that these kinds of symptoms can continue for long periods.
- Be mindful of stigma about mental health, some families may be reluctant to access services.

6 Louise Casey CB, Review into the Needs of Families Bereaved by Homicide 2011 – https://www.justice.gov.uk/downloads/news/press-releases/victims-com/review-needs-of-families-bereaved-by-homicide.pdf

Explain the need for a review/ internal investigation

- Ensure families are provided with an explanation as to why the Mental Health Provider organisation is conducting a review and investigation, the purpose of the investigation and the format of the report findings.
- Be clear with families that the purpose of the report is for the organisation to learn, implement change and to minimise any reoccurrence and not to apportion blame.

Family involvement in reviews and investigations

- Families have told us that they want the NHS to be honest with them and to know what happened, why it happened, how it happened and if there is anything that can be done to prevent reoccurrence.
- Offer families the opportunity to assist with the scope of the internal investigation by contributing to the Terms of Reference and listen to any comments they may have.
- Families can also be a vital source of information and insights about a person's care and treatment.
- Allow families the opportunity to read any interim report findings and provide them with sufficient time to comment on the report content and any potential recommendations.
- All information and reports should be preceded with a phone call or meeting with the family.
- No unplanned or new information should be sent without warning.
- Ensure families are asked how they want their loved one to be referred to in the report
- Ask families how they want to receive the report and offer a meeting at your offices, or a location of their choice. If the report is to be sent to their home address, always ask if they will have support at home when they receive it or whether they want a member of the investigation panel/identified point of contact to take it to them.
- Ensure both the interim and final reports are written in plain English[7]
- The Mental Health Provider should remain in contact with the families following the final report to update them on progress with the recommendations.
- Openness and transparency with families on how long recommendations will take to put in place is essential including explanations of any known delays and what may be causing them.

Delays

- If families have chosen to be updated at regular intervals, the agreed single point of contact will need to ensure they update them of any delays in the investigation and the reasons for these.

7 https://www.gov.uk/government/publications/making-written-information-easier-to-understand-for-people-with-learning-disabilities-guidance-for-people-who-commission-or-produce-easy-read-information-revised-edition-2010

- Sometimes the Police investigation and criminal proceedings can impact on the timings of the internal investigation. However, it is preferable for all concerned for this internal investigation process to proceed as planned and the Mental Health Provider should have good communication links with the Police investigation and be able to run both in parallel.

The role of the Mental Health Provider nominated point of contact/family liaison lead

- It helps families enormously to have one point of contact within the Mental Health Provider.
- Some Mental Health Providers have created a dedicated Family Liaison role within their trust.
- This family liaison/point of contact person needs a detailed and wide-ranging understanding of the complexities of sudden and traumatic death and to be well-connected to support services, including:
  - HM Coroners post mortems and inquests
  - Police Family Liaison
  - Coping with the media
  - Advocacy and counseling support
  - Benefits
  - What the court process involves
  - Statutory investigations
  - NHS Investigation

Publication of reports

NHS England, London has obtained legal advice on the release of investigation reports to relatives following mental health homicide. The advice is clear: investigation reports should always be released to families.

Mental Health Providers and Independent Investigators should draft reports in the knowledge that disclosure is highly likely to be requested.

Other investigations

- Wherever possible investigations should continue alongside criminal proceedings but this should be considered in discussion with the Police.
- In exceptional cases (i.e. following a formal request by Police, Coroner or judge) and in accordance with the Police Senior Investigation Officer strategy, the Mental Health Provider investigation may be put on hold and this should be discussed with the Police FLO on how best to advise and support the family during this period.
- There could be opportunities for joint working with other organisations including the Police and potentially the Local Authority with other types of investigation such as Domestic Homicide Reviews (DHRs) and/or Serious Case Reviews (SCRs). NHS England's Patient Safety Team can advise on collaboration with other agencies.
- Central to this process is the involvement of all relevant parties, which includes the service user, victim(s), perpetrator(s) and their families and carers and mechanisms to support openness and transparency throughout. There should be an agreed single point of contact and this should ideally be the Police Family Liaison Officer once formalised via the Senior Investigation Officer strategy.

Staff Support

The impact of a mental health-related homicide on the staff involved can be far-reaching.

Soon after the incident, it is helpful to hold a debrief session with the teams who cared for the alleged perpetrator. This is an opportunity to share experiences in a safe environment. This meeting is separate from the internal investigation and is an opportunity for staff to talk through the incident.

Ensure that staff involved are offered appropriate support via individual and team debriefs, followed by further referrals to other support as necessary. Support will also be required for those staff whom may also know the victim.

This mix of informal and formal support should then continue at team and individual supervision. It is important that line managers are aware and supported to create time to listen and help staff to reflect on their practice.

Mental Health Provider Trusts will also have Occupational Health services and counselling services available for staff. People react in different ways and it is important to keep track of delayed or repressed responses.

In the days and weeks following the incident encourage staff to record accurately their contact with the alleged perpetrator. This can help ensure they have a prepared record for any forthcoming or future investigations.

The process of investigating a mental health-related homicide is long and can take years to complete. There are often high expectations around the evidence within the report and sharing the learning needs to be planned and executed with care and attention.

Regular communication and updates can help staff during this difficult time. Often this is as simple as describing the investigation process as they might be unfamiliar with it, or need
a reminder, and allaying their fears. Knowing where they are in the process and what the next steps are can be helpful.

Senior leaders in the organisation can set the tone with compassionate leadership, a commitment to personal and professional development, a safe environment to listen and give feedback and mutual trust and respect in teams and across the organisations.

It will be important to reach out to all staff groups involved, including students, agency staff and recently qualified staff and those who might be experiencing a situation of this kind for the first time.

"This needs to be talked about as a possibility, at induction, in training. We need to understand the potential for serious incidents, the process and systems in place, the emotional impact."

Serious Incident Team Member

Independent Investigation Following a Mental Health-Related Homicide

Following the initial internal investigation report and subsequent criminal proceedings, in the case of mental health-related homicide, an independent investigation may be commissioned.

In London, the mental health independent investigations are coordinated and commissioned by NHS England (London).

There are a number of independent investigation agencies. These agencies are invited to tender, in a process that is fully compliant with the Public Contracts Regulations 2015.

The decision on whether an independent investigation is required is made by the Independent Investigation Review Group (IIRG). This is a multi-agency group in London which includes members from the Metropolitan Police Service, health services, and commissioning groups in-line with the Serious Incident Framework (April 2015) and the investigation of serious incidents in mental health services (Department of Health, 2015).

In addition to the above legislation requirements, the decision to commission a full independent investigation into the care and treatment of the alleged perpetrator provided by the Mental Health Provider, will also depend on the quality of the internal report, the level of involvement of families of the victim(s) and alleged perpetrator(s) and any other relevant stakeholders.

Following the decision made by the Independent Investigation Review Group to commission an Independent Mental Health Investigation, and once the tendering (appointment of an independent investigation team) process has been completed, NHS England will inform the families and other relevant stakeholders of their decision, share and contribute to the proposed Terms of Reference and offer to meet to introduce the investigators and describe the process that they will follow, including opportunities for families to contribute.

NHS England, in collaboration with all relevant stakeholders, will:

- Agree to a single point of contact for each stakeholder
- Support the activity of the independent investigators and help them as much as possible to meet with the relevant staff and family members in as timely a manner as possible.

The independent investigators will want to:

- Meet with the victim's family to listen to their concerns and to ask them if they would like to contribute to the investigation
- Meet with the alleged perpetrator's family to listen to their concerns and to ask them if they would like to contribute to the investigation
- Meet with the alleged perpetrator if they are prepared to take part.

- Meet with Mental Health Provider senior staff and staff involved in the care of the alleged perpetrator.

It is important the independent investigators listen to the concerns of those involved and that the investigation answers the questions they may have. The independent investigators need to share their findings and discuss the proposed recommendations with all involved.

> *"We are not there to blame, or find fault, we are looking for improvements that reduce likelihood of reoccurrence and improve the quality of care. This is not about individuals."*
>
> **Independent Investigator**

24

Engaging families to support continuous learning

Mental Health Providers should offer families the opportunity to take part in evaluating the recommendations and actions that result from investigation findings.

It is important that the learning identified can be evidenced and updates on actions taken provided to those involved in the process within the agreed timescales. Families should also be updated at regular intervals until the actions are completed.

Sometimes, when people have been through this process, they might wish to volunteer to help the organisation to improve and develop. Not everyone will want to get involved in this activity, but those who do have reported that it can be fulfilling.

The experience of a family can help staff to understand the impact of incidents of this kind and help the organisation to learn. For organisational culture to change and service quality to improve it is vital that the experience of care, from all perspectives is fully understood.

"Waiting for answers can take a long time, it can seem never ending."

Victim Family Member

When involving families all standard principles of engaging and involving members of the public in health quality improvement activities apply:

- Approach involvement from the perspective of families – what will the experience of working with your organisation be like, what do they need from you?
- Reward participants for their contribution – always reimburse out of pocket expenses and wherever possible offer other incentives such as payment.
- Ensure there is clarity of purpose to the participation – this is not a "box filling exercise," be absolutely clear about what families can contribute and how you will build their insights into improvement activities.
- Consider carefully how to communicate.
- Create a space for equal partnerships between professionals and families.
- Think beyond the meeting and find a range of ways for people to participate.

Help and Support

Advocacy after Fatal Domestic Abuse

Specialises in guiding families through Inquiries including domestic homicide reviews and mental health reviews, and assists with and represent on inquests, Independent Office for Police Conduct (IOPC) inquiries and other reviews. Help and support with impartial media advice and advocacy to support with media enquiries. www.aafda.org.uk
Telephone: 07768 386 922.

Child Bereavement UK

Supports families and educates professionals when a baby or child of any age dies or is dying, or when a child or young person (up to age 25) is facing bereavement. This includes supporting adults to support a bereaved child or young person. All support is free, confidential, has no time limit, and includes face to face sessions and booked telephone support. www.childbereavementuk.org
Telephone: 0800 028 8840.

Child Death Helpline

Provides a freephone helpline for anyone affected by a child's death, from pre-birth to the death of an adult child, however recently or long ago and whatever the circumstances
of the death and uses a translation service to support those for whom English is not a first language. Volunteers who staff the helpline are all bereaved parents, although supported and trained by professionals.
www.childdeathhelpline.org.uk
Telephone: 0800 282 986/0808 800 6017

Cruse Bereavement Care

Offers free confidential support for adults and children when someone dies, by telephone, email or face-to-face.
www.cruse.org.uk.
Telephone: 0808 808 1677

Hundred Families

Offers support, information and practical advice for families bereaved by people with mental health problems, including information on health service investigations.
www.hundredfamilies.org

INQUEST

Provides free and independent advice to bereaved families on investigations, inquests and other legal processes following a death in custody and detention. This includes deaths in mental health settings. Further information is available on its website including a link to 'The INQUEST Handbook: A Guide For Bereaved Families, Friends and Advisors'.
www.inquest.org.uk
Telephone: 020 726 3111

National Survivor User Network

Is developing a network of mental health service user and survivors to strengthen user voice and campaign for improvements. It also has a useful page of links to user groups and organisations that offer counselling and support. www.nsun.org.uk

Patients Association

Provides advice, support and guidance to family members with a national helpline providing specialist information, advice and signposting. This does not include medical or legal
advice. It can also help you make a complaint to the CQC.
www.patients-association.org.uk
Telephone: 020 8423 8999.

Respond

Supports people with learning disabilities and their families and supporters to lessen the effect of trauma and abuse, through psychotherapy, advocacy and campaigning. www.respond.org.uk

Samaritans

Provide emotional support to anyone who is struggling t cope and needs someone to listen 24 hours a day.
www.samaritans.org
Telephone: 116 123.

For any queries or concerns, Mental Health Providers are asked to contact NHS England London:
england.londoninvestigations@nhs.net

Language

A number of terms and expressions, such as mental health-related homicide have been used in the document that have been chosen because they appear to be the most readily accepted at time of writing.

We have referred to the person who has died as the victim and their family are described as the family of the victim. We acknowledge that this term is exclusive and that families are all different and can be complex.

The person with a mental health condition who it is alleged to have killed the victim is referred to throughout as alleged perpetrator and their family as family of the alleged perpetrator.

We recognise that people have their own preferred language and acknowledge that some of the terms may sound impersonal, it is not our intention to offend.

This information has been produced in parallel with materials and podcasts for Mental Health Providers, available here: www.england.nhs.uk/london/our-work/mhsupport

April 2019

NHS England (London) Investigations
england.londoninvestigations@nhs.net