HS007 Incident Reporting and Investigation including Duty of Candour Policy

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Change Log

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2	References updated	S Rowden	H D'Angelo		
3	Serious incident updated Unexpected death of a child	M Clancy			

	Fishbone diagram Incident decision tree				

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HS007 Incident Reporting Procedure

1. Introduction

The incident reporting and investigation policy has been influenced by events and enquiries into failures within health and social care systems. The Francis Inquiry report was published on 6 February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust. The Inquiry identifies a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety. The report made recommendations in order to change the culture including, openness, transparency and candour throughout the healthcare system (including a statutory duty of candour).

In February 2013 Professor Sir Bruce Keogh was asked to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. A number of areas were identified as core foundations of a high quality service including understanding issues around the organisation's safety record and ability to manage these (such as compliance with safety procedures or policies, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety). Also governance and leadership how the board is assured of the performance, to ensure the organisation is safe and how it uses information to drive quality improvements.

The independent review into Southern Health Care (2015) highlighted that when someone does die unexpectedly this is identified so that the correct processes and appropriate levels of enquiry are made with a view to learning and taking preventative action in future.

The Children's Trust is committed to being an open, learning organisation from floor to Board and ensuring a full understanding of factors which have led to an incident.
The purpose of reporting and investigating is to:

- Identify risks
- Learn from incidents that have occurred
- Improve the quality of care for the children we support
- Maintain the safety of the children, families, staff, volunteers and visitors at The Children's Trust.

The detailed procedures for the management and investigation of Serious Untoward Incidents are set out within the Trust's Emergency Procedures File.

2. Purpose

To provide staff with an agreed method of reporting, investigation and management of incidents and development of action plans, where appropriate.

To ensure that each department, and The Children's Trust as a whole, has accurate information on incidents so that trends can be identified, learning from events takes place and steps taken to prevent similar incidents from occurring in the future.

Where appropriate, to support the investigation of complaints and provide evidence in pursuance of litigation claims, both for and against The Children's Trust.

The purpose of this policy is to provide guidance to ensure all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.

The principles of this document apply to all communications with children and their families when errors have been made, this applies to incidents as well as complaints.

3. Definitions

Duty of Candour

A contractual duty requiring The Children's Trust to ensure that children/families are informed of errors causing moderate, severe harm or death. The child and family must also be provided with support. This includes receiving an apology, as appropriate, and the investigations findings and actions to prevent recurrence are shared.

Being Open

Being open refers to the process for communicating adverse events. It is a process of actions and behaviours that are determined by the Ten Principles of Being Open which can be found in Appendix 1.
Organisations are said to be 'open' when the prevailing culture visibly encourages key behaviours. These include honesty, openness, appropriate sharing of information and a willingness to learn from experience to change how the organisation functions.

Serious Incidents

A Serious Incident requiring investigation is defined as an accident or omission incident that occurred in relation to NHS funded services and care. 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.

The occurrence of a serious incident demonstrates weaknesses in a system or process that needs to be addressed to prevent future incidents leading to avoidable death or serious harm to children or staff, future incidents of abuse or future reputational damage to the organisation involved.

There is no definitive list of incidents that constitutes a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. The definitions below set out circumstances when a serious incident must be declared:

- Unexpected or unavoidable 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 – including those where the injury required treatment to prevent death or serious harm, abuse, Never events, incidents that prevent (or threaten to prevent) and organisations ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in loss of confidence in healthcare services.
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of a 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 or organisation 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, safeguarding Audit Review, safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused / contributed towards the incident.(Serious Incident Framework, NHS England Patient Safety Domain March 2015).

- A Never Event
- An incident or series of incidents that prevents or threatens to prevent, an organisations ability to continue to deliver and acceptable quality of healthcare services, including but not limited to the following;
  - Failures in security, integrity, accuracy or availability of information often described as data loss or information governance related issues
  - Property damage
  - Security breach/concern
  - Inappropriate enforcement of care under the Mental Health Act (1983), Mental Capacity Act (2015) including Deprivation of Liberty
  - Systemic failure to provide acceptable safe standards of care
  - Activation of a Major Incident Plan
- Major loss of confidence in a service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

It may be appropriate for a ‘near miss’ to be classed as a serious incident because the outcome of the incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether it should be classified as a serious incident should be based upon an assessment of:
The likelihood of the incident occurring again if processes remain unchanged
The potential or harm to children, staff or the organisation should the incident occur again

This does not mean the ‘near miss’ should be reported as a serious incident, but the process should be used to understand and mitigate that risk.

The needs of those affected should be the primary concern of those involved in the response to the investigation of serious incidents. Children and their families must be involved and supported throughout the investigation process.

Investigations under this Framework are not conducted to hold any individual or organisation to account, as there are other procedures for this purpose such as; criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation such as the Care Quality Commission, Nursing and Midwifery Council, Health and Care Professionals Council and General Medical Council. Investigations should link to these other processes where appropriate.

Serious incidents must be declared internally as soon as possible and immediate action must be taken to establish facts, ensure the safety of children, other service users and staff, and to secure all relevant evidence to support further investigation. The child and their family should be informed as soon as possible. The commissioner must be informed in writing or verbally within 2 working days of it being discovered. Regulatory bodies must be informed such as Ofsted within 24 hours and CQC without delay by the Registered Manager or Responsible Individual in their absence. Other partners such as the police or local authority should be informed as required.

The recognised system for conducting investigations is Root Cause Analysis and this should be applied to serious incidents.

Any non-contributory issues identified during the course of an investigation may also require further investigation and recommendations.

Serious incidents should be closed by the relevant commissioner when they are satisfied that the investigation report and action plan meets the required standard. Incidents can be closed before the actions are complete but there must be mechanisms in place for on-going monitoring and implementation. This ensures that lessons can be learnt to prevent similar incidents recurring.

National Never Events

Never Events are a particular type of serious incident that meets all of the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at national level, and should have been implemented by all healthcare providers.
- Each Never Event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

- There is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
- Occurrence of a Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.
- It is anticipated the Never Event list will be reviewed annually by NHS England.

(Revised Never Events Policy Framework, NHS England Patient Safety Domain March 2015).

Near miss
"An event not causing harm, but has the potential to cause injury or ill health", [Health & Safety Executive (HSE) October 2016].

Accident / Incident
"An event that results in injury or ill health", [HSE October 2016].

Medication incident
The National Reporting and Learning Systems (NRLS) defines a 'patient safety incident' (PSI) as, 'any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care'.

Medication errors are any PSIs where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose.
[NHS England March 2014].

Child Behavioural Incident
Challenging behaviour is defined as "Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson, 2001): Challenging Behaviour: Analysis and intervention in people with learning disabilities. Cambridge University Press 'Challenging behaviour' is how we talk about a range of behaviours which some people with severe learning disabilities may display to get needs met.

4. Emergency Procedures

In the event of the incidents below, refer to the Children's Trust Emergency Procedures File for appropriate action.

Procedure & Protocols Following a Serious Untoward Incident involving a Child / Young adult

- M4 Medical Emergency – Child stops breathing / cardiac arrest / sudden unexpected death
- A2 Accident involving serious illness / major injuries for a child
- C5 Child missing / absconding
- S1 Safeguarding – reporting concerns about children.

Procedures involving staff, volunteers / visitors

- A1 Accidents involving serious / major injuries or fatality
- M2 Emergency Medical Incident: potential occupational blood borne virus exposure
- O1 Off site emergencies involving threatening incidents or mugging.

5. Duty of Candour/Being Open Grading of Response

'*Being Open'* begins with the detection of an event. The response should be guided by the level of severity of the event. It is the view of The Children's Trust that it is expected that the child and individual with parental responsibility, is informed of any harm arising as a result of an incident or the potential for harm following a near miss. For this reason, it is a mandatory field in the online incident reporting system.

Staff are encouraged to apologise when things go wrong, offering sympathy and demonstrate a caring attitude. An apology is not an admission of liability. The Duty of Candour Policy does not require prevented patient safety incidents to be reported to parents/relatives. The decision of whether to communicate these to parents/children depends on local circumstances and advice can be sought from a line manager if there is concern. Low harm incidents should always be reported to the child and/or parents.

The Duty of Candour will apply to moderate, severe harm or death incidents.

All communications with parents should have the underlying principle of being in partnership, based on respect. It is most important that communication with the family is open, honest, comprehensive and timely and maintained over the being open process and not delayed due to investigations etc. It is paramount that communication of moderate, severe harm or death incidents occurs as soon as possible with parents as part of the Duty of Candour.

As part of the Duty of Candour process, records must be made of all conversations, whether face to face, by telephone or letter in the child's records. Complaint investigations are recorded separately in the complaint file, not in child's records. This is to avoid discrimination against families.

Although the Duty of Candour applies to health care and patient safety the definitions can be applied to all incident severities.

Grade of incident	National Patient Safety Definition	Actions
No harm (including prevented safety incident/near miss)	Incident prevented that had potential to cause harm but was prevented and no harm caused. Incident not prevented and occurred but no harm was caused.	Children/parents are not usually contacted or involved in investigations and these types of incidents are outside the scope of Duty of Candour. It is decided locally whether 'no harm' events (including prevented patient safety incidents) are discussed with parents, their families and carers, depending on local circumstances and what is in the best interest of the child.
Low harm	Any safety incident that required extra observation or minor treatment and caused minimal harm. Minor treatment is first aid, additional therapy or additional medication.	Unless there are specific indications or the parent requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local level with the participation of those directly involved in the event. Reporting to the Clinical Governance team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication should take the form of an open discussion between the staff.

		Low incidents are outside the scope of Duty of Candour but staff should apply the principles of being open.
Moderate harm	Any safety incident that results in a moderate increase in treatment and / or caused significant but not permanent harm Moderate harm may also be caused by negligent acts or omissions. Moderate increase in treatment is transfer to hospital as in an inpatient or outpatient or prolonged episode of additional care	A higher level of response is required in these circumstances. The Head of Nursing & Care should be notified immediately and be available to provide support and advice during the *Being Open* process. Once the level of harm is validated to be moderate or higher, the 'Being Open' process should be applied. **Apply the Duty of Candour process**
Severe, significant harm or death	Any safety incident that directly results in death. Serious harm to one or more children, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure; allegations of abuse; adverse media coverage or public concern about the organisation	A higher risk of response is required in these circumstances. The Head of Nursing & Care and the Director of Clinical Services should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the Duty of Candour process**

	One of the core set of 'Never Events' outlined by the NPSA	

6. The Children's Trust Incident Reporting Arrangements

An electronic Incident Report Form must be accurately completed and submitted for all incidents via the electronic Incident & Risk Assessment Reporting system (IRAR). This should be completed as soon as possible (within 24 hours) following the incident. Where electronic access is not possible, a hard copy may be completed for entering at a later date onto IRAR – Appendix 8.

The incident should be risk rated and the severity of the incident identified and recorded on IRAR in order to determine the level of investigation required.

On successful submission of the electronic form, a unique incident number will be generated.

7. Duty of Candour Process

Process for acknowledge, apologising and explaining when things go wrong

See Appendix 2 Duty of Candour Flow Diagram.
The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply the 'duty of candour'' approach.

This can be identified by any of the following mechanisms:

- Via staff at the time of the incident
- Via staff retrospectively
- By child/ family/ carer raising a concern, either at the time, or via a complaint or claim in retrospect
- Via the incident reporting system
- Via other sources, such as the incident being highlighted by another child, visitor or non – clinical staff

Where necessary immediate clinical care should be given to prevent further harm.

Initial discussion

Following identification of an incident, a preliminary team discussion should be undertaken to establish; as soon as possible to the incident, once the child is safe

- Basic clinical facts
- Assessment of the incident and determine level of immediate response required
- Individual responsible for discussing / liaising with child/ relative/ carer
- Whether child/family support is required
- Immediate support required for staff involved
- A clear communication plan

- Is it a safeguarding incident? If yes, refer to the safeguarding policy before informing parents

Identifying who should be responsible
In determining who will be responsible for communicating with the child/ family carers the individual should:

- Have a good relationship with the child and / or their parents
- Have a good understanding of the relevant facts
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to the child, parents and colleagues
- Have excellent interpersonal skills, including being able to communicate with children and / or their parents in a way they can understand
- Be willing and able to offer an apology, reassurance and feedback to the child and /or their parents.
- Be able to maintain a relationship with the child and / or their parents and to provide continued support and information
- Be culturally aware and informed about specific needs of the child or their parents

When should the initial discussion be held?
The initial Duty of Candour discussion with the child and / or their carers should occur as soon as possible after recognition of the incident. Delay in disclosure should be avoided whenever possible. If the incident occurs out of hours it may be necessary to wait until a senior member of the team is available to contact the parents. The communication can occur by any appropriate means – fact to face is best, but it can be a telephone call or e-mail to those parents who prefer this method of communication.

Initially, it is worth noting that something has gone wrong but that the cause is not yet known. It must be communicated to the child and their family/ carers that we will be taking the event extremely seriously, that the event will be investigated and that the findings of the investigations will be shared with them.

This initial communication must be recorded in the child's records with a heading 'Duty of Candour Meeting'. Date, time and people present or taking part in the phone call. Outline the apology, what was discussed, concerns raised by the family and arrangements for future communications and support.

An offer to meet should be made to the family, this is usually at the end of the investigation so the findings can be shared and discussed, but may also occur before the investigation starts or during the process. The approach is agreed with the family and this may change at any stage during the investigation.

Factors to consider when timing this discussion include:

- Some families may require more than one meeting to ensure that all the information has been communicated to and understood by them.

- Availability of key staff involved in the incident and in the Duty of Candour process.
- Availability of the child's family and / or carers
- Availability of support staff, for example a translator or independent advocate, if required
- Arranging the meeting in a sensitive location.

Written information regarding the content of this meeting must be given to the family.

Provision of additional support

Support of the child, their family/ carers
Children, their family/ carer should be provided with support as is necessary during the process of Duty of Candour. At any face to face meeting, they should be encouraged to be accompanied by another family member/ friend/ representative. Where appropriate, an independent advocate or interpreter should be offered.

Where the child/young person is assessed not to have capacity
Where the child/young person has a formal assessment or lack of capacity, the principles of 'Being Open' still apply. In circumstances where the child/young person has a registered person with Lasting Power of Attorney (LPA), it may be a legal requirement that they are informed (dependent on the terms of the LPA). If there is no LPA for the, child/young person it is best practice that the family and or carers for the child/young person are informed of the incident. The occurrence of this conversation and the grounds for it must be recorded in the child/young person's medical records.

Professional support
It can be very traumatic for staff to be involved in an event. The Children's Trust are committed to ensuring that staff feel supported through the Duty of Candour process. Staff are also encouraged to seek support from their relevant professional body.

Additional, confidential support is available to staff from
- Occupational Health
- People Team
- Workplace Options
- Staff are encouraged, if appropriate to seek advice from their trade union representative.

Risk management and system improvement
The Children's Trust supports the root cause analysis (RCA) approach to looking at the cause of child safety incidents.

Multiprofessional responsibility
The Children's Trust acknowledges that care is delivered through multi professional teams and the investigation into child's safety incident/ complaint or claim is focused on

systems and process, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process.

Confidentiality
Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the child, parents and staff involved.

It is good practice to inform the child, their family and carers about who will be involved in the investigation, and give them the opportunity to raise any objections. Communication outside the clinical team should be strictly on a 'need to know basis'. Equally the relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

Continuity of care
Children/families have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to.

Requirements for documenting all communication
All discussions and communication with the child, their family or carers should be carefully detailed within the care file.

Where it occurs as the result of a child safety incident, this will be recorded within the investigation report.

Process for encouraging open communication between organisations, teams, staff, patients/carers.
'Being Open – a duty to be candid' forms part of education programmes. These encourage staff to 'be open' with children, their relatives and carers, and make explicit their requirement to do so.
Where the incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by The Children's Trust or the other agency, there is an obligation to fully co–operate with them and to communicate collaboratively with them.

Procedure for conducting different levels of investigations
The Children's Trust have an identified group of senior staff who are trained as investigating managers. At least one member of the investigation team must be trained in root cause analysis.

At the onset of the investigation a team must be established. The number of staff on the team will be determined on a case by case basis but, as a minimum should include;

- Investigation manager
- Medical and/or nursing lead
- Social worker, to provide child/family support
- For severe incidents the Director of Clinical Services/ Medical Director

The investigating manager will be appointed by the Head of Nursing & Care or the Children's Trust School Head Teacher, dependent upon the nature of the incident.
The investigating manager can be from the clinical area where the incident occurred, but they must be independent of the incident and not involved in the team where the care was provided.

Appendix 3 outlines the time frames in relation to categories of incident.

Appendix 4 outlines the Investigation Process. This process will also apply to those incidents which do not fall under the Duty of Candour.

Unexpected Child Death

An unexpected death is defined as a death which was not anticipated as a significant possibility 24 hours before the death occurred, or where there was a similarly unexpected collapse, leading to or precipitating the events which led to death (Surrey Safeguarding Board 2016).

The resuscitation procedure must be followed until death can be confirmed by a doctor, during working hours by The Children's Trust medical team, out of hours dial 999 for an emergency ambulance who will continue resuscitation until hospital.

If there is an unexpected child death and the child has not been transferred to hospital the team must ensure the following is carried out:

For unexpected deaths or for young people subject to a Deprivation of Liberty Order, the coroner must be informed by the doctor.

The police must be informed by the medical team or shift leader dial 101.

Contact the Head of Nursing & Care or the On call Clinical Manager out of hours for advice.

Ensure the environment and equipment around the child remains undisturbed as much as possible until the Coroner's Office advise it is safe to remove.

Staff involved in the unexpected death should document in the child's notes prior to photocopying for the Coroner's Office.

Photocopy all documentation to send to the Coroner's Office, do not send original copies unless requested.

Any equipment which could have been involved in the child's death should be stored and not used until the Coroner/Police have indicated it can be put into use or destroyed

The Child Death Overview Panel (CDOP) must be notified by the medical team within 24 hours of a child's death. As soon as a professional becomes aware of a child death they should notify the Surrey Single Point of Contact by completing and returning a Form A Notification of Child Death and a Form B Agency Report on the Surrey Safeguarding Children's Board website
http://www.surreyscb.org.uk/professionals/guidance-protocols/child-deaths/

Single Point of Contact
CDOP Coordinator cdop@surreycc.gcsx.gov.uk Tel: 01372 833319

Staff involved should prepare statements as soon as possible in order to give a contemporaneous record of events

A serious incident should be declared and the investigatory process begin as soon as possible

Process for learning from Investigations

- *No harm or low harm incidents*

Reflection can be undertaken by the manager or supervisor, as appropriate to facilitate the learning process.
The reflection will then be uploaded on the IRAR system. And the learning points cascaded through teams via the team meeting system, clinical governance and health & safety forums.

- *Moderate/Severe incidents*

A summary of all moderate/severe clinical incidents will be presented to the Clinical Governance & Safeguarding Committee for review. Incidents relating to education will be presented to the Education Governance Committee. Health and Safety and any other incidents will be presented to the Finance and General Purposes Committee. The action plans from the investigations will be overseen by the committee to ensure they are completed within the agreed time frame. The Board receives minutes from Clinical Governance & Safeguarding Committee, Finance & General Purposes and the Education Governance Committee and Key Performance Indicators detailing numbers of incidents including those which cause moderate to severe harm.

- Non-contributory issues

Any non-contributory issues identified during the course of an investigation may also require further investigation and recommendations.

The Operational Leadership Team meeting will discuss themes from incidents and identify organisational learning. Recommendations will be made and an action plan implemented which will be monitored via the Health & Safety Committee which will feed into the Finance & General Purposes Committee.

The learning from these incidents will be cascaded via newsletters, managers' meetings and team meetings. Key learning themes are made anonymous and used within the

training. The Clinical Education and Training Team will regularly explore these incidents in scenarios and case studies in mandatory, clinical and developmental training.

Policies, procedures and guidelines are regularly reviewed and updated to include the learning from incidents and complaints.

8. Monitoring of Incidents

The Children's Trust Board review all moderate and severe incidents on a 3 monthly basis.

Clinical Governance Committee (sub-committee of the Board)
Every 3 months reports on incidents involving the children are prepared by the Head of Nursing & Care and reported to the Clinical Governance Committee. These define statistics and trends and are elaborated by a specific report on medication incidents.

The Children's Trust School Head Teacher reports on all incidents logged by the school to the Governing Body who meet each term and to the Clinical Governance Committee.

Independent Visitor
The Trust's Independent Visitor who attends to meet the requirements of Regulation 44 of the Children's Home Regulation 2015, reviews the incident reports within The Children's Trust Houses and includes the findings in the monthly report. A copy of the report is kept on file for the Ofsted inspectors and circulated to the Board of Governors.

Finance and General Purposes Committee
Health and Safety and other incidents of moderate severity and above which are non-clinical or education related will be presented to the Finance and General Purposes Committee in order to monitor and ensure implementation of any action plans.

9. Disciplinary Action

The Children's Trust encourages open and honest reporting. Prior to initiating an investigation the manager will consult the Incident Decision Tree flow chart to determine whether a root cause analysis or disciplinary investigation should commence. Members of staff involved in the incident must be informed as to whether a disciplinary or root cause investigation is being undertaken. In instances where a root cause analysis investigation has commenced and it becomes clear that there may be a disciplinary case to answer, the investigation can continue but the member/s of staff must be informed that the matter will be dealt with in accordance with the Children's Trust Disciplinary policy and procedures.

10. Notifications

The following notifications are required by law to be reported to the Care Quality Commission/Ofsted via the Registered Manager,

- Death of a child/young person – that occurred whilst services were being provided. In The Children's Trust School, all deaths must be reported to the minister of education. Refer to the Children's Trust End of Life Policy, CS016.

- Any abuse or allegation of abuse – abuse in relation to the child/young person means sexual abuse, physical or psychological ill treatment; theft, misuse or misappropriation of money or property; or neglect and acts of omission which cause harm or place at risk of harm. Refer to the Children's Trust Safeguarding Policy, CS003.

- Events that stop or may stop the service from running safely and properly – a level of staff absence or vacancy, or damage to the service's premises that mean that people's assessed needs cannot be met; the failure of a utility for more than 24 hours; the failure of fire alarms, call systems or other safety-related equipment for more than 24 hours; and other circumstances or events that mean the service cannot, or may not be able to meet service user assessed needs safely.

- Serious injuries to people who use the service which include: injuries that lead to or are likely to lead to permanent damage or damage that lasts or is likely to last more than 28 days; injuries or events leading to psychological harm.

- Where there is any incident relating to a child which the Registered Manager considers to be serious.

These notifications identify the person they are about, by the use of initials only.

Medicines and Healthcare Products Regulatory Agency (MHRA)

Any incident relating to medical equipment should be notified formally to the MHRA using the relevant form supplied by that office.

Managers in those areas affected can report directly to the MHRA at the following address:

Manager
Medicines and Healthcare Products Regulatory Agency
151 Buckingham Palace Road
Victoria
London
SW1 9SZ.
Tel: 020 3080 6000.
Email: info@mhra.gsi.gov.uk.

Incidents relating to adverse drug reactions are reportable on the yellow forms in the British National Formulary (BNF). Reporting can be done electronically via www.yellowcard.gov.uk.

Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR 2013)

Under RIDDOR, we have a duty to make reports to the Incident Centre.

The following work-related incidents are reportable:

- Work-related deaths
- Work-related accidents which cause certain specified serious injuries or which result in a worker being incapacitated for more than 7 consecutive days
- Certain dangerous occurrences (near miss accidents)
- Over 7 day injuries to workers
- Injuries to a person who is not at work, such as a member of the public, which are caused by an accident at work and which result in the person being taken to hospital from the site for treatment.

The timeframes for reporting are:

- Death, dangerous occurrence or specified injury – immediately by the quickest and most practical means with online submission within 10 days
- Reports of over 7 day injuries - online submission within 15 days.

Certain occupational diseases, where these are likely to have been caused or made worse by work must also be reported as soon as these are known to us.

Guidance, including timeframes for reporting, can be found on The Loop under Health & Safety/Emergencies/Reportable Incidents.

The Incident Manager will, on receipt of a reportable Incident Report, identify the manager responsible for the Riddor investigation and follow up actions, then monitor and record the progress and results of the investigation. The RIDDOR Investigation Form on IRAR must be completed [Appendix 7].

The Health & Safety Manager is responsible for completing online RIDDOR submissions, and informing the Director of Finance / Senior Accountant.

Police

Apparent criminal incidents will, by their nature, be reported to the police. These may include assaults, actual or threat, theft, vandalism, suspicious activity or unexpected deaths.

Section 47 Safeguarding investigations may also be led by the police as deemed appropriate.

An electronic incident form must be completed for all above incidents.

Local Authority Social Workers
The child's local authority social worker will be informed of incidents under the Duty of Candour policy of moderate and report to the LADO.

Commissioners
The child's commissioner will receive anonymised investigation reports of incidents under the Duty of Candour Policy of moderate and above

11. Monitoring and Audit

This policy will be monitored by the following indicators:
All moderate and serious clinical incidents will have Duty of Candour disclosures and offers of Duty of Candour meetings.
Any difficulties will be raised at the monthly Clinical Governance meetings or Health & Safety Committee Meetings.

This process will be overseen by the Clinical Governance Committee reporting to the Board of Trustees.

12. Review

This policy will be reviewed at intervals not exceeding 3 years, or more frequently if there is significant change.

HS007 Incident Reporting and Investigation including Duty of Candour

References / Recommended Reading	Date
Serious Incident Framework, NHS England	**March 2015**
National Patient Safety Agency Being open Gateway reference 13015	**November 2009**
Revised Never Events Policy & Framework, NHS England	**March 2015**
The Children's Home Regulations	**March 2015**
The Health & Social Care Act	**2008**
CQC Guidance for providers on meeting the regulations, Regulation 20 Duty of Candour	**2014**
HSE INDG453 Reporting accidents and incidents at work, A brief guide to RIDDOR 2013	**October 2013**
Health & Safety Executive, www.hse.gov.uk	
NHS Improvement A just culture guide	**March 2018**

Appendix 1

The Ten Principles of Being Open (National Patient Safety Agency)

Being open is a process rather than a one-off event.

1 *Principle of acknowledgement*
All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the child and/or their parents inform staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all staff. Denial of concerns will make future open and honest communication more difficult.

2 *Principle of truthfulness, timeliness and clarity of communication*
Information about an incident must be given to children and/or their parents in a truthful and open manner by an appropriately nominated person. Parents want a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.

Communication should also be timely: children and/or their parents should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident investigation is undertaken, and children and/or their parents should be kept up-to-date with the progress of an investigation.

Children and/or their parents should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and using medical jargon which they may not understand should be avoided.

3 *Principle of apology*
Children and/or their parents should receive a sincere expression of sorrow or regret for the harm that has resulted from an incident. This should be in the form of an appropriately worded and agreed manner of apology, as early as possible. Both verbal and written apologies should be given. Based on local circumstances, it should be decided who is the most appropriate member of staff to issue these apologies to children and/or their parents. The decision should consider seniority, relationship to the child, and experience and expertise in the type of incident that has occurred. Verbal apologies are essential because they allow face-to-face contact between the child and/or their parents and the team. This should be given as soon as staff are aware an incident has occurred. It is important not to delay for any reason, including: setting up a more formal multidisciplinary ‘Being open’ discussion with the child and/or their parents; fear and apprehension; or lack of staff availability. Delays are likely to increase the child’s and/or their parent’s sense of anxiety, anger or frustration.

A written apology, which clearly states The Children's Trust is sorry for the suffering and distress resulting from the incident, must also be given.

4 *Principle of recognising child and parent expectations*
Children and/or their parents can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face-to-face meeting with representatives from the organisation. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Children and/or their parents should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a child requiring additional support, such as an independent patient advocate on a translator.

5 *Principle of professional support*
The Children's Trust must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report incidents. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

To ensure a robust and consistent approach to incident investigation, organisations are advised to use the NPSA's Incident Decision Tree (IDT). The IDT has been developed as an aid to improve the consistency of decision making about whether human error or systems failures contributed to an incident. It is designed for use by anyone who has the authority to exclude a member of staff from work following a patient safety incident. More details can be found in Seven Steps to Patient Safety and on the NPSA website: www.npsa.nhs.uk

Where there is reason for the organisation to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve its position, and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation.

Organisations should also encourage staff to seek support from relevant professional bodies such as the General Medical Council, Royal Colleges, the Medical Protection Society, the Medical Defence Union and the Nursing and Midwifery Council.
6 *Principle of risk management and systems improvement*

Root Cause Analysis (RCA), Significant Event Audit (SEA) or similar techniques should be used to uncover the underlying causes of an incident. Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness. Every organisation's Being Open policy should be integrated into local incident reporting and risk management policies and processes. Being open is one part of an integrated approach to improving patient safety following a patient safety incident. It should be embedded in an overarching approach to risk management that includes local and national incident reporting, analysis of incidents using RCA or SEA, decision making

about staff accountability using the IDT and an organisational approach that follows Seven Steps to Patient Safety.

7 *Principle of multidisciplinary responsibility*
Any local policy on openness should apply to all staff who have key roles in the child's care. Most healthcare provision involves multidisciplinary teams and communication with children and/or their parents following an incident that led to harm, should reflect this. This will ensure that the Being Open process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual. To ensure multidisciplinary involvement in the Being Open process, it is important to identify clinical, nursing and managerial opinion leaders who will champion it. Both senior managers and senior clinicians who are local opinion leaders must participate in incident investigation and clinical risk management.

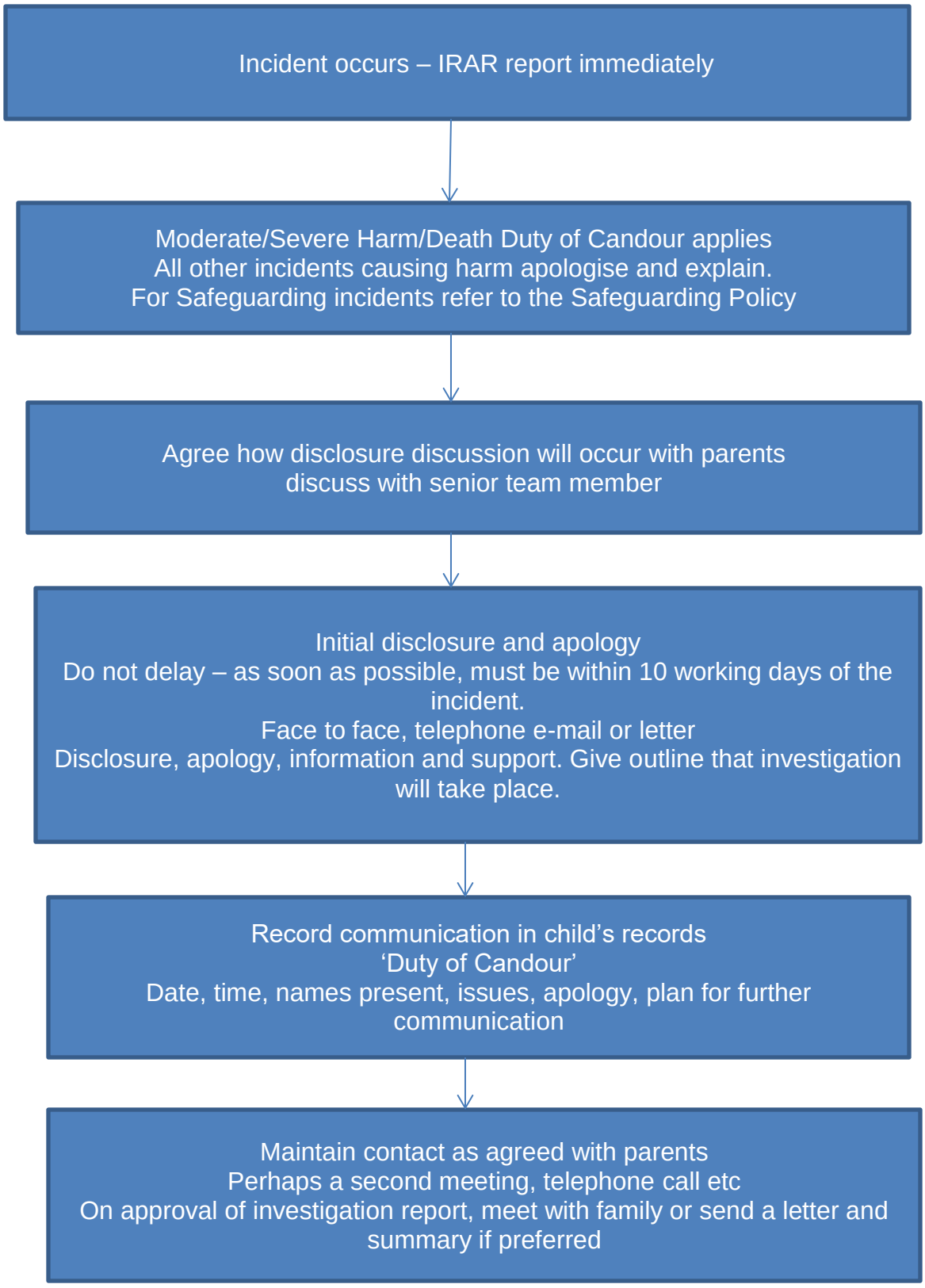
8 *Principle of clinical governance*
Being open requires the support of patient safety and quality improvement processes through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff workers so that they can learn from incidents. Continuous learning programmes and audits should be developed that allow organisations to learn from the child or families experience of Being open and monitor the implementation and effects of changes in practice following an incident.

9 *Principle of confidentiality*
Policies and procedures for being open should give full consideration of, and respect for, the child's and/or their parents and staff privacy and confidentiality. Details of an incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved with the patient. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the child and/or their parents about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

10 *Principle of continuity of care*
Children are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a child expresses a preference for their needs to be taken over by another team, the appropriate arrangements should be made for them to be moved or feel confident with the team caring for them.

Appendix 2

Duty of Candour Flow Diagram



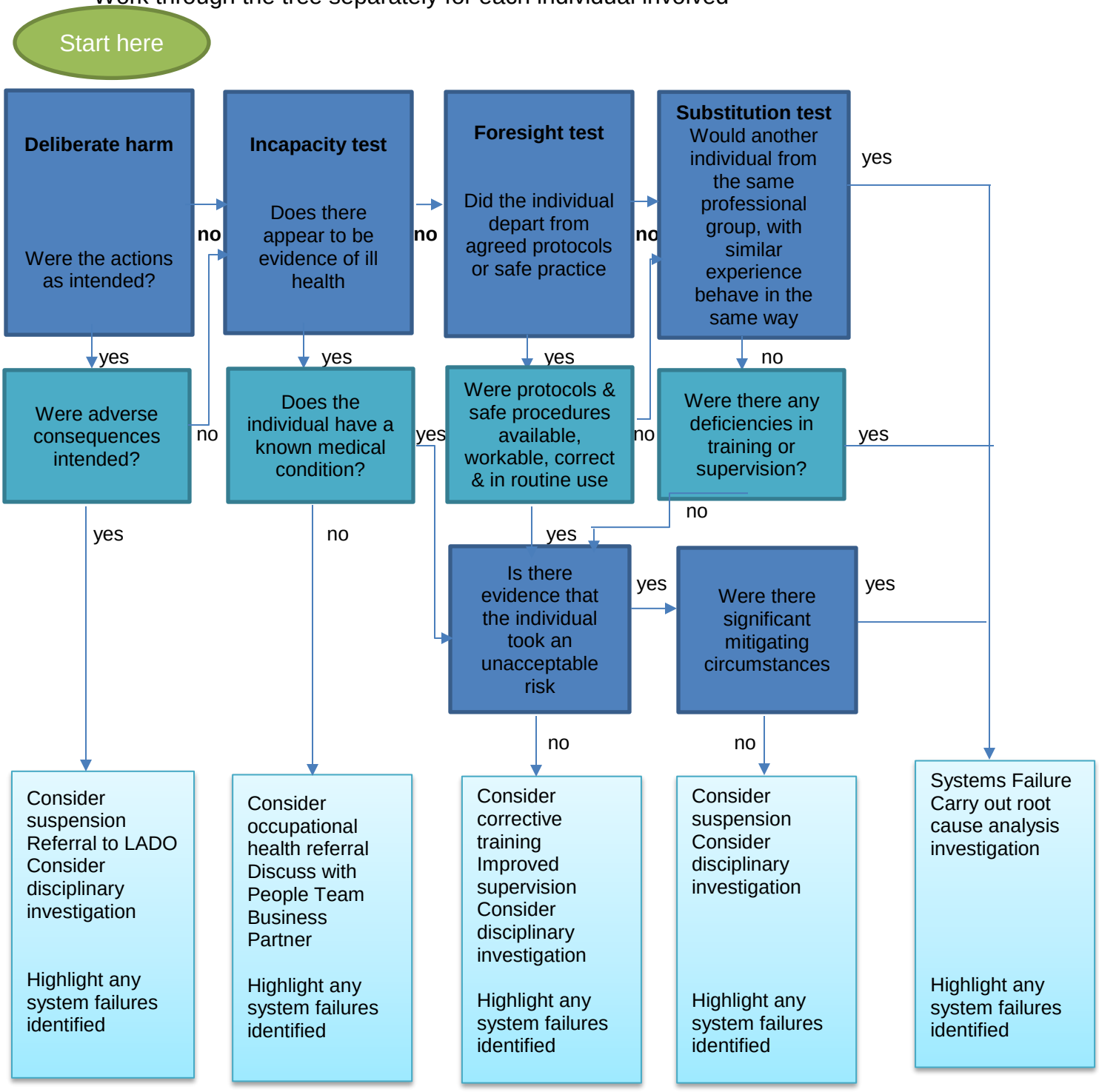
Appendix 3

Duty of Candour Time Scales

	Requirement under Duty of Candour	Responsible Person	Timeframe
1	Child or their family must be informed that a suspected or actual incident has occurred (moderate, severe harm or death)	Shift Leader, lead therapist or consultant responsible for the episode during which the incident occurred. Head of Nursing & Care should be made aware	Within 24 hours (or next working day if senior support is required)
2	Initial notification of incident should be verbal (face to face where possible) unless family decline notification or would prefer e-mail contact. Sincere expression of apology must be provided verbally. This must be recorded	Head of House, Nurse Manager, Professional Therapy Lead or Consultant responsible for the episode when the incident occurred	Maximum of 10 working days
3	Offer of written notification. Including sincere apology must be provided in writing. Whether declined or accepted this must be recorded.	Head of Nursing & Care, Head of Therapy & Research, Consultant	Maximum 10 working days from incident being reported on IRAR
4	Step by step explanation of the facts (in plain language) must be offered. This may just be an initial view, pending investigation	As above	As soon as practicable
5	Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded	As above	No time frame prescribed but documentation must be contemporaneous
6	Emerging information (whether during or after investigation) must be offered	As above	As soon as practicable
7	Investigation process	Appointed investigating officer	Completed within 28 days
8	Share incident investigation report (including action plans). Ensure they are written in plain language.	As above (all investigations are reviewed by the Director of Clinical Services or the Medical Director)	Within 10 working days of the report being signed off as complete and incident closed
9	Provide copies of any anonymised information shared with the parents	Head of Nursing & Care to co-ordinate	As required

Appendix 4
The incident decision tree flow chart

Work through the tree separately for each individual involved



Based upon James Person's culpability model

Appendix 5

Investigation Process

A root cause analysis approach will be used for investigations. This is a structured investigation process which utilises tools and techniques to identify the true causes of an incident or problem, by understanding what, why and how a system failed. Analysis of system failures and true causes enables targeted and, where possible, failsafe actions to be developed and implemented which demonstrate significantly reduced likelihood of recurrence.

Independent investigations – Must be Commissioned or Conducted by those independent to the organisation, for incidents of high public interest or attracting media attention.

RIDDOR Investigations must be carried out using the RIDDOR Investigation Form, which is completed by the Line Manager, with the support of the Health & Safety Manager. (Appendix 7)

Investigation Management

Investigations should take a maximum of 28 days
Fact find – 60% of time spent gathering data
Analysis – Only once all the facts have been gathered
Conclusion – Develop targeted failsafe solutions/recommendations

Gather Documentation

Incident report
Health records
Guidelines, policies and procedures
List of key staff involved, staff rotas
Training and supervision records
Medical equipment maintenance records

How to retrieve information from people

Review entries in records
Conduct interviews
Request statements

Equipment

Check any equipment which may have been involved

Timelines

Draft a standard timeline

Identify Care or Service Delivery Problems

Only once the data has been gathered can you begin to identify problems:

What are care or service delivery problems?
Every point where something happened that shouldn't have
Or
Something that should have happened didn't

Care Delivery Problem
Problems that arise in the process of care or therapy, usually actions or omissions by staff

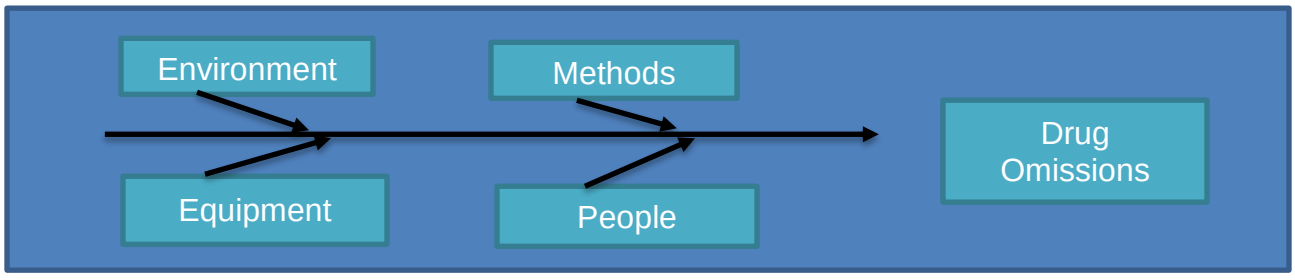
Service Delivery Problem
Acts or omissions identified during the analysis of the incident, but not associated with direct care provision

Cause and effect (fishbone)
Cause and effect analysis helps you to think through the causes of the problem, including possible root causes, before you start to think through a solution – not just symptoms. By identifying all possible causes and not just the most obvious, you can work towards removing the problem. Working through cause and effect analysis enable those involved to gain insight into the problem, develop possible solutions and create a snapshot of the team's collective knowledge.

Use this tool when you are trying to determine why a problem is occurring. It will help the investigator to fully understand the issues and identify all possible causes not just the obvious one.

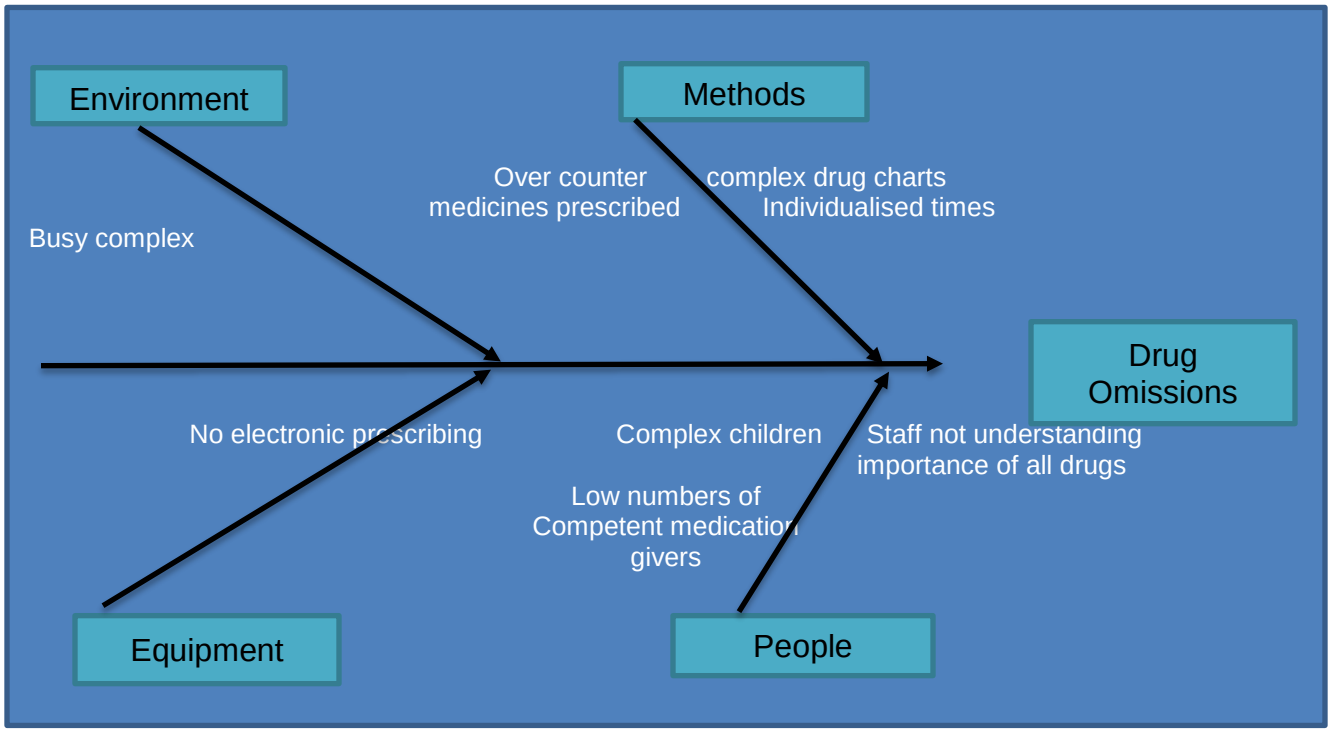
For example
Identify the problem

Identify the major factors, draw four or more branches off the large arrow to represent main categories of potential causes and label each line. Categories could include: Equipment, environment, procedures and people. Make sure the categories are relevant to the particular problem.



Take each of the main categories and think of possible factors contributing to the problem. Explore each one to identify more specific causes of causes, adding and

labelling more lines off the spine. Continue to branch off until every possible cause has been identified. Complex causes may need to be broken down in to sub-causes. Show these as lines coming off each cause line.
Analyse your diagram. By this stage the diagram should show all the possible causes of your problem. Depending upon complexity and importance it should be possible to investigate the most likely cause further.



Find the root cause
The root cause is the fundamental contributory factor. The one which had the greatest impact on the system failure. One which if resolved will minimise the likelihood of recurrence both locally and across the organisation.

Find the lessons learned
Sometimes investigations show no root causes. However the investigation may still identify

Primary influencing factors
Variations to acceptable practice which had a bearing on but did not cause the incident
Significant unrelated safety issues
The investigation may still identify unrelated issues for action or research

Appendix 6 Root Cause Analysis Investigation Report

The Children's Trust
For children with brain injury

IRAR Number:
Version:
Incident Date:
Duty of Candour Timelines & Actions
• Serious incidents must be declared internally as soon as possible and immediate action must be taken to establish facts, ensure the safety of children, other service users and staff, and to secure all relevant evidence to support further investigation. • The child and their family should be informed as soon as possible. • The commissioner must be informed in writing or verbally within 2 working days of it being discovered. • Regulatory bodies must be informed such as Ofsted within 24 hours and CQC without delay by the Registered Manager or Responsible Individual in their absence. • Other partners such as the police or local authority should be informed as required.
Date incident declared and details of actions taken:
Date child and their family should be informed:
Date Commissioner informed – note if informed verbally or in writing:
Date Ofsted informed:
Date CQC informed:
Date police or other partners informed and details of who has been informed:
Incident Description and Consequences
Detection of incident:
Incident Description:

Incident Type:
Actual effect on child/person or other (property, reputation):
Severity of the incident:
Involvement and Support of child and parents/staff/visitors
Date child/family informed:
Duty of Candour: Involvement and support of patient and relatives
Involvement and support provided for staff involved:
Findings:
Care and/or service delivery problems
Contributory Factors
Non-contributory Factors
Root cause

Lessons learned
Conclusions:
Recommendations:
Arrangements for shared learning:
Author and job title:
Report date:
Checked by:

Chronology (timeline) of events	
Date and time	Event

Name of affected person			Incident No	Date of incident	Investigation closed date
Outline of incident					
Number	Recommendation	Actions progress/ comments	Deadline Date	Actions completed	Lead

Appendix 7

RIDDOR Accident Investigation Form

Name [of injured person]: **Date** [of accident]:

Location [of accident]:

Activity

What was the task being carried out at the time of the accident?
Was the task part of the person's normal job?
Was the person authorised to do the task, or be in the area?
Was the task being carried out on normal time or overtime?
Was there any breach in the procedures laid down?
Who was the first person at the scene?
Was the accident reported immediately? If at a later date / time, please specify.

Statements

Were there any eye witnesses? [Attach statement]
Were there any employees in the immediate vicinity? [Attach statements]
Did anyone find the injured person? [Attach statements]

Location / Equipment

Have any defective tools / equipment been involved? Specify details.
Are there any defective environmental issues [such as poor lighting, uneven floors, bad weather etc.]? Specify details.
Have any chemicals been involved? Note type & amount.
Have any other factors contributed to the incident? Specify details.
Have photos been taken of the place where the accident happened and of any equipment involved? Take relevant photos & please log at what stage photos were / are being taken.
Has the area been made safe? [Specify details].

Documentation

Are there training records to show the injured person was trained in the task? [Attach record]
Were there any safe systems of work / work instructions in place?

Were equipment / tools inspections and servicing up to date? [Attach records]
Is there a risk assessment covering the activity? [Please specify].

Select the most appropriate Direct & Indirect causes
DIRECT CAUSES:

Unsafe act [any act that deviates from a generally recognised safe way of doing a job & increases the likelihood of an accident]	
	Operating without authority
	Failure to make secure
	Operating at unsafe speed
	Failure to warn or signal
	Nullifying safety devices
	Using defective equipment
	Using equipment unsafely
	Taking unsafe position
	Repairing or servicing moving / connected equipment
	Horseplay
	Failure to use protection
	Other: please specify.

Unsafe conditions [any environmental condition that may cause or contribute to an accident]	
	Inadequate guards and safety devices
	Inadequate warning systems
	Fire & explosion hazards
	Unexpected movement hazards
	Poor housekeeping
	Protruding hazards
	Congestion, close clearance
	Hazardous atmospheric conditions
	Hazardous placement or storage
	Unsafe equipment defects
	Inadequate illumination, noise
	Hazardous personal attire
	Other: please specify.

INDIRECT CAUSES:

Personal factor [any condition or characteristic that causes or influences a person to act unsafely]	
	Lack of hazard awareness
	Lack of job knowledge
	Lack of job skill
	Conflicting motivations: **Saving time & effort** **Avoiding discomfort**

	Attracting attention **Asserting independence** **Seeking group approval** **Expressing resentment**
	Physical and / or mental incapacities
	Poor motivation
	Stress
	Other: please specify.

Source causes / Job factors [any circumstance that may cause or contribute to the development of an unsafe condition]

	Design & engineering
	Unsuitable purchase
	Normal wear through use
	Abnormal wear and tear
	Lack of preventative maintenance / poor maintenance
	Outside contractors
	Poor leadership / supervision
	Abuse / misuse
	Poor ergonomics
	Other: please specify.

Print name: **Job role:**

Signature: **House / Dept.:**

Date:

THIS PART IS TO BE COMPLETED BY THE HEALTH & SAFETY MANAGER

Preventative Actions / Recommendations

No.	Action	Who	Closure Date

Check List for reporting:

Incident Centre [HSE]	Ref No:
Finance Dept. to forward to Trust's Insurers	
Other: please specify	

Supporting Documentation:

Incident Report	
Accident Investigation – RIDDOR Accidents	
RIDDOR Report F2508/a	
Training records [relevant to the incident]	
Photos	
Statements	
Service history [if relevant]	
H & S meeting minutes [if relevant],	
Pre & post risk assessments,	
Any other relevant documentation	

Print name: **Signature:**

Date:

Appendix 8 Incident Report

Use the 24 HOUR CLOCK
Complete this report with as much detail as is available as soon as possible after the event.
This report must be sent to the Incident Report Manager within one working day of the incident.
FIRE INCIDENTS – please report fire incidents on a Fire Incident Form, HS001 F1 Fire Policy.

1	**What sort of incident are you reporting: (***please circle)*			
Accident/Incident	Medication	Behavioural	Complaint	Compliment
Was this a near miss?	Yes	No		

2	**Tell us where the incident occurred and who told you about it**		
When did the incident occur?:	Date:	Time:	
Where did it happen?:	Location:		Area:
Who reported it?:			
Who was it reported to?:			
When was it reported?:	Date:	Time:	

3	**Please Describe the incident**
Description:	

4	**Please select the type Incident you are reporting**
Primary Cause:	
Secondary Causes: *(Please do not use the primary cause of the incident. If none, leave blank.)*	

5	**Describe the actions taken to resolve the incident:**
Describe what actions you took at the time of the incident. Type “None” if no action taken:	

6	**Please enter the details of the person affected by the incident:**

Affected person: Child	Learner	Child contact	Employee	Volunteer	Other
Name:					
Date of Birth:		Primary Contact Name:			
Age at time of incident:		Relationship to child:			
Known as:		Home phone:			
Child Resides:		Work phone:		Mobile:	
7	**Please indicate which Risk Rating you feel is the most appropriate for this incident (this will be re-evaluated by your manager):**				
Low	Moderate	High	Extreme		
8	**Where applicable please enter the main house of residence of the child:**				
House:					
9	**Enter details of which person with Parental Responsibility was informed , by whom and when:**				
Responsible adult informed:					
Date and time informed:	Date:	Time:			
Informed by:					
10	**Please indicate if any injuries occurred:**				
Were any injuries sustained:	Yes:	No:			
11	**Enter details of injuries sustained during the incident:**				
Injury site *(e.g. Arm)*		type: *(e.g. Bruise)*			
Injury description:					

12	Was any medical treatment/first-aid given on-site?	
	Yes	No

13	Full details of treatment given				
Date & time Doctor/ First-Aider called:		Date:		Time:	
Date & Time of treatment:		Date:		Time:	
Observations on Examination:					
Treatment given:					
Given by: Name:	Child Contact	Employee	Volunteer	Other	
Witnessed by: Name:	Child Contact	Employee	Volunteer	Other	

14	Was any intervention required?	
	Yes	No

15	Enter information about the intervention taken			
Date & Time of intervention:	Date:	Time:	Duration of Intervention:	
Description of events leading to the behaviour requiring containment/restraint i.e. what happened that caused the child to be behave inappropriately?:				
Description of behaviour requiring containment/restraint:				
How did you intervene?	Physical Restraint	Sanctions Applied	Other	
Description of way in which you intervened:				

What happened next i.e. how did the child/young person respond to intervention:
Effectiveness of intervention used:
Consequences of the intervention e.g. injury to staff or witness, damage to objects:
Child examined by Registered Nurse or Doctor (within 24 hours): Examined by: Date & Time of Examination: Date:
What action was taken?:
16 **Could this be a potential Safeguarding incident?**
Yes No
17 **Is this a possible RIDDOR incident?**
Yes No

18	**Select what you consider to be the Primary Causative Factor of this incident, plus list any secondary causes.**
Primary factor:	
Secondary Causative Factors: *(Please do not use the same Causative factor again)*	

19	**Other people affected**
Please add details of other people affected by this incident:	
20	**Witnesses**
Were there any Witnesses to the incident:	Yes No
21	**Enter details of any Witnesses to the incident**
Type: Name: Home Phone: Mobile:	

22	Please take a moment to reflect on the incident
What was your role – what did you do?:	
What contributed to the incident? *Consider distractions, time, staffing, environment and whether a policy/procedure was/was not followed and why*	
Reflecting on the above, what would/could you have done differently?:	
What have you and your team learned from this incident?:	
What practice changes will you and your team make as a result?:	
How do you/your manager plan to implement these changes and evaluate the effectiveness of that plan?:	

23	Please indicate if this incident is Highly Confidential	
	Yes	No

24	Tell us who needs to be told about the incident

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For children with brain injury

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Private and Confidential

Appendix 9

Dear

I am writing following the conversation you had with *insert name* on *insert date.*

I would like to express my sincere apologies that your son/daughter *insert name* has been involved in an incident – *insert details.*

I would like to assure you that we are taking the incident very seriously and we are undertaking a full investigation in an effort to understand exactly what happened and, once this is completed, we would like the opportunity to discuss our investigation and findings with you.

The initial investigation will take up to 28 working days to complete and there may be a number of actions that come out of the investigation. There may also be additional information that comes to light as the investigation proceeds and we have agree that we will contact you via telephone/e-mail to ensure you are kept informed.

When our investigation is complete we will contact you to arrange a mutually convenient time to discuss our findings. *Insert name of investigator* is leading the investigation and you can contact them on xxxxxxx or by e-mail xxxxxxxx.

I recognise you may not feel any further communication would be of any help and if this is the case please contact me to let me know. Just as importantly if there is anything else you would like to mention to assist us with our investigation please do contact *name of investigator.*

Yours sincerely

Director of Clinical Services

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Private and Confidential

Appendix 10

Dear

Further to my letter dated *insert date*, I am writing following the completion of the investigation (known as a Root Cause Analysis) into *(give details of the incident)*. I would also like to thank you for meeting with *insert name* to discuss the findings and recommendations of the investigation.

I and the staff at The Children's Trust are very sorry for any suffering and distress caused as a result of this incident. I wish to assure you that we have conducted a full and thorough investigation and have learnt from the events surrounding *insert child's name.* As a result of the investigation, we have agreed to implement a number of actions, which include:

Insert learning actions

I would like to thank you for bringing this matter to our attention/your assistance with our investigation and once again, apologise for any distress this has caused you and *name of child*.

If you have any further questions please do not hesitate to contact me.

Yours sincerely

Director of Clinical Services

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