Appendix IV

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

October 2013

CONTENTS

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAI). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure has been developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning
- fulfilling statutory and regulatory requirements
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will not only support governance at a local level within individual organisations but will also improve existing regional governance and risk management arrangements by facilitating openness, trust, continuous learning and ultimately service improvement.

John Compton
Chief Executive

SECTION ONE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.
www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to DHSSPS in line with Circular HSS (PPM) 06/04
www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.
www.dhsspsni.gov.uk/gpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.
http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.
www.dhsspsni.gov.uk/gpi_quality_standards_for_health___social_care.pdf

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.
http://www.dhsspsni.gov.uk/hss__sqsd_19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order

previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009)
www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.
www.dhsspsni.gov.uk/hsc-sqsd-22-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department,
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).
http://www.dhsspsni.gov.uk/hsc_sqsd_10-10.pdf

In May 2010 responsibility for management of SAI reporting transferred from the DHSSPS (Department) to HSCB working in partnership with the Public Health Agency (PHA). Following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' to HSC Trusts, Family Practitioner Services (FPS) and Independent Service Providers.
http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20-%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance,

which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2005 the Regional Adult Protection Forum produced standardised, regional policies and procedures in the 'Safeguarding Vulnerable Adults' document, a framework based on best practice. This document represented a major new phase in improving adult protection arrangements across the region.
www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf

In February 2011 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide' perpetrated by a service user known to/referred to mental health and/or learning disability services, in the two years prior to the incident. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 13.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required when a serious incident occurs.
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health, Social Services and Public Safety (DHSSPS) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users.

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies.

- Clarify the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the investigation.

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

SECTION TWO

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in DHSSPS Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation & Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB FPS Adverse Incident Protocol. On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community & Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and investigated by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up investigation may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the investigation. In

these instances refer to Appendix 12 – Guidance on Joint Investigations.

3.5 Incidents reported and investigated by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DHSSPS issued circular HSS (MD) 06/2006 – a Memorandum of Understanding – which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

The MOU has been agreed between the DHSSPS, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an

incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being investigated by the Coroner's Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation has the potential to impede a SAI investigation and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and investigation, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

*It is acknowledged these incidents should already have been reported to RQIA as a **'notifiable event'** by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being investigated as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 14.

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1. serious injury to, or the unexpected/unexplained death of:
- a service user (including those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

4.2.3. unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.4. unexpected or significant threat to provide service and/or maintain business continuity;

4.2.5. serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.6. serious self-harm or serious assault *(including homicide and sexual assaults*)
- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old*

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.8. serious incidents of public interest or concern relating to:
- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The new HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 15

5.0 SAI INVESTIGATIONS

SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of investigation focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 investigation, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 investigation immediately following the incident occurring. The level of investigation should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 15) may assist organisations in determining the level of 'seriousness' and subsequently the level of investigation to be undertaken. SAIs which meet the criteria in 4.2 above will be investigated by the reporting organisation using one or more of the following:

5.1 Level 1 Investigation – Significant Event Audit (SEA)

Most SAI notifications will enter the investigation process at this level and an SEA will immediately be undertaken to:
- assess why and what has happened
- agree follow up actions
- identify learning.

The possible outcomes from the investigation may include:

- closed – no new learning
- closed – with learning
- requires Level 2 or 3 investigation.

(refer to Appendix 5 guidance on SEA investigations)

If it is determined this level of investigation is sufficient, an SEA report will be completed (see Appendix 4) and sent to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported.

If the SEA determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a Level 2 or 3 investigation. In this instance the SEA report will still be forwarded to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 investigations.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 investigation following a SEA.

When a Level 2 or 3 investigation is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Investigation Team for consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the investigation report to the HSCB. (Refer to Appendix 6 – template for Level 2 & 3 investigation reports).

The investigation must be conducted to a high level of detail (see Appendix 6 – template for Level 2 & 3 investigation reports). The investigation should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 10 Guidance notes on membership of review teams for Level 2 Investigations).

Level 2 RCA investigations may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final investigation report (Refer to Appendix 12 Guidance on joint investigations).

On completion of Level 2 investigations, the final report must be submitted to the HSCB:

- within 12 weeks from the date the incident was discovered, or

- within 12 weeks from the date of the SEA.

5.3 Level 3 – Independent Investigation

Level 3 investigations will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and Membership of the investigation team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 11 Guidance notes for Level 3 investigations).

The format for Level 3 investigation reports will be the same as for Level 2 investigations (see Appendix 7 – guidance notes on template for Level 2 and 3 investigations).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to a SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see Appendix 13).

5.4 Involvement of Service Users/Relatives/Carers in Investigations

It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate.

The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Investigation Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template and submitted to the HSCB within **4 weeks (6 weeks by exception)** of the SAI being notified.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 & 3 of the RCA Report, outlining TOR and membership of the investigation team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA investigation reports must be fully completed using the RCA report template and submitted to the HSCB **12 weeks** following the date the incident was discovered, or from the date of the SEA.

LEVEL 3 – INDEPENDENT INVESTIGATIONS

Timescales for completion of Level 3 investigations will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 investigation.

6.3 Investigation Report Extensions

LEVEL 1 INVESTIGATIONS – SEA

Extensions **will not** be granted for this level of investigation.

LEVEL 2 INVESTIGATIONS - RCA

In most circumstances, all timescales for submission of RCA investigation reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where an investigation is particularly complex, perhaps involving two or more organisations or where other external organisation such as PSNI, HSCNI etc; are involved in the same investigation. In these instances the reporting organisation may request **one** extension to the normal timescale i.e. 12 weeks from timescale for submission of SEA report. This request **must be approved by the DRO** and should be requested when submitting the SEA report.

LEVEL 3 INVESTIGATIONS – INDEPENDENT

All timescales must be agreed with the DRO at the outset of the investigation. One extension may be granted, if agreed by the DRO.

6.4 Responding to additional information requests

Once the investigation report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that both the investigation and action plan are comprehensive.

If the DRO is not satisfied that the report reflects a robust investigation additional information may be requested. Responses to additional information requests must be provided in a timely manner:

- Level One investigation within **1 week**
- Level Two or Three investigation within **4 weeks.**

Progress in relation to timeliness of completed investigation reports will be monitored and reported to HSCB/PHA Regional SAI Group. Any variance from timescales and processes will be escalated, if necessary, to the HSCB's bi-monthly meetings with Trusts.

7.0 OTHER INVESTIGATIVE PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC' Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the

outcome of the SAI investigation and there may be aspects of the complaint which will not be part of the SAI investigation and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI investigation. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the investigation of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child Protection and Adult Protection

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the investigation of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in **parallel** as separate investigations to the SAI process with the relevant findings from these investigations informing the SAI investigation and vice versa. However, all such investigations should be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults.

In these circumstances, the DRO should liaise closely with the HSC Trusts on the progress of the investigation and the likely timescales for completion of the SAI Report.

On occasion the incident under investigation may be considered so serious as to meet the criteria for a Case Management Review (CMR)

for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Transferring SAIs to other Investigation Processes

Following notification and initial investigation of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews
- Independent / Public Inquiry.

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI and inform all relevant organisations.

7.5 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 18 of the SAI notification form (Additional Information following Initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **5 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI investigation will be required. The reporting organisation may however continue to investigate as an adverse incident or in line with other HSC investigation processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the investigation report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI investigation process from situations where there is the probability of disciplinary action, or criminal charges. The SAI investigation team must be are aware of the clear distinction between the aims and boundaries of SAI investigations, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients, the investigation to determine root causes and learning points should still be progressed ***in parallel*** *with other investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.*

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
    - learning letters
    - learning newsletter
    - thematic reviews;

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations, which should run in parallel with the dissemination of any regional learning issued by HSCB/PHA.

9.0 REGIONAL ADVERSE INCIDENT LEARNING SYSTEM (RAIL)

Future introduction of any regional learning system, such as the Regional Adverse Incident Learning System (RAIL), will include establishing links with the procedure for learning from SAIs to contribute to a regional whole system approach to learning in health and social care.

10.0 TRAINING AND SUPPORT

10.1 Training

Training will be provided to ensure that those involved in SAI investigations have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI investigation team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on investigation processes, policy distribution and communication updates.

10.2 Support

The HSCB/PHA will develop a panel of 'lay people' with professional areas of expertise in health and social care, which organisations can call upon to act as a chair and/or a member of a SAI investigation team (particularly when a degree of independence to the team is required).

The HSCB/PHA will ensure lay people are trained in investigation techniques for all three levels of investigation (similar to training as indicated above).

If a DRO wants a particular clinical view on the SAI investigation, the Governance Team will secure that input, under the direction of the DRO.

11.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. As a minimum the HSCB would recommend the following measures be adopted when transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail – All e-mails containing patient identifiable information sent outside of the HSC e-mail network must be encrypted. E-mails sent within the secure HSC Network (e-mail addresses ending in [redacted] or [redacted]) are more secure however attachments/content that contains patient level information should still be protected. This can be done by password protecting Microsoft Word and Excel attachments. Passwords can then be relayed via the telephone to ensure the correct individual gains access.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel [redacted]

12.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations on any immediate action to be taken following notification of a SAI;
- agreeing the Terms of Reference for Level 2 and 3 investigations;
- reviewing completed SAI investigation reports and liaising with other professionals (where relevant);
- liaising with reporting organisations where there may be concerns regarding the robustness of the investigation or where there are any issues with proposed action plans;
- identification of regional learning, where relevant.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

SECTION THREE

13.0 PROCESS

13.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents[redacted]

HSC Trusts to copy RQIA at seriousincidents[redacted] in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with section 3 of this procedure

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated correspondence submitted to the HSCB/PHA and this should NOT be the patients H &C Number or their initials. (See section 11 – Information Governance)

Note: Appendix 2 provides guidance notes to assist in the completion of the SAI Notification form

13.2 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents[redacted]

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 13.1 of this procedure.

13.3 Acknowledging SAI Notification

On receipt of SAI notification HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising of the HSCB unique identification number, and requesting the completion of SEA Report within 4 week (6 weeks by exception) from

the date the incident is reported. Where relevant, RQIA will be copied into this receipt (Refer to Appendix 14 – Administrative Protocol between HSCB and RQIA)

13.4 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

13.5 Investigation Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 investigation reports.

Timescales for submission of investigation reports will be in line with section 6.0 of this procedure.

On receipt of an investigation report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the investigation report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed.

If the DRO is not satisfied that the report reflects a robust and timely investigation s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received.

When the DRO (*in conjunction with relevant professionals/officers*) is satisfied (*based on the information provided*) that the investigation has been robust and recommendations are appropriate, he/she will complete an internal DRO Form validating their reason for closure.

13.6 Closure of SAI

On receipt of the internal DRO Form, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant).

This will indicate that based on the investigation report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions

required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On some occasions and in particular when dealing with particularly complex SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

13.7 Regional Learning from SAIs

If the DRO identifies any regional learning arising from the SAI investigation, this will be considered by the HSCB/PHA regional group and where relevant, will be disseminated as outlined in section 9.0.

13.8 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

14.0 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

APPENDICES

APPENDIX 1

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE**
3. FACILTY / DEPARTMENT:	**4. DATE OF INCIDENT: DD / MMM / YYYY**
5. CONTACT PERSON:	**6. PROGRAMME OF CARE:** *(refer to Guidance Notes)*

7. DESCRIPTION OF INCIDENT:

DOB: DD / MMM / YYYY *(complete where relevant)* **GENDER: M / F** **AGE: years**

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	**DETAIL:** *(refer to Guidance Notes)*	**ADVERSE EVENT:** *(refer to Guidance Notes)*

8. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

9. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

10. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
11. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	**YES**	**NO**	**N/A**

12. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
any death of a child (up to eighteenth birthday) in a hospital setting or who is a Looked After Child or whose name is on the Child Protection Register	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide,homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

13. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	**YES**	**NO**
If 'YES' (*full details should be submitted*):		

14. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	**YES**	**NO**
If 'YES' (*full details should be submitted including the date notified*):		

15. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHERS:** *(please specify where relevant, including date notified)*
DHSS&PS EARLY ALERT		
SERVICE USER / FAMILY		
HM CORONER		
INFORMATION COMMISSIONER OFFICE **(ICO)**		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE **(NIAIC)**		
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE **(NIHSE)**		
POLICE SERVICE FOR NORTHERN IRELAND **(PSNI)**		
REGULATION QUALITY IMPROVEMENT AUTHORITY **(RQIA)**		
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP **(NIASP)**		

16. LEVEL OF INVESTIGATION REQUIRED: *(please select)*	**LEVEL 1**	**LEVEL 2***	**LEVEL 3***

*** FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6**

17. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

18. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]
and (*where relevant*) seriousincidents[redacted]

Guidance Notes
HSC SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

All Health and Social Care Organisations, Family Practitioner Services and Independent Service Providers are required to report serious adverse incidents to the HSCB within 72 hours of the incident being discovered it is acknowledged that not all the relevant information may be available within that timescale, however, there is a balance to be struck between minimal completion of the proforma and providing sufficient information to make an informed decision upon receipt by the HSCB/PHA.

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB/PHA to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REF NO.** *Insert the unique incident number / reference generated by the reporting organisation.*
3. FACILTY / DEPARTMENT: *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4. DATE OF INCIDENT: DD / MMM / YYYY** *Insert the date incident occurred*
5. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**6. PROGRAMME OF CARE:** *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

7. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE. Where relevant include D.O.B, Gender and Age. All reports should be anonymised – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE:	**DETAIL:**	**ADVERSE EVENT:**
Insert CCS Stage of Care Code description	*Insert CCS Detail Code description*	*Insert CCS Adverse Event Code description*

8. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

9. CURRENT CONDITION OF SERVICE USER:

Where relevant please provide details on the current condition of the service user the incident relates to.

10. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
11. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please select and specify where relevant)*	**YES**	**NO**	**N/A**

12. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*	
serious injury to, or the unexpected/unexplained death of: - a service user - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
any death of a child (up to eighteenth birthday) in a hospital setting or who is a Looked After Child or whose name is on the Child Protection Register	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

13. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**
if 'YES' *(full details should be submitted):*		

14. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *where there appears to be a breach of professional code of conduct*	**YES**	**NO**
GENERAL MEDICAL COUNCIL **(GMC)** GENERAL DENTAL COUNCIL **(GDC)** PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)** NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)** LOCAL MEDICAL COMMITTEE **(LMC)** NURSING AND MIDWIFERY COUNCIL **(NMC)** HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)** REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)** SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)** OTHER – PLEASE SPECIFY BELOW		
if 'YES' *(full details should be submitted including date notified):*		

15. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHER:** *(please specify where relevant)*

DHSS&PS EARLY ALERT		Date informed:	
SERVICE USER / FAMILY			
HM CORONER			
INFORMATION COMMISSIONER OFFICE (ICO)			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)			
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE (NIHSE)			
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)			
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)			
16. LEVEL OF INVESTIGATION REQUIRED: *(please select)*	**LEVEL 1**	**LEVEL 2***	**LEVEL 3***

*** FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6**

17. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. *(delete as appropriate)*

Report submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

18. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further investigation may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents[redacted] with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further investigation under the SAI process.

The HSCB/PHA will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full investigation report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED INVESTIGATION REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]
and (*where relevant*) seriousincidents[redacted]

APPENDIX 3

HSC INTERFACE INCIDENTS NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MMM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MMM / YYYY *(complete where relevant)* **GENDER: M / F** **AGE: years**

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (***full details should be submitted in section 7 below***)	

7. PROVIDE SUFFICIENT DETAILS TO ALLOW FOLLW UP:

8. IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE INVESTIGATION AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ **DESIGNATION:**

_____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]

APPENDIX 4

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE:	
DATE OF SIGNIFICANT EVENT:	
DATE OF SIGNIFICANT EVENT MEETING:	
SEA FACILITATOR/ LEAD OFFICER:	
TEAM MEMBERS PRESENT:	

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

Where a Level two or three investigation is recommended please complete the sections below

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

APPENDIX 5

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

TITLE: *Insert unique identifier number*	*Self- explanatory*
DATE OF SIGNIFICANT EVENT:	*Self- explanatory*
DATE OF SIGNIFICANT EVENT MEETING:	*Self- explanatory*
SEA FACILITATOR/ LEAD OFFICER:	*Refer to guidance on Level one Investigation team membership for significant event analysis –Appendix 9*
TEAM MEMBERS PRESENT:	*Self- explanatory*

WHAT HAPPENED?

(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user, the team, organisation and/or others).

WHY DID IT HAPPEN?

(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)

WHAT HAS BEEN LEARNED?

(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)

WHAT HAS BEEN CHANGED?

(Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or. introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.

Action plans should be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan).

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

(Following the SEA it may become apparent that a more in depth investigation is required. Use this section to record if a Level two or three investigation is required).

APPENDIX 6

Insert organisation Logo

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

2.0 THE INVESTIGATION TEAM

3.0 INVESTIGATION TERMS OF REFERENCE

4.0 INVESTIGATION METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

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APPENDIX 7

Health and Social Care Regional Guidance

for

Level 2 & 3 RCA Incident Investigation/Review Reports

INTRODUCTION

This document is a revision of the template developed by the DHSSPS Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing investigation reports and should be used, in as far as possible, for drafting all **HSC Level Two and Level Three** incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The investigation report presents the work of the investigation team and provides all the necessary information about the incident, the investigation process and outcome of the investigation. The purpose of the report is to provide a formal record of the investigation process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident investigation/reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of investigation, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE INVESTIGATION TEAM

Refer to GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and investigation team role of the members of the Investigation team. The Investigation team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of investigation to be undertaken. However, best practice would indicate that investigation / review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 INVESTIGATION TERMS OF REFERENCE

Describe the plan and scope for conducting the investigation. State the level of investigation, aims, objectives, outputs and who commissioned the investigation.

The following is a sample list of statements of purpose that should be included in the terms of reference:

- To undertake an investigation/review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the investigation/review - the scope and boundaries beyond which the investigation should not go (e.g. disciplinary process) – state how far back the investigation will go (what point does the investigation start and stop e.g. episode of care) and the level of investigation;
- To review the outcome of the investigation/review, agreeing recommendations,

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 INVESTIGATION TERMS OF REFERENCE

actions to be taken and lessons learned for the improvement of future services;

- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes to be involved;
- To agree the timescales for completing and submitting the investigation report, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 INVESTIGATION METHODOLOGY

This section should provide an outline of the type of investigation and the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Investigation Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;
- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors

6.0 FINDINGS

- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the investigation should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the investigating organisation
- Learning that is relevant to other organisations.

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

APPENDIX 8

MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the investigation
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

LEVEL ONE INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP FOR SIGNIFICANT EVENT ANALYSIS

The level of investigation of an incident should be proportionate to its significance; this is a judgement to be made by the Investigation Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a level one investigation, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The investigating team should appoint an experienced facilitator or lead investigating officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the write up of the Significant Event Analysis report
- Ensure learning is shared

APPENDIX 10

LEVEL TWO INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation undertaken will determine the degree of leadership, overview and strategic review required. The level of investigation of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Investigation Team.

The core investigation team should comprise a minimum of three people of appropriate seniority and objectivity. Investigation teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist investigators). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide - February 2012*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under investigation. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the investigation team.

It may be helpful to appoint an investigation officer from within the investigation team to co-ordinate the review.

APPENDIX 11

LEVEL THREE INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation shall be proportionate to the significance of the incident. The same principles shall apply, as for level two investigations. The degree of independence of the investigation team will be dependent on the scale, complexity and type of the incident.

Team membership for level 3 investigations will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the level 3 investigation commencing.

APPENDIX 12

GUIDANCE ON JOINT INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the investigation and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the investigation and action. There may, however, be good reason to vary this arrangement e.g. where a patient has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the investigation as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single investigation report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided , then all services are required to provide information / involvement reports to the investigation team
- All service areas should be represented in terms of professional makeup / expertise on the investigation team
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved.
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined.
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel.
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought.
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Investigation Team Membership (Refer to Appendix 9 to 11)
- Guidance on completing HSC Investigation Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 13

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE - 2013

1. *INTRODUCTION AND PURPOSE*

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised October 2013. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user (*who will remain anonymous*) with a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and/or learning disability services, in the 12 months (1 year) prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. *THE PROCESS*

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2013.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2013

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and
- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIME SCALES

The notification to the Trust of a SAI, resulting in homicide, to the Trust is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

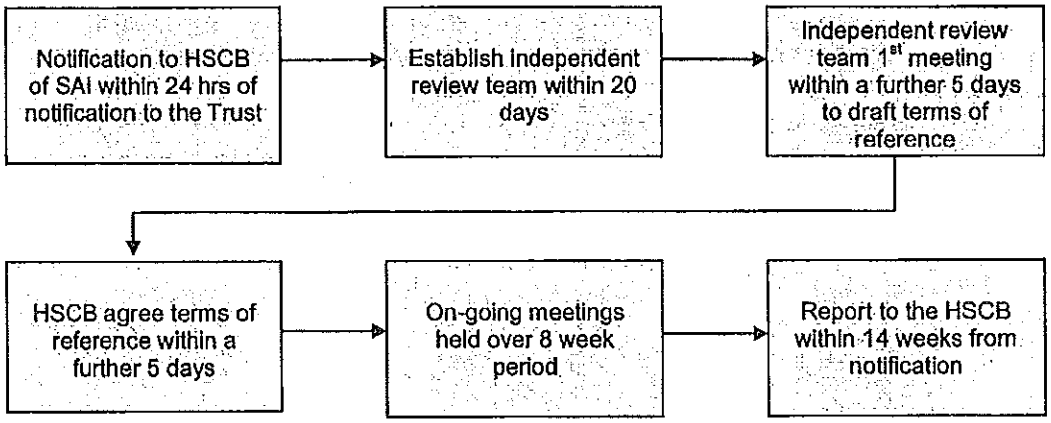
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, Social Services and Public Safety (DHSSPS) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 14

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY & INDEPENDENT/REGULATED SECTOR

ADMINISTRATIVE PROTOCOL

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for investigation report will also be copied to RQIA.

2. On receipt of the investigation report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the investigation report to RQIA, together with an email advising of a **3 week** timescale from receipt of investigation report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: seriousincidents[redacted]
and RQIA: seriousincidents[redacted]

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APPENDIX 15

HSC Regional Impact Table – with effect from April 2013

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media Interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

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DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

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