Mid Essex Hospital Services NHS
NHS Trust

Investigation of and Learning from Adverse Events, Complaints and Claims Policy	**Policy** **Register No: 08089** **Status: Public**

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Document Review History

Review No	Reviewed by	Review Date

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will be the document on the intranet

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1. Introduction

1.1 Mid Essex Hospital Services NHS Trust (the Trust) acknowledges the risks associated with the occurrence of untoward incidents to the provision of a safe environment for all patients, staff and others. They can however be seen as an opportunity for proactive risk management i.e. learning from what has happened and looking ahead to see how we can prevent the same things, or worse, from happening again and thereby reduce future risk to the Trust.

1.2 This document provides additional guidance to the Risk Event Information booklet used during Investigation and Root Cause Analysis training. It will assure staff within the Trust on how and when investigation processes should be put into place following untoward incidents. It also looks at how we can learn from these events, where there have been unexpected outcomes or things have 'gone wrong'.

1.3 This policy extends to all members of the Trust. Specific responsibilities are set out in the following paragraphs and individuals should be aware of their statutory obligations to the reporting and management of Untoward Incidents, Near Misses and Serious Untoward Incidents, as outlined in the Policy & Strategy for Risk Management, Health & Safety and Clinical Governance and Serious Untoward Incident Policy.

1.4 The Trust recognises the benefits of learning from its untoward incidents, complaints and claims. This Policy has been developed in addition to the Risk Event Information booklet and to ensure that:

- All untoward events are investigated appropriately and any safety lessons identified shared with all relevant internal and external stakeholders;
- All common risks or trends associated with untoward incidents, complaints and claims are identified in a timely manner;
- Where risks have been identified, action plans are developed and implemented effectively.

2.0 Equality & Human Rights Impact Statement

2.1 This policy embraces Diversity, Dignity and Inclusion in line with emerging Human Rights guidance. We recognise, acknowledge and value difference across all people and their backgrounds. We will treat everyone with courtesy and consideration and ensure that no - one is belittled, excluded or disadvantaged in anyway shape or form.

3.0 Objectives

3.1 The key objectives of this Policy are to:

- Ensure that a thorough investigation appropriate to the severity of the incident, complaint or claim is conducted by competent personnel in a timely manner
- Communicate with all relevant internal and external stakeholders to share any safety lesson identified in investigations of incidents, complaint and claims
- Ensure that where appropriate action plans are developed, monitored and implemented for all investigations.

- Conduct an analysis of data relating to incidents, complaints and claims to identify any trends or common risks and share this information with all relevant individuals or groups
- Communicate any identified trends or common risks to all relevant internal and external stakeholders and where necessary develop action plans to reduce these risks.
- Develop an open and just culture within the Trust which encourages both local and organisational learning from all untoward incidents

4.0 Responsibilities

4.1. The Chief Executive as the Accountable Officer for the Trust has overall responsibility for Corporate Governance and this Policy.

4.2. The Director of Patient Safety has delegated responsibility for Corporate Governance and risk management and will Chair the Organisational Learning Group and report to the Trust Board on matters relating to this Policy.

4.3. The Governance Manager has responsibility for implementing this Policy and will sit on the Joint Health & safety Working Group, reporting directly to the Director of Patient Safety any issues that may arise.

4.4. Day to day implementation of this policy is delegated to the Risk Manager and PALS & Complaints, Claims and Litigation Manager.

4.5. The Governance, Risk and PALS & Complaints, Claims and Litigation teams will ensure:

- That a relevant senior member of staff appoints an appropriate, competent investigating officer for all untoward events;
- Co-ordinated approach is undertaken to investigation, through training in accordance with the Learning & Development Strategy (training needs analysis);
- Co-ordinated approach is undertaken in the aggregation of data, through the Organisational Learning Group, correlating information from incident reports, PALS & Complaints, Claims and Litigation for the purpose of identifying key trends;
- Aggregated data relating to untoward incidents, complaints and claims is analysed and reported to the Patient Safety Committee or specific groups and individuals;
- Trends or common themes in aggregated data relating to untoward incidents, complaints and claims are identified at the Organisational Learning Group are communicated to all relevant individuals or groups;
- Where a ‘learning point’ has Trust wide applicability, to ensure the dissemination of this point throughout all relevant parts of the organisation; using appropriate communication mediums (eg featuring a regular column in ‘Staff Focus’)
- Where appropriate action plans are developed by respective division and monitored effectively;
- All organisation learning points identified during investigations are communicated to the relevant internal and external stakeholders.
- They work with other stakeholders in order to proactively address potential risks and feedback to the appropriate groups any local or organisation

changes required.

4.6. Heads of Department, Senior Managers and General Managers are responsible for ensuring the comprehensive investigation and relevant actions are undertaken of all untoward events graded as high or extreme risk.

4.7. Line Managers/Supervisors are responsible for the investigation and subsequent assessment review of all untoward events graded as a low or moderate risk.

4.8. Investigating Officers will ensure:

- They have sufficient knowledge, training and experience to undertake the investigation based upon the level of risk, in accordance with the Learning & Development Strategy (training needs analysis)
- Appropriate investigation of untoward events they have been appointed to are conducted thoroughly and within the respective statutory and agreed timescales; in line with Serious Untoward Incident Policy
- That the Governance, Risk and PALS & Complaints, Claims and Litigation teams as appropriate are notified of any unavoidable delays in their investigation as soon as possible
- A comprehensive report is produced, supported with recommendations or where appropriate corrective actions already taken to the relevant parties;
- All local actions are implemented as soon as possible and where relevant included in the divisions risk assurance framework
- All learning points are communicated to the relevant groups.

4.9. All Staff will:

- Receive induction and mandatory training updates to ensure they are aware of their statutory obligations to the reporting and management of Untoward Incidents, Near Misses and Serious Untoward Incidents, in accordance with the Learning & Development Strategy (training needs analysis)
- Report all untoward events in line with the Trusts Serious Untoward Incident Policy
- Cooperate fully with any investigation conducted on behalf of the Trust and provide all factual information that may assist in the investigation;
- Ensure that all learning points within their control communicated to them are implemented.

5.0 Definitions

5.1 The National Patient Safety Agency document 'Doing Less Harm', refers to the following statement of requirement: "Adverse patient incidents are subject to an appropriate level of local investigation and causal analysis and, where relevant, an action plan is prepared".

5.2 The Trust guidance applies to all types of untoward events, whether clinical or non-clinical, including incidents giving rise to complaints or claims and which affect patients, employees or the public and/or the organisation.

5.3 For the purpose of this guidance the term Untoward Event refers to any untoward incident, complaint or claim; Immediate Cause is defined as the factor(s), which triggered the actual incident; Contributory Factor is defined as

the circumstance(s) which contributed to the occurrence of the incident, but which by itself or themselves would not have caused the incident to arise and Root Cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

6.0 Investigations

6.1 All reported untoward events are graded according to the actual impact, and also the potential future risk to patients, staff and the organisation should a similar incident occur again. This will help to establish the level of local investigation and causal analysis that should be applied.

6.2 The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an actual incident or a near miss. Guidance on investigation is in appendix 1.

6.3 Not all incidents need to be investigated to the same extent or depth. Having assessed each incident against the risk grading matrix, the level of investigative and analysis effort should be expended in relation to the risk level (i.e. Red, Yellow or Green) and whether the incident resulted in harm (i.e. adverse event or near miss) as indicated in the following table;

Severity: taking account of the controls in place and their adequacy, how severe would the consequences be of such an incident? Apply a score according to the table, The score should be applied if any one of the conditions is true – eg. a level '5' clinical risk only needs to meet the level '5' threshold under 'clinical':

Level	Descriptor	Strategic	Financial	Clinical	Reputation	Legal
5	Catastrophic	Major impact on direction of Trust strategy	Above £3m	Patient death/s. Multiple permanent disabilities/ emotional injuries	Major adverse public and national interest with long term damage to Trust reputation/ credibility	Criminal prosecution- no defence. Executive officer fined or imprisoned
4	Major	Major impact on individual strategic objective	£1,001k - £3m	Severe long – term injury / disability/ emotional injury to patient	Adverse publicity, locally contained with short to mid-term damage to Trust reputation / credibility	Civil action – no defence, Trust fined or alternative judgement against Trust. Executive officer dismissed
3	Moderate	Noticeable impact but strategy still on course	£301k - £1m	Moderate short-term injury to patient/ Severe patient dissatisfaction	Short term local adverse publicity with short term minor damage to reputation	Contestable civil action
2	Minor	Minor importance in terms of strategy	£100k - £300k	Moderate patient dissatisfaction	Local press interest. Local public/political concern	Legal challenge/ Minor out-of-court settlement
1	Insignificant	Zero effect on strategy	Less than £100k	Minimal clinical impact	Limited publicity	Minor breach of legal/ regulatory requirements with minimal impact

Likelihood: taking account of the controls in place and their adequacy, how likely is it that such an incident could occur? Represents the probability of the risk occurring within the next 12 months, apply a score according to the following scale:

Level	Descriptor	Range
5	Almost Certain	More than 90%
4	Likely	31% to 90%
3	Possible	11% to 30%
2	Unlikely	3% to 10%
1	Rare	Less than 3%

Risk Score/Action to be taken

LIKELIHOOD	SEVERITY					
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic	
1 – Rare	Low 1	Low 2	Low 3	Low 4	Low 5	No action this 12 months
2 – Unlikely	Low 2	Low 4	Med 6	Med 8	Med 10	Action within 12 months
3 – Moderate	Low 3	Med 6	Med 9	High 12	Extreme 15	Action within 6-12 months
4 – Likely	Low 4	Med 8	High 12	Extreme 16	Extreme 20	Action within 6-12 months
5 – Almost Certain	Low 5	Med 10	Extreme 15	Extreme 20	Extreme 25	Urgent Action

6.4 Red events

High Risk events (Red) may be reportable, (in accordance with the Trust Serious Untoward Incident Policy) to the East of England Strategic Health Authority and the investigation will be overseen by a senior manager. Red untoward events, should be the subject of a full root cause analysis by the investigating manager. Red near misses should also be the subject of a full root cause analysis, but it is recognised that the effort involved in investigating and analysing serious near misses may sometimes be less than that required for a serious adverse event. Indeed, it may be the case that there are certain commonly recurring serious near misses (e.g. a group of complaints that relate to the same subject but have not actually resulted in harm) for which an aggregate root cause analysis might be more appropriate. The Divisional Manager or Organisational Learning Group will ensure appropriate leads share the Action plan with all relevant individuals and groups

6.5 Yellow events

Moderate risk events (yellow) will be investigated by line managers. The investigation into Yellow untoward events will usually be less full than for Red incidents. An attempt should be made however, by the investigating officer to establish cause(s) and contributing factors using the general methodology for root cause analysis. Local risk assurance frameworks and health & safety action plans should be discussed at Divisional team at meetings and bilaterals.

6.6 Green events

Green untoward events should only be subject to limited investigation and aggregate review in terms of causal analysis by Line Managers or Team leaders. If the Organisation Learning Group establish aggregated risks these will be drawn to the attention of the relevant division and will be included in their risk assurance framework. Line Managers and/or Supervisors should feedback the investigation findings to the staff involved in the event.

6.7 Reducing Risk

6.7.1 In order to reduce the risk levels of any incident, complaint or claim re-occurring the best means is to put in place effective systems through which

severity is made less likely.

6.7.2 It is important that any measures put into place from the action plan do not increase any transferred risk elsewhere.

6.7.3 The monitoring of risk reduction measures will be tracked by the Organisational Learning Group, as part of ongoing trend monitoring and in some cases by local or Trust wide audit.

6.8 Involving External Agencies

6.8.1 From time to time the Trust will need to involve external agencies in its investigation and learning processes. It is implicit in these procedures that the decision to involve an external body to carry out an investigation rests with the Director of Patient Safety or out of hours the On-call Director.

6.8.2 The Trust recognises that for certain types of incident the decision to involve an external body in the investigation process, is an immediate and statutory duty. The table below sets out guidance on which agencies may be involved, who is responsible for alerting them and time scales. Where the requirement is immediate the on-call Director must be notified and or involved in the decision, however time should not be lost in making the initial contact.

Manager	Time Scale	Agency	Type of Incident Investigation where support may be required
Senior Manager	Immediate	Police Fire Rescue Service	Serious road traffic event (death or serious collision) involving a Trust vehicle, Suspected murder, industrial accident resulting in death Fire incidents on Trust premises
Director of Finance	All	NHS Counter Fraud Agency	Incidents involving the theft and/or misappropriation of NHS property
Duty Director	All	MHRA Other NHS organisations HSE NHS Estates Police Social Services Information technology consultant	Serious medical equipment failures/faults Clinical audits RIDDOR, COSHH incidents Technical advise/investigationof Estate incidents Sexual assaults, theft, criminal damage, theft of controlled drugs Child protection & Vulnerable Adult incidents IT incidents

This is not an exhaustive list

6.9 Investigation Recommendations

6.9.1 Feedback from investigations, internally or externally must be made back to the investigating office to ensure local and/or organisational learning from incidents, complaints or claims are followed through. They will ensure that any action plan is led by the appropriate Divisional Manager and included in the Bi-lateral meeting notes for that Division. Trust wide learning and risks scoring above 12 will be raised to the attention of the Trust Executive Board through the organisational risk assurance framework.

6.9.2 Where the investigation identifies immediate or underlying causes involved, the Investigating Officer may be able to either take remedial action immediately or make recommendations for possible solutions to prevent recurrence, by highlighting to the Organisational Learning Group, and/or Health & Safety Group for inclusion within the Trust's Health & Safety Action Plan and/or inclusion in the local risk assurance framework.

6.9.3 If recommendations fall within the remit and level of authority of the Investigating Officer, they should be implemented without delay. If however, they are of a wider scope, require additional resources or have implications across the Trust, the risk and recommendations should be flagged up to their Line Manager, Director and the Risk or PALS, Complaints, Claims and Litigation Teams for incorporation onto the appropriate Trust risk assurance framework.

6.10 The Organisational Learning Group will review all Red incidents and ensure that a root cause analysis has been undertaken. This will usually result in an Action plan being drawn up with prioritised actions, responsibilities, timescales and indicators to measure the effectiveness of actions taken. Divisional Managers and Service Directors will account for the implementation of agreed actions following incident reviews.

6.11 It is important that progress on implementing recommendations or action plans are tracked and that the effectiveness of actions taken is monitored. Effective actions result in demonstrable improvements in safety and, where appropriate, quality of care.

6.12 Any change in organisational culture and practice as a result of lessons learnt will be embedded in the appropriate training, review of the risk assessment and communication of the resultant controls through Policy or Procedure change that will be updated on the Trust's Intranet and through Staff focus

7.0 Root Cause Analysis

7.1 Unless the fundamental, or root causes of adverse events are properly understood, lessons will not be learned and Serious Untoward Incident Policytable improvements will not be made to secure a reduction in risk. Adverse incidents rarely arise from a single cause; there are usually underlying failures in management systems, which have helped to create the circumstances leading to the incident.

7.2 The purpose of root cause analysis is to identify the Immediate, Contributory and Root causes of the incident and recommend remedial actions through an Action plan.

7.3 It is not proposed, in this guidance, to include a detailed explanation of RCA. A full and detailed explanation of root cause analysis techniques and how they should be applied can be found at www.npsa.nhs.uk some of the tools used can be identified in the Risk Event Information booklet used during Investigation and Root Cause Analysis training.

7.4 However RCA would normally include the following steps:

- Identify the incident
- Preserve direct evidence from the scene & make detailed records/complete Risk Event form (Datix)
- Chart the event with current knowledge
- Gather documentary and other evidence
- Revise the chart
- Arrange and carry out interviews
- Revise the chart
- Identify causal factors
- Analyse causal factors
- Decide on and cost options for improvement
- Provide an investigation report
- Ensure implementation of action plan, phased if necessary

7.5 The Organisational Learning Group will review the investigation report and analyse all the factors to identify possible risk treatments. The ultimate focus for the Organisational Learning Group will be on the underlying causes, as described earlier, the management, organisational, cultural and contextual factors. The Organisational Learning Group will use the Investigation Report to summarise their findings and produce an action plan ensuring local and organisational learning takes place.

7.6 Action plans should be designed to eliminate the root cause(s). This may involve changes in training, policies, procedures, equipment etc.

7.7 Where it is not practicable to implement risk treatments identified within the Action plan, the risk(s) should be logged on the appropriate Risk Assurance Framework to enable monitoring and review by the Patient Safety Committee.

8.0 Analysis

8.1 Some untoward events in isolation may be graded as a low risk but may be indicative of a higher risk trend. As a consequence the Risk and PALS & Complaints, Claims and Litigation teams conducts a quarterly analysis on all untoward events data to identify any common risks or trends, reporting to the Patient Safety Committee.

8.2 Further quantitative data relating to the number and severity of incidents and complaints and qualitative description of key lessons learnt from complaints, incident reports, PALS and claims will be presented to the Patient Safety Committee by the Joint Health & Safety Working and Organisational Learning Groups in the form of report on a Bimonthly basis. The reports will contain aggregated data on the following:

- untoward events and any emerging trends
- moving and handling related events

- patient safety events
- needle stick events
- violence and aggression related events
- clinical events

8.3 The Organisational Learning Group will receive regular reports from each work stream within the Trust's clinical governance/ patient safety department and ensure clinical audit lessons are appropriately adopted.

8.4 These groups will also examine investigation recommendations and learning points to allow Risk and Claims, Complaints and Litigation Teams to focus their resources effectively.

8.5 Where appropriate any learning points, common risks or trends from untoward events will be communicated to all relevant individuals or groups via email, safety alerts and/or local groups. Common 'learning point' that have Trust wide applicability, will be disseminated throughout all relevant parts of the organisation; using appropriate communication mediums (eg featuring a regular column in 'Staff Focus')

8.5 The Joint Health & Safety Working Group will report to the Patient Safety Committee on the Groups Health & Safety action plan

8.6 The Organisational Learning Group will report quarterly to the Patient Safety Committee to make recommendations for actions to be approved.

9.0 Communication of Learning Points

9.1 Implementing recommendations and Action plans, and monitoring the effectiveness of action taken, will provide a certain level of evidence to demonstrate that the Trust is learning from untoward events. Learning, however, is not simply about taking someone out of their environment for some 'remedial training'. We need to ensure that lessons learnt and changes made are communicated across the Trust so we can show continuous improvement as an organisation.

9.2 It will be the responsibility of Line Managers and Investigating Officers to feed back to individuals with regard to lessons learned from adverse events and to monitor progress against Action Plans drawn up.

9.3 The Organisational Learning Group will provide feedback to the Patient Safety Committee on lessons learned through Root Cause Analysis and will have responsibility for monitoring progress against Action plans.

9.4 Sharing learning points may be communicated, both internally and externally, through a variety of ways including the following:

- Training both Mandatory and Induction
- Staff Focus
- Emailed Risk Alerts
- Safety Alerts
- Managers and Staff Briefings

9.5 The Organisational Learning Group will also highlight these issues within reports to the Patient Safety Committee. Residual risk that cannot easily or immediately be resolved will be highlighted to the Health & Safety Group to be

added to the Action Plan or Local Assurance Frameworks

9.6 Local Risk and Assurance Frameworks will be monitored at bi-laterals. The Trust Risk Assurance Framework will address any risks scoring above 12 will be monitored by the Trust's Executive Board

9.7 The Joint Health & Safety Group will also monitor implementation of safety lessons by the risk assessments presented to the group and annually in the risk management report to ensure that these lessons are being translated into improvements in the organisational culture and practice

10.0 Training

10.1 All new staff will receive risk management training as part of their induction programme. This will include awareness responsibilities to report incidents and the process for investigation. Refresher training will be provided as detailed in the Learning & Development Strategy (training needs analysis);

10.2 Additional training will be provided, where appropriate, to managers and team leaders on conducting investigation including root cause analysis and statement taking.

10.3 Training needs in relation to incident reporting and investigation are detailed in the Learning & Development Strategy (training needs analysis);

11.0 Monitoring and Review

11.1 Implementation of this policy will be monitored via the Organisational Learning Group which meets Bimonthly.

11.2 The Joint Health & Safety Group will use the following key performance indicators to monitor the effectiveness of this policy:

- 20% reduction in fall events
- Reduction in needle stick incidents
- Evidence of incident report analysis
- Evidence of investigation of all incidents

11.3 The Organisational Learning Group will ensure that changes made to Organisational culture and practice through risk reduction are implemented at local and organisational levels, as necessary by ensuring policy and procedure are formulated and communicated to the Trust staff, through training and the use of appropriate communication mediums (eg. Trust Intranet and Staff Focus)

11.4 The Organisational Learning and Joint Health & Safety Groups will ensure action plans and local risk assurance frameworks are updated and that stakeholders are kept aware of any changes to the actions arising from their investigations.

11.5 The Patient Safety Committee will ensure that it reviews quarterly updates and that all Divisions respond to complaints within the timescales.

11.6 This policy will be reviewed at least on an annual basis by the Risk Manager, liaising with the Governance and PALS, Complaints, Claims & Litigation Managers

Guidelines for Conducting Investigations

Dependant on the risk and frequency of the events, based upon the risk matrix identified earlier an appropriate level of input into the investigation should be considered. eg.Green risk scores 1-5 should be adequately dealt with locally; Yellow events 6-10 will require the scope of the investigation to review assessments or procedures in place; Red risks 12-16 will require a degree of input from the Divisional Manager and subject to the Organisational Learning and/or Joint Health & Safety Working Groups assurance that action plans and local assurance frameworks have been addressed, and will be subjected to Root Cause Analysis; Red risks 20+ may be Serious Untoward Incident Policys and should be communicated immediately to the Duty Director for the Director of Patient Safety and as soon as possible to the Governance Manager, Risk Manager and/or PALS Complaints Claims and Litigation Manager to ensure appropriate investigation is led.

Incident investigations should:

- Identify reasons for substandard performance
- Identify underlying failures in management systems
- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm
- Satisfy mandatory and other reporting requirements

A good investigation is prompt and thorough, to the necessary level. Where possible, remedial action or solutions will be recommended. If the investigation is not done as soon as practicable after the event, conditions and memories will fade. There are five components of any investigation:

- Collect evidence about what happened
- Assemble and consider the evidence
- Compare the findings with relevant standards, protocols or guidelines, whether these are particular to the Trust or national, to establish the facts, draw conclusions about causation
- Make recommendations for action to minimise risk of recurrence
- Implement the recommendations and track progress

Collecting Evidence

The sources of information and methods that can be used in investigation typically fall into the three following categories:

- Direct observation which is crucial to avoid losing important evidence about the scene, equipment involved, relationships between parts etc
- Documentation which identifies what has been recorded as happening at the time, helps establish what should have happened, as well as providing evidence of prior risk assessment, inspections, tests etc
- Interviews which, conducted sensitively, provide both direct testimony as well as an opportunity to check back on any issues arising from examination of the physical and documentary evidence.

Although these are distinct and important elements of a thorough investigation, they

complement each other. They provide an opportunity to 'read across' from one part of the process to another to check reliability and accuracy as well as resolve differences and gaps in evidence.

Adverse incidents seldom arise from a single cause; there are usually underlying failures in management systems, which have helped create the circumstances leading to the incident.

Depending on the severity of the incident the investigation may need to stand the scrutiny of various statutory bodies such as: Coroners Courts, Civil Courts and Public Enquiries. The investigating officer should maintain a full log of the investigation; this will record dates, times, names and actions.

The maintenance of a contemporaneous log of the investigation will assist the investigator to order and understand the investigation and provide a full account of how the investigation was progressed. It should be remembered that statutory bodies have the power of seizure and the investigation log and investigation paperwork may be taken as evidence by the Police, Health & Safety Executive, Ombudsman, etc. The investigation log is the investigators record of his/her actions and it is good practice to take a personal copy, as the original may be included as evidence, which the investigator may be questioned about at a later date.

Completed incident and complaints investigations reports, logs, evidence etc., must be forwarded to the Risk or PALS Complaints, Claims and Litigation Management Departments who will ensure they are kept and filed securely. This includes Accident, Untoward Incident, Serious Untoward Incident and Claims Investigations.

Completed vehicle accident investigations should be forwarded to the Transport and Security Manager who will ensure that they are kept and filed securely.

Assembling and Considering the Evidence

Good investigations identify both immediate and underlying causes, including human factors. Immediate causes include the patient, the task, the work environment and the people involved, either individually or as part of a multidisciplinary team. Underlying causes are the management, organisational, cultural and contextual factors that explain why the event occurred. Getting to the root of the problem by identifying the key underlying, or root causes, will help ensure development of an effective action plan later on in the process that, if properly implemented, should prevent or significantly reduce the risk of recurrence.

Comparing findings with relevant standards & protocols

The next stage of the investigation is to compare the conditions and sequence of events with relevant standards, guidelines, protocols etc. This helps to minimise the subjective nature of investigations and to generate recommendations, which have the maximum impact and relevance. The objectives are to decide:

- If Serious Untoward Incident Policytable standards/procedures etc. have been set to control all the factors influencing the event
- If standards/procedures etc. exist, are they appropriate and sufficient?
- If the standards/procedures were good enough, were they applied or implemented appropriately?
- Why any failures occurred?

Making Recommendations

Where the investigation identifies immediate or underlying causes involved, the Investigating Officer may be able to either take remedial action immediately or make recommendations for possible solutions to prevent recurrence within an Action Plan

If recommendations fall within the remit and level of authority of the Investigating Officer, they should be implemented without delay. If however, they are of a wider scope, require additional resources or have implications across the Trust, the risk and recommendations should be flagged up to their Line Manager, Director and the Risk Team for incorporation onto the appropriate risk assurance framework.

The Organisational Learning Group will review all Red incidents and ensure that a root cause analysis has been undertaken. This will usually result in an Action plan being drawn up with prioritised actions, responsibilities, timescales and indicators to measure the effectiveness of actions taken.

It is important that progress on implementing recommendations or action plans are tracked and that the effectiveness of actions taken is monitored. Effective actions result in demonstrable improvements in safety and, where appropriate, quality of care.

Staff Issues

Serious incidents, many of which will directly involve Trust staff, the investigating officer should be mindful of the needs of the individuals involved. Trust employees may need support and or counselling, to help them through difficult situations. Investigating officers must ensure staff support is put in place, were necessary, at the start of the investigation.

Any member of staff involved in a complaint, incident or claim can obtain immediate advice and support from their line manager or the Risk, PALS, Complaints Claims and Litigation Teams. All staff involved should have the opportunity to provide information and statements about the incident, and have feedback on the outcome of the investigation. For further information for staff involved in an adverse incident, including complaints and claims refer to the Support for staff (involved in an adverse incident) Poicy.

During the progress of an adverse incident investigation, the investigating officer should regularly ensure those involved are updated appropriately.

Staff: Statement Writing

Before providing a written statement, particularly if it relates to an incident that occurred some time ago, make sure that you have access to any relevant records. Always ensure you use the Templates used by the Trust (see the Risk Event Information booklet if unclear). Give brief curriculum vitae details at the beginning of the statement:-

- Full name
- Post held and grade
- Qualifications (years' experience in the relevant profession)
- Confirm the date, time and location of the incident.
- Your account must be as accurate as possible and above all, factual.
- Describe exactly what you did (or didn't do) in relation to the incident in as

much detail as possible.
- Explain your reasons for what you did (or didn't do).

Detail the event in chronological order, giving dates and times where possible. Do not include any of the following in the written statement:-

- Hearsay, (i.e. someone else's views or version of events)
- Speculation or Hypothesis
- Views on causes
- Opinions on quantity of work provided by offer staff
- Derogatory comments about what has happened
- Avoid jargon and clichés. It is acceptable to use technical words, but you should try to explain these in lay terms wherever possible.
- Abbreviations should only be used if the full terminology is given at least once, followed by the conventional abbreviation in brackets.

Statements should be legible, preferably typed and carefully checked before being signed. Sign and date your statement at the foot of each numbered page. Remember to keep a copy for your own records.

Guidelines to Managers: Obtaining Witness Statements.

Remember you are in a position of responsibility and therefore need to:-

- Conduct yourself professionally
- Be discreet
- Be objective
- Keep your opinions to yourself and deal with facts
- Do not discuss the case or your findings with anyone
- Make sure that you understand the issue to be investigated.

Examine the tasks and sub-divide them into their natural components – e.g.:-

- Who needs to be interviewed?
- Which systems need to be examined?
- What addition information needs to be obtained? e.g. – Policies, Codes of Conduct or Job Descriptions etc.

When staff are interviewed consider – e.g. –

- How should they be approached, and what information you give them before they attend. Send a letter or telephone explaining that the meeting / interview is one of fact finding only to give their accounts of the event in question.
- Sometimes staff have already made a statement, but the purpose of your meeting will be to ensure that a detailed thorough statement is available and to ask any relevant questions to clarify points.
- Although on occasions freely written text may be an appropriate form of statement, in most cases it is preferable for this to be in the form of a record of the actual dialogue. This entails the recording of the questions asked and the answers given during the interview.
- Remember, statements must be signed by the interviewees to be valid.

Depending on the system of note taking used, the interviewee should sign a copy of the notes after being given the opportunity to read them and make changes if necessary, either directly after the meeting or not more than 24 hours later.

Are you asking them to attend at reasonable times bearing in mind their off-duties, needs their work or places and/or have you given them sufficient time to prepare themselves? Which is the most appropriate environment for the interviews to take place? It should be a forum setting where business cannot be overheard or overlooked.

- Offer each member of staff the opportunity to be accompanied by his/her trade union or employee representative, or, work colleague or friend not acting in a professional capacity. Make it clear in your notes that you have done this.
- Do you need someone with confidential status to record the dialogues/events at the interviews? Remember, when introducing such people to interviewee's stress that the note takers are acting confidentially.
- Which aspects can each member of staff to be seen help with. Pre-prepare and record your questions, leaving spaces for answers and any additional questions. Ensure that your questions follow a natural flow so as not to confuse the interviewees.

During the interview, and as a member of staff relates events, ask questions to clarify or expand on the various points. Questions must be open and reflective, probing and summarizing. Interviewers must avoid leading questions or statements, and try not to create hypothetical scenarios.

Have your notes typed up as soon as possible after the interviews whilst your mind is still fresh. Check them thoroughly to ensure that they bear true reflections of what was said/happened etc.

Refer to people (members of staff and clients) during interviews and in your notes using proper names not 'nick/pet names'.

Collate all your information, i.e. notes, records of events and interviews, statements, copies of relevant policies and procedures etc in a logical order. Index you information on numbered pages and under appropriate sections. Present your information professionally.