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Principles for full investigation of serious incidents involving patients under the care of mental health and intellectual disability provider organisations

COLLEGE BRIEFING

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A large group of stakeholders also provided comments on earlier drafts of this paper.

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Background

Serious incidents can occur that put patients, carers, family members, friends, staff, members of the public, or the provider organisation at risk or cause them harm. Learning from serious incidents is essential, and a culture of openness should be present in every organisation. However, despite healthcare providers being under greater pressure to investigate and learn from serious incidents, there is a lack of evidence about how we can learn from such incidents. In addition, the threshold for what is classed as a serious incident varies between organisations, which can make comparing methods of investigation and learning challenging. Moreover, the quality of the investigations varies and there is also variation in the way that patients and families or carers are engaged in the process. [1]

The Royal College of Psychiatrists is committed to addressing standards for investigations. Through its Invited Review Service, the College has identified a set of guiding principles. The purpose of this document is to set out the principles of good practice for investigations conducted by mental health and intellectual disability provider organisations, following serious incidents in both the NHS and independent sectors across the whole of the UK. The principles were developed following a literature review of existing frameworks and guidance, followed by consultation with experienced investigators and other stakeholders, including service user and carers.

Although serious incident investigations serve organisational needs, they are important to patients, families and, in cases involving violence, victims of incidents. In the text below we have referred to families for the sake of plain English, but it is clear there is a range of potential interested parties, other than the professionals involved, depending on the nature of the incident. There are sometimes difficult judgements to be made about who to fully include in the investigation process, but the assumption should be of the greatest possible inclusiveness. In cases where the incident does not involve the death of the patient, they should be consulted wherever appropriate. In cases where other service users are affected by the incident, consideration should be given to the most appropriate support for them.

This document does not offer a definition of a 'serious incident'. Criteria are set by organisations according to the nature and circumstances of their services. Similarly, we have not recommended specific thresholds for full investigations (as opposed to single-investigator case note reviews). This document is concerned with serious incident investigations conducted by more than one investigator, involving investigatory interviews with staff, patients or relatives. Examples of serious incidents include events that result in the death of a patient by suicide. The focus is on the quality of the investigation rather than

1. House of Commons Public Administration Select Committee Report, Investigating Incidents in the NHS 2014-15. Sixth Report of Session 2014-15, House of Commons, March 2015 www.publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf

the range of types of incident that should be investigated. It is good practice for an investigation report to set out what serious harm occurred that necessitated the investigation.

There are some incidents where there will be both a criminal investigation and a serious incident investigation. Under these circumstances, there should be consultation between the service provider and the police at a senior level to avoid criminal investigations being compromised and avoidable delays in identifying problems that require remedial action. Criminal and serious incident investigations are equally important. Where there may be a need to suspend a serious incident investigation whilst criminal investigations proceed, the likely length of the suspension should be agreed and justified by police and provider organisations at a senior level. In addition, serious incident investigatory processes need to take competing interests of witnesses into account, for example where a staff member has been criticised and is also providing evidence, or where the family member is a victim. Similarly, potential competing interests of investigators should be declared in final reports.

Principles of serious incident investigations

1. The purpose of serious incident investigations is to find out what has happened and, in light of this, assess whether actions need to be taken to avoid future incidents.
2. All serious incident investigations should have terms of reference that identify the scope of the investigation and the timescale for reporting. Terms of reference, specific to the case, should be set by senior managers in consultation with lead investigators and families.
3. Provider organisations should make first contact with families of the incident as soon as possible. This first contact should be aimed at meeting the family's support needs and should not be inhibited or constrained in anticipation of an investigation. Families should be provided with information about what has happened as quickly as possible. Provider organisations should observe the spirit of Duty of Candour principles as well as any formal obligations. An early expression of regret and apology is important, provided that it can be made with a quality of authenticity.
4. Family members and staff should have the opportunity to give evidence to the investigators and to comment on findings prior to publication. Regular contact should be maintained during the investigation.
5. The greatest possible degree of openness and transparency should be given to staff, patients and families.

6 Staff and families should be given a realistic expectation of investigatory timeframes in writing. They should also be provided with information about what to expect from the investigatory process and be kept informed of any delays in progress.

7 The investigation should be conducted independently of the treating team involved in the incident and their direct managers. The level of independence should be proportionate to the seriousness of the harm caused by the incident. In some cases, external oversight or external investigation will be required and the final report should justify the degree of independence of the investigation. In addition, competing interests of those undertaking the investigations should be declared.

8 Serious incident investigations should be conducted by skilled investigators who have the relevant training, clinical experience and knowledge base. Whilst experienced investigators can conduct high-quality investigations into incidents in services outside of their sphere of clinical experience, at least one member of the investigation team should have service-specific expertise.

9 The composition of the team conducting the investigation and reasons for their selection should be set out in the report. Where there is a review panel overseeing an investigation, the chair of the panel should have relevant experience, expertise and training.

10 Some experienced investigators find investigatory instruments useful. Appropriate use of these tools requires training and the instruments cannot, in themselves, be relied upon to deliver a competent and useful investigation. In all cases, investigatory instruments should be regarded as adjuncts to investigation, and no investigation should be entirely reliant upon them. Their use is often neither necessary nor appropriate.

11 Reports should be written in plain English, with all specialist vocabulary explained, so that they are fully comprehensible to readers with no professional background in mental health. Reports should be as succinct as possible. Whilst developing a timeline may be useful for the investigators, it should only be set out in the report if it illuminates points that could not be made more concisely in prose. The findings in the conclusion of the report should logically flow from the evidence in the body of the report. The recommendations should be clear and focus on improvements that can be made to prevent similar incidents happening in the future. Where reports are long and/or complex, there should be an executive summary, setting out the main conclusions and recommendations,

12 Where specific questions are set out in the terms of reference, these should be explicitly answered. If a question cannot be answered, the report should make the reasons for this clear.

13 Recommendations should be limited to a small number that can be monitored and implemented within a specific time frame. The individual responsible for overseeing completion should be identified. SMART (specific, measurable, achievable, realistic,

and time-based) can be a helpful framework to use in writing recommendations. The recommendations should explicitly take the organisation's existing action plans and safety priorities into account. Incidental findings that affect quality of care, but lie outside of the terms of reference, should be thoroughly investigated or a separate investigation should be recommended.

14 Complex recommendations should lead to the prompt development of an organisational action plan, which should be implemented and monitored against a specific timescale. A log of progress should be kept and should be available to internal and external agencies. Recommendations should not be implemented by simply cascading information to managerial staff.

15 Wherever possible, there should be no more than one provider investigation into a single set of facts, unless this is unavoidable, in which case the investigations should not run concurrently. Where multiple agencies need to be involved in a single investigation, the investigation should be led by the agency with the greatest competence in the issues of concern. Where there is both a complaint and a serious incident investigation, these should constitute a single investigation.

16 Information governance agreements should be in place to ensure information sharing between local organisations. Good quality investigations depend on access to full records, both old and current. If some records are missing or inaccessible, caveats should be made on the reliability of findings and the appropriateness of recommendations.

17 Adequate time and resources should be allocated to staff acting as investigators. Time should be allocated within their job plans, or they should be temporarily relieved of some other duties to facilitate a timely and high-quality investigation.

18 Good investigations should support appropriate accountability at individual, managerial, and corporate levels. Undertakings to conduct 'no blame' investigations are unrealistic. Investigations should be part of an organisational 'just culture' whereby individual contributory factors are identified and the response to errors of judgement or lapses by individuals is supportive. Sanctions should only be considered where clear personal culpability is evident. Referrals to regulatory bodies should occur where there is prima facie evidence that the professional may be unfit to practise. However, referral to regulators in the absence of such evidence, without suspension from duty, is damaging to the quality of care that those professionals can provide to their patients and should be avoided.

19 When holding individual professionals to account, due regard should be paid to the managerial environment in which they work. Where investigators believe that an individual professional may be subject to criticism, the professional should be advised of this matter and should be allowed to have a representative or friend present when they are interviewed.

20 Investigators should be accountable for the quality of their work, and adhere to values of fairness, timeliness and transparency. Mechanisms of accountability, appeal and complaint should be set out in the terms of reference. Investigators should ensure that their training and continuing professional development plans include elements relevant to their investigatory role.

21 Accountability requires an awareness of values and standards that are held by a peer group. Investigators should participate in peer group meetings with other investigators to discuss serious incident investigations that they have conducted, the processes involved, and problems encountered.

22 Where multiple factors contribute to the incident occurring, and no single root cause is identified, this finding should be stated clearly in the report. With complex problems, the report should explain what happened and set out lessons learned even where these measures alone would not have prevented the incident.

23 The fullest version of the final report should be shared with all staff interviewed and with families, insofar as this is compatible with appropriate confidentiality. Where individuals are criticised in the report, a draft version should be shared with them, to give them the opportunity to comment. Responses should be appended to the final report, with permission.

24 Staff and families should be given the opportunity to feed back on their level of satisfaction with the process, including the fairness, timeliness and transparency of the investigation and report.