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Learning from catastrophic incidents

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Initial Impact

(Emergency planning)

- Managing a crime scene
- Closure of clinical area – under police control
- Dispersal of patients – noting any Home Office Restrictions/ Liaison with Ministry of Justice
- Establish incident room
- High Level Incident Coordination meetings – Exec Directors, Chief Constable, HSE
- Deep clean and recommissioning of clinical area

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Communications Plan

- Ministry of Justice
- CCGs
- NHS England Specialist Commissioners
- Area Teams
- Public Protection Teams (Local Constabulary)
- Local Safeguarding Teams
- CCQ
- HSE/RIDDOR
- Universities
- NHS Improvement (Monitor)
- Media - press statements

Support to the family

- Appoint Executive Director as point of contact;
- Signpost to bereavement support;
- Arrange condolence letter from Prime Minister;
- Death in service payment & pension;
- Arrangements for final pay cheque;
- Explain the investigative processes and provide regular updates;
- Establish what questions the family have to inform TOR
- Offer memorial service at local Church/Cathedral;
- NHSLA payment;
- Union Support;
- Access to legal advice for the family;

Support to staff

- Facilitated debrief immediately following the incident for staff on duty;
- 2nd facilitated debrief within 24 hours for other unit staff not on duty;
- Set up “Telephone buddies”;
- Students on placement supported by respective universities;
- Set up OH Clinic within 72 hours to assess the fitness of staff wanting to be at work;
- OH appointments, counselling and individual psychology sessions offered to all unit staff;
- Collaboration between unions & dedicated Staff Side meeting to sign post to additional services;
- Temporary redeployment, phased return to work, staff requiring longer absence can have A/L and unsocial hours pay protected and be given specialist “ at risk status” to assist with redeployment;
- Support for witnesses during investigative process – noting that they may be interviewed multiple times and possibly under caution.

How many investigations??

Article 2 ECHR – the State is required to undertake an investigation into the death of a person where the death may have been caused by agents of the state

- Police homicide investigation – Court Case
- Internal Investigation (NHS Serious Incident Framework)
- HSE (death in the workplace) jointly with police
- Inquest
- Independent Homicide Inquiry (HSG 94/27)

Internal Investigation

- Expect delays – police will indicate that witnesses should not be approached by trust investigating officers to limit to risk of contaminating the police evidence gathering;
- Establish effective TOR – share with all involved parties;
- Appointed suitably qualified/trained investigators;
- Document **everything**, retain **everything;**
- Record all interviews and retain digital record;
- Negotiate deadlines with relevant commissioners;
- Ensure final report is robust and honest – *"tell it like it is!"*

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Internal Investigation

Consider specifics of any case

- Patient Care
- Staffing
- Policy issues
- Corporate issues

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Patient Care

- What are the documented risks/ care plans?
- Is a patient able to “mask” behaviour that might have given clues?
- Are any factors not identified via risk assessment?
- Are previous risk incidents properly assessed?
- Is an appropriate plan in place?
- Is an audit trail of that/those risks appropriate?
- Is the placement/admission appropriate?
- Are health care records comprehensive and conscientious?

Staffing

- Are staffing levels appropriate/adequate in terms of numbers and skill mix?
- Are staff appropriately briefed about patient history/factors?
- Are staff appropriately trained?
- Is there regular clinical/management supervision and appraisal?
- Did circumstances lead to an increased reliance on agency/bank staff?
- Are staff aware of relevant polices and practices, are there failures in adherence?
- Is the unit run in a way which combines clarity of expectation with good person centred care – how can this be demonstrated?

Policy Issues

- Are policies properly disseminated and training provided – does the breadth/depth of policies lead to “policy blindness?
- Are the requirement of the Code of Practice met (MHA)?
- Do policies meet the standards of general guidance (DoH, CQC, NSHLA, HSE etc.)?
- Are unit/ward specific policies fit for purpose?
- Are audit systems in place which review, identify problems, design solutions and then audit the effect?
- Are policies up to date?

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Corporate Issues

- Is the ward/unit appropriately integrated into the mainstream of the Trust's services?
- Whether, and how, good practice is disseminated?
- How are issues identified and is there an appropriate chain of accountability?
- Is there an appropriate balance between devolved decision-making and corporate accountability?
- Is there an appropriate corporate framework to support devolved services?
- Is patient experience surveyed, understood and acted upon?
- Have any previous issues identified by other regulatory agencies been acted upon?

Corporate Issues (cont.)

- Is there a culture of proper risk assessment and adherence to health & safety concerns – both on the unit/ward and across the whole organisation – how can this be demonstrated?
- Do teams within the unit/ward/organisation communicate effectively?
- Is the environment fit for purpose?
- Is there effective, care specific, interagency communication?

Investigation Action Planning

- Establish monthly Executive Director led meeting;
- Maintain detailed note of these meetings, including attendees, all actions/updates on actions & assurances received;
- Monthly updates to Governance Committee (or equivalent) and Trust Board;
- Share action plans & updates with external agencies, where appropriate e.g. HSE;
- Maintain evidence base via a clearly identified senior manager;
- Maintain all of the above until all actions are completed, together with demonstrable evidence;
- ASSURANCE, ASSURANCE, ASSURANCE…….

HSE Investigation

- Interviews with all ward/unit staff/ CEO & Director of Operations – some under caution;
- Review of all associated documents (including internal investigation report & associated action plans;
- Notification of contravention – if incident considered a Material Breach of H&S Law;
- Fee for Intervention (FFI) - £129 per hour (includes part hours!);
- Legal advice – especially if aspects of differing legal frameworks Law are at odds e.g. H&S at Work Act 1974 v Code of Practice, Mental Health Act 1983 (2007)
- It may take a long time……several years!!

HSE Investigation (cont.)

Restrictions may be placed on circulation of internal investigation report (this may even include the family and staff within the workplace)**.** Circulation of internal investigation report restricted by

Section 31 (g) and 31 (g) - (i) of the Freedom of Information Act.

"*Information which is not exempt information by virtue of section 30 is exempt information if its disclosure under this Act would, or would be likely to, prejudice –*

g) The exercise by any public authority of its functions for of the purposes specified in subsection (2)

HSE Investigation (cont.)

- The purposes referred to in subsection (1)(g) to (i) are—
- (a)the purpose of ascertaining whether any person has failed to comply with the law,
- (b)the purpose of ascertaining whether any person is responsible for any conduct which is improper,
- (c)the purpose of ascertaining whether circumstances which would justify regulatory action in pursuance of any enactment exist or may arise,
- (d)the purpose of ascertaining a person's fitness or competence in relation to the management of bodies corporate or in relation to any profession or other activity which he is, or seeks to become, authorised to carry on,
- (e)the purpose of ascertaining the cause of an accident,

HSE Investigation (cont.)

- f)the purpose of protecting charities against misconduct or mismanagement (whether by trustees or other persons) in their administration,
- (g)the purpose of protecting the property of charities from loss or misapplication,
- (h)the purpose of recovering the property of charities,
- (i)the purpose of securing the health, safety and welfare of persons at work, and
- (j)the purpose of protecting persons other than persons at work against risk to health or safety arising out of or in connection with the actions of persons at work.

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Challenges & Questions?