Memorandum of Understanding

Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive

Foreword

This protocol coincides with a changing culture in the NHS. Public and patient safety is being put at the forefront of everyday practice. This requires openness on the part of the individuals working in the NHS in reporting errors, ensuring that lessons are learned for the future and that patients concerned receive proper treatment. It also requires fairness when considering whether action is to be taken against the individuals concerned.

Some patient safety incidents involve systems failures while others may also involve the failure of an individual or individuals. We recognise the important role of the NHS in investigating such failures using methods being developed by the Department of Health, the National Patient Safety Agency and the Health and Safety Executive.

The Department of Health is pursuing its commitment to patient safety among other things by encouraging a shift in the NHS from a prevailing culture of blame to one that is fair and just. All experience in other high risk industries shows that a culture in which blame predominates in the handling of errors and adverse incidents creates a climate of fear leading to concealment of safety problems. This can lead potentially to more, rather than fewer, incidents.

As a result, the police and HSE may conduct initial investigations into matters of concern reported to them and the threshold for taking these forward is usually set at a high level. This means that such investigations should take place only where there is clear evidence of a criminal offence having been committed or where a breach of health and safety requirements is the likely cause or a significant contributory factor.

In taking forward such investigations, we recognise that the safety of the public and of patients is our first priority and that this requires a

Introduction

1. NHS patient safety incidents involving unexpected death or serious untoward harm and requiring investigation by the police and/or the Health & Safety Executive (HSE) are rare. However, there has been an increase in the number reported in the past few years. Such incidents must be handled correctly, both for the sake of public safety as well as confidence in the NHS, police and HSE and in the interests of fairness and justice.

2. It is important that investigations into such incidents - be they conducted by the NHS, police and/or HSE - are carried out effectively and consistently. These investigations and any remedial actions need to ensure that:

   - public and patient safety is assured
   - patients, where appropriate their relatives, and NHS staff are informed, consulted and supported
   - health & safety in the NHS workplace are safeguarded
   - NHS services are maintained as far as possible
   - the NHS can learn effectively from the incident to reduce future risks to patients
   - the actions of NHS staff and services are properly and promptly examined where appropriate
   - criminal investigations that may be necessary are conducted promptly and effectively with appropriate support from the NHS, helping to expedite decisions on any prosecutions
   - links are made to investigations conducted by coroners to ensure coordination and minimise duplication
   - links are made to other types of reviews or investigations as appropriate, for example, serious case reviews on children who die or are seriously injured where abuse or neglect is the cause or a factor in the death or injury

been sought. All have offered strong support for the development of the protocol.

5. Guidelines to the NHS, an additional chapter in the Police murder manual dealing with investigations in healthcare and internal guidance to HSE inspectors support the protocol. A joint training programme is also being commissioned to spur the development of good practice. This will be aimed at NHS staff, police officers and HSE inspectors. A list of documents relevant to the protocol appears in annex 1.

6. Criminal investigations into deaths at work are covered by an existing agreement between the Association of Chief Police Officers (ACPO), HSE, Crown Prosecution Service and local authorities known as the *Work-related deaths protocol* (WRDP, see annex 1 for details). This memorandum of understanding does not affect the operation of the WRDP but should be used in conjunction with it.

other concerns coming to light e.g. fraud. In such instances, the NHS Counter Fraud and Security Management Service must be informed.

2.6. For the purposes of this protocol, an NHS patient is defined as: 'A person receiving care or treatment under the NHS Act'.

Patient safety incidents that may involve the police or the police and HSE

2.7. The types of patient safety incident that may prompt an NHS Trust to involve the police are those that display one or more of the following characteristics:

- evidence or suspicion that the actions leading to harm were intended
- evidence or suspicion that adverse consequences were intended
- evidence or suspicion of gross negligence and/or recklessness in a serious safety incident, including as a result of failure to follow safe practice or procedure or protocols.

2.8. The police and/or HSE may also investigate an incident following contact by patients, relatives or, in the case of the death of a patient, by a coroner. Further information about the coroner is given in the NHS guidelines.

2.9. NHS guidelines contain general definitions of terms such as gross negligence, manslaughter, recklessness and corporate manslaughter.

2.10. Some accidents to patients must be reported to the HSE by NHS Trusts under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). HSE will normally investigate all fatal accidents reported under RIDDOR, but not accidents to patients that arise from medical treatment or diagnosis.

5. Securing and preserving evidence

5.1. It is easy in the immediate aftermath of a patient safety incident to overlook the need to secure and preserve evidence. This may be particularly true of busy clinical areas that are in constant use by patients and staff and when people are following routine Trust operational practice *e.g.* sterilising a piece of equipment after a procedure or operation.

5.2. However, safeguarding physical, scientific and documentary evidence may be critical to understanding what has happened, thereby protecting public safety and ensuring the conduct of a satisfactory investigation by any agency. Destruction of evidence may also delay the introduction of safety measures. It may also lead to a more protracted and complex investigation than would otherwise have been necessary. For example, the absence of the packaging and batch number of a piece of equipment may lead to a delay in the Medicines and Healthcare products Regulatory Agency issuing a medical device alert to the NHS or instituting appropriate investigations into a device or medicine.

5.3. It is especially important that evidence is retained where a criminal offence is suspected, since failure to do so may undermine legal proceedings.

5.4. Even in incidents where concerns arise long after the event, it is important to make every effort to secure and preserve all available evidence.

5.5. A record must also be kept and receipts obtained wherever possible of any NHS documents, records or other items passed to other agencies.