GUIDELINES FOR THE NHS

In support of the 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 the Health & Safety Executive

Gateway ref: 7407

November 2006

Purpose of NHS guidelines

1. The guidelines should be read in conjunction with the Memorandum of Understanding (MOU) *Investigating patient safety incidents involving unexpected death and serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive*. This was published on the 20th February 2006. and can be found at Available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4129918&chk=P5hkFZ

2. These guidelines provide practical advice to NHS organisations about what to do when faced with a patient safety incident or incidents that may require investigation by the police and/or Health & Safety Executive (HSE). They provide information about:

   - Scope of the memorandum of understanding including the definition of an NHS patient
   - Identifying incidents
   - Investigating incidents and making a referral
   - Preserving and safeguarding evidence
   - Conduct and management of the Incident Coordination Group
   - Sharing information
   - Supporting patients, relatives and NHS staff
   - Handling communications/media

3. The guidelines set out what is considered to be good practice when dealing with patient safety incidents. They have been produced in consultation with other organisations including the police, HSE and the National Patient Safety Agency (NPSA).

The appendices contain guidance about:

14. NHS organisations should as necessary also inform organisations with an advisory or analytical function such as:
    - Department of Health – Patient Safety & Investigations Branch
    - Serious Hazards of Transfusion (SHOT)
    - Health Protection Agency (HPA)
    - National Patient Safety Agency (to whom all incidents must be reported)
    - NHS Litigation Authority
    - National Confidential Enquiries
    - Strategic Health Authority
    - Monitor (for Foundation Trusts)

15. Further details about these organisations are to be found in Appendix C along with website addresses and contact information. If necessary, NHS organisations can also seek advice from the Department of Health's Patient Safety & Investigation Branch [see contact details at paragraph 8] and/or the Healthcare Commission.

16. NHS organisations have the legal responsibility to ensure the security of patients and staff. This work is overseen nationally by the CFSMS. Locally, this is the responsibility of the Security Management Director (SMD) and the Local Security Management Specialist (LSMS). If, during the course of an investigation of patient safety, any incidents come to light concerning poor security, the LSMS must be notified as soon as practicable.

<u>Making a referral to the police and/or HSE</u>

17. There will be occasions when the NHS will need to refer matters to the police; NHS organisations may need to consider whether a safety incident should be reported to the police and/or HSE. In these circumstances, it is best practice to make early contact with the police and/or HSE to discuss concerns and to take their advice on further

action. The NHS organisation's risk manager or equivalent person with risk management responsibility, with the agreement of the chief executive or nominated representative, should take responsibility for ensuring that this advice is sought and, if necessary, a referral made. The roles, responsibilities and working practices of the police and HSE are described in more detail in Appendix B.

18. It is impossible to present a comprehensive list of examples that may prompt an NHS organisation to consider a referral. Most incidents are investigated by the NHS; therefore circumstances should be sufficiently serious and criminal intent suspected to warrant a police investigation. This decision should be taken by an appropriately senior person, preferably at executive level in the organisations. The general criteria set at paragraph 2.7 (page seven) of the MOU protocol should guide this decision making.

19. Unexpected deaths and/or incidents resulting in serious untoward harm to patients may be reported by NHS organisations to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). RIDDOR places a legal duty on employers and those in control of premises to report some work-related accidents, diseases and dangerous occurrences to the relevant enforcing authority for their work activity. For the NHS, this is usually the HSE.

20. Accidents to patients that arise from medical treatment or diagnosis in the main are exempt from this requirement. The HSE does not investigate all accidents, but it will normally investigate all fatal accidents under RIDDOR. Such incidents may also be referred to the HSE by the police or via the coroner. In all these circumstances a criminal investigation may be launched by the HSE and this will be conducted according to the Memorandum of Understanding to which these guidelines refer.

21. The law requires the following work-related incidents to be reported:

- Deaths
- Major injuries
- Over-three day injuries – where an employee or self-employed person has an accident and the person is away from work or unable to work normally for more than three days
- Injuries to members of the public where they are taken to hospital
- Work-related diseases
- Dangerous occurrences – where something happens that does not result in a reportable injury but which could have done

22. The matter of when and what to report to the HSE should be discussed with the NHS organisation's risk manager or equivalent in the first instance. Further advice should be sought from the HSE's Incident Contact Centre on 0151 922 9235 in the first instance or reference can be made to the HSE or RIDDOR website (www.riddor.gov.uk) and a RIDDOR reporting form (F2508) can filled out and submitted online.

23. At the point of referral the NHS organisation's risk manager, or another appropriately qualified individual should take responsibility for preserving any relevant evidence and, if appropriate, safeguarding the scene.

Case Study 1

Mrs R, an 89-year-old widow was admitted to a small district general hospital on 1 February 2000 via the accident & emergency department after a fall at home, where she lived independently with some social services support.

She had broken her leg and needed an operation and a Thompson's arthroplasty was carried out on 2 February. Mrs R recovered well immediately after the operation. She was starting to move around with the help of regular physiotherapy.

On the morning of 7 February a nurse tending to a patient in the bed next to Mrs R's noticed that she was struggling for breath, retching / regurgitating and was drowsy. The nurse went to Mrs R who looked pale and clammy. Mrs R needed suction to her airway but the suction unit above the bed did not work when turned on. A suction unit was brought from a nearby bed, but tubing was missing from it. The staff managed to create some suction from the unit at Mrs R's bed, but her condition did not improve, so a crash call was put out. The team attended as Mrs R suffered a respiratory arrest; shortly afterwards she suffered a cardiac arrest. Efforts to

preserving it in a fridge. Receipts should be obtained and a record kept where any evidence – including equipment – that is handed to another agency.

Communicating

36. A senior member of staff – usually the risk manager - needs to take responsibility for briefing the police and/or the HSE about what evidence is available, where it is, who has had access to it and what efforts have been made to protect it.

37. It is important that the NHS, police and/or HSE work together to keep patients, relatives, injured parties and NHS staff informed and to provide support as appropriate. The organisations should therefore, as far as possible, agree and follow a liaison strategy for each incident. Such a strategy should be agreed at the first meeting of the Incident Coordination Group and as necessary at subsequent meetings.

Case Study 2

SL, a 23-year-old patient, had a long history of recurrent, chronic lung infections and severe asthma. He also had a psychiatric history, which included several overdoses and a history of cutting himself. He had been admitted several times to both psychiatric and general hospitals for his mental health problems and his chronic lung infection.

SL was cared for in a side room on a respiratory ward and was more or less self-caring. He administered a nebuliser and his regular medications were kept in a patient bedside medication locker. One afternoon his primary nurse went to check him and found him dead in bed. He had a 10ml syringe attached to his intravenous line and there was an empty medicine bottle next to his bed.

The nurse immediately instigated the crash procedures. The crash team noted that the circumstances of death seemed unusual. SL's history of taking overdoses was noted and that there was an empty medicine bottle next to him. The staff disturbed as little as possible. Intravenous lines were kept in situ and everyone made sure not to disturb the scene which included furniture, clothes, bed linen, medicine bottles and packaging as well as disposable items.

The senior manager was called and after discussion with the trust board lead for patient safety and the crash team, police were called.

The senior manager instigated the serious incident procedure, secured the patient's clinical notes, put the side room out of bounds and prevented unauthorised people from entering the patient's room.

The senior manager was designated to take the lead and acted as the coordinator for liaising and briefing the police.

example, the process involved where a coroner's post-mortem and/or inquest is necessary).

Case study 3

XY was a nine-year-old child who had an operation on a finger after he hurt it playing in the garden.

He was given a general anaesthetic and ventilation was started using a Laryngeal Mask Airway (LMA). It then became apparent that he was not responding correctly.

As the emergency situation progressed, all items of the patient breathing circuit (PBC) were changed except the angle connector. Attention was directed towards possible medical conditions. This went on for some time.

A specialist registrar was asked to help and eventually checked the PBC, taking it apart and re-connecting it but by then XY had stopped breathing.

The registrar subsequently discovered that there was a disposable protective cap from an intravenous (IV) giving set blocking the angle connector in the PBC.

XY's death was reported to the coroner, who referred it to the police.

Points to note

Referral was made from the coroner to the police in this event, because there was a similarity between this incident and one that had occurred elsewhere three months earlier.

Supporting NHS staff

52. Patient safety incidents and the ensuing investigation(s) have a considerable effect on the staff involved. Appropriate and timely support should be made available to them. This may include professional counselling.

53. Those involved in an incident should be encouraged to contact their professional association and/or union representative. Legal advice for those involved, including witnesses, should usually be provided through professional associations and/or unions rather than by NHS organisation solicitors. In the case of staff that do not belong to a professional