

## **SERIOUS INCIDENT, INVESTIGATION & REPORTING POLICY & PROCEDURES**

### **Purpose**

The purpose of this document is to support management to undertake thorough investigations into serious incidents, in order to be able to demonstrate that root cause analysis has been applied and actions identified and implemented and therefore help mitigate the risk of such an incident reoccurring. This process will be helpful to reassure any commissioners, insurers and any other relevant parties that the organisation is competent in all aspects of Governance and has an ethos of striving for continuous improvement.

This document will expand upon the headings on the Investigation Report Template that accompanies it and is designed as a 'user guide' for the template.

### **The Investigator and the Terms of Reference**

The first thing for an organisation to do when a Serious Incident (SI) has occurred is to identify someone through whom all information about the incident must flow. Ideally this would be the person that is going to investigate the incident. This person should not have been directly involved in the incident. It should be a senior person within the organisation (Manager or nominated Trustee). In extreme certain cases it may mean an external person or agency competent in investigations may be required, in which case a process will need to be agreed.

The Terms of Reference (TOR) should form the parameters of the investigation, show what is in and out of scope. See the TOR list on the template. Note that whilst the investigation must restrict itself to the facts, it may need to take into account relevant factors, such as shortage of resources contributing to an accident for example – i.e. not just focussing on the accident itself.

In the process of the investigation, sensitivity and confidentiality may be required, if clients or their family are involved. Equally, if the incident involves a safeguarding alert, then it may be necessary to tell the client that information will need to be shared with people that need to know.

The investigation must lead to an outcome. This is usually one or more recommendations for action by the organisation. This might be increased or repeat training for individuals involved, or a policy or procedure that will require a review. It may even be that a whole service should be reviewed. The investigation

should be 'timely'; there are no strict time scales around this kind of thing, but time should not be wasted - the investigation should be progressed as efficiently as possible. Learning the lessons from an investigation is the most important reason for undertaking one in the first place. No organisation can truly prevent all serious incidents from happening, but they can minimise the chance of them happening and the impact if they do happen. They do this through planning and risk assessing and through learning from any previous incidents.

## **The Investigation Process**

With an investigator now in place, the first focus is to get a factual description of the events that surround the incident. This will mean speaking to people who were involved or who may have witnessed the event. This may include clients, or service users and/or their families. It usually includes staff or volunteers and may even include members of the public, or contractors etc.

The focus must be on the facts. The investigator must not assume or give their own opinion on events.

The report should start with a summary of the events, although it is usually only possible to complete this section once everyone involved has been spoken to, so effectively it is the last piece to complete, but the first thing to read. Completing this will enable the investigator to also complete a chronology of events – this should start at the very beginning i.e. just before the incident occurred and go through the time line of events right up to and including the reporting of the incident both through any internal and external channels, as appropriate.

## **People, Equipment and Circumstances**

Now we start to get into the detail of the incident. Firstly, thinking about people – consider who was involved (staff, volunteers, clients, family, trustees, members of the public, contractors etc.) and run through these questions about their involvement:

- Were those people expected to be there, doing what they were doing at the time of the incident? If not, why were they there?
- Is there anyone that should have been present but was not? If so, why not?
- Was the incident caused by someone's actions or inactions? Was this unexpected behaviour? If so, could this have been planned for?
- Did any person's immediate response to the incident make the outcome worse?
- Is training relevant? Could this incident have been avoided if anybody present had been trained in a particular field or had had expired training

refreshed?

- Are checks relevant? If checks on a person's competency or history had been made, could the incident have been avoided? Similarly, think about any equipment or vehicles that were used which were a contributory factor:
- Was the equipment the correct type for what it was being used for?
- Was it in good condition? Can its condition be demonstrated (i.e. does it have a service record)?
- Was it being used correctly by a qualified person?

### **And the circumstances**

- Were the events or activity during which the incident took place a usual or regular occurrence, or was it unexpected?
- Had the activity previously been risk assessed? If not, should it/could it have been and if so when and how long ago was the last review?
- Were there any external, unforeseen factors that could not have been mitigated for? What were they?

### **Intervention and Immediate Action Taken**

Record what was done in the immediate aftermath of the incident, by both those people that were present, or that discovered the incident shortly afterwards and also by the organisation. Was any agency, person or group of people contacted about the incident and if so, whom? What, if any, reports were made and to whom?

### **Relevant Past History**

Refer to any previous incidents or events that may have occurred that were similar. Were the lessons learned from those incidents applied and changes made to process etc? What were the similarities exactly? – people, process, equipment for example?

### **Review of any Staff/Volunteer Witness Statements**

It is standard practice, in the event of a serious incident, that those present, particularly staff or volunteers, are asked to give statements which describe their account of what took place. Staff do not need to seek independent representation for such interviews, as this is entirely fact-finding, but they should sign any statements that they give.

The interviews should be conducted by the investigator. It might be possible to ask any other witnesses unconnected to the organisation what they saw also. The signed

and dated witness statements should be retained for any future reference. It is important that the statements are the true words given by the witnesses and not interpretations by the investigator of what was said – so, recorded speech, not reported speech. Equally, no leading questions – simply ‘What happened?’ ‘What did you see?’ ‘Who was there?’ etc.

Where witness presence or actions are being described in any report narrative, only their initials should be used SP, PJ, RF etc. not their names, for reasons of data protection.

### **Engagement with Service User(s)/ Clients and/or Family**

As stated above, it may be useful or necessary to speak to clients or family if they were present during a serious incident. Signed statements are not required, but it would be appropriate to record people’s comments in writing, ‘Mrs J said....’ For example. The line of questioning should be the same and as per the staff witness statements, the people should only be identified by initials, for example, ‘Mr R’, ‘Mrs J’ etc.

With all interviews or questions and especially with any older people involved, use a kind, calm, non-accusatory voice – remember you are just trying to establish what happened, not send anyone to jail. Be sensitive and aware of any protected characteristics that any ‘interviewee’ may have.

### **Analysis**

Once the available evidence and statements have been gathered, the investigator then needs to begin to analyse what has been collected, so as to state what caused the incident and what if anything, the organisation needs to learn and needs to change to mitigate the risk of it reoccurring.

There are a number of factors that should be taken into account, when doing the analysis and these are based largely on the areas of focus in the investigation process, as outlined above:

- People Factors – did the incident occur because of certain actions or inactions by those people involved?
- Team & Social Factors – Did team dynamics or relationships play a role?
- Communication Factors – Did the incident occur because of poor or no communication, either written or verbal?
- Task Factors – Was the task undertaken during the incident unusual, with no procedure or process attached?
- Education & Training Factors – Does training play a part? Was training expired or not done at all for any staff/volunteers involved in the activity around the incident?

- **Equipment & Resource Factors** – Was poorly maintained equipment or a lack of proper equipment a factor? Was it being used correctly? Were there adequate resources, including human, to undertake the activity?
- **Working Conditions** – Were environmental conditions during the incident unusual, extreme, not planned for? Consider this factor both inside and outside of buildings, such as poor maintenance, if relevant
- **Organisational & Management Factors** – Was the organisation ill-prepared for this eventuality, either through staffing, equipment, training, policy, business continuity planning, supervision etc? Was any lack of management presence or leadership a factor?
- **Client/Service User Factors** – If the incident involved a client, was their presence or behaviour a factor in any way? Could it have been predicted? Could it have been risk assessed for? Were there needs known and planned for, if relevant?

## **Conclusions**

Once all evidence, statements and factors have been analysed, it should be possible for the investigator to arrive at a conclusion. This is very important, as without it, there can be no mitigation against any future occurrence, which would denote a non learning organisation.

What conclusion has the analysis arrived at? It may have been a pure accident, that could not have been foreseen, such as a lightning strike, but in all likelihood, there will be a more mundane and human factor that means the incident was avoidable, or could be made avoidable in the future. The objective is not to apportion blame however, but to determine the cause of the incident and take action to fix it. It is possible of course that neglect or inappropriate or reckless actions on the part of those involved need to ensue. Equally, simply a change of training, procedure, policy, equipment, or contractor etc. could be required. Each incident is different and may have a different cause and a different conclusion.

## **Recommendations**

From the conclusion come the recommendations - the things that the organisation will do, change, put in place, take away, stop etc. in order to mitigate the chances of this happening again.

The whole investigation process should not only produce a conclusion and recommendations, but it should be summarised in a report that expands upon all of the headings in this guidance and in the Investigation Template that accompanies it.

This report is essentially for an internal audience only, whether that be senior staff, management and/or trustees. The findings and the recommendations however

should of course reach those parts of the organisation in which the incident occurred and in which it potentially could reoccur.

The investigation report does not need to be shared more widely (unless an external investigator, regulator or insurer requires it).

If a complaint has arisen around the incident and clients or family wish to know the outcome, they do not need to see the full report – a short, summarised version could be produced, or even just the basic findings and recommendations given to them. There is one important actor here though:

### **The Duty of Candour**

Organisations should be open and honest about serious incidents where there was harm or a risk of harm. That is, the findings and recommendations should be shared with those who need to know - those who were impacted by the incident or who funded or regulated the activity, or those with responsibility for safeguarding – they should not be hidden away, obfuscated, and kept from these audiences. An anonymised version of the incident and the recommendations suitably redacted, could even be made available to other partners in the network, so they too can learn from others how incidents can arise, be investigated and mitigated for.

### ***POLICY STATEMENT***

***All Policies and Procedures held by Age Concern Petersfield & District are regularly reviewed and may be amended from time to time to reflect any changes in Legislation, regulatory guidance or internal policy decisions, as well as for any other reasons determined by the Board of Trustees. The latest versions will always be reflected on our website.***

**INVESTIGATION REPORT TEMPLATE**

<b>Date of Event or incident:</b>	
<b>Reference Number:</b>	
<b>Name of Investigator(s):</b>	
<b>Position(s):</b>	

**Terms of Reference for Investigator(s)**

1. To undertake an initial investigation into the event or incident led by a competent, senior person within the organisation
2. To consider any other relevant factors raised by the event or incident
3. To deliver an outcome, including recommendations, actions and lessons learned
4. To ensure sensitivity and consider the privacy of people using the service and their friends and relatives if involved
5. To ensure confidentiality is maintained throughout and details of the event are only shared with those who have a need to know

**Summary, including Consequences**

Expand the headings below to give further information

*This template is accompanied by a set of guidance notes, which you may find helpful when expanding upon the headings below.*

**Factual Description of Events**

**Chronology of Events** *(Please include to whom the event has been reported e.g. Network Serious Incident Report, Charity Regulator, CQC or other care regulator, LA Safeguarding Team, commissioner, insurer etc.)*

**People, Equipment & Circumstances**

**Intervention/ Immediate Action Taken**

**Relevant Past History (i.e. similar events)**

**Review of any Staff Witness Statements**

**Engagement with Service User and/or Family**

## **Analysis**

Consider the following factors when analysing the event and its causes and expand each heading with further information

**People Factors**

**Team & Social Factors**

**Communication Factors**

**Task Factors**

**Education & Training Factors**

**Equipment & Resource Factors**

**Working Conditions**

**Organisational & Management Factors**

**Client/Service User Factors**

## **Conclusions**

Give conclusions to the investigation and include any actions to be undertaken.

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