FORENSIC MENTAL HEALTH SERVICES
MANAGED CARE NETWORK
www.forensicnetwork.scot.nhs.uk

Review of Critical Incident Reviews Procedures in Forensic Mental Healthcare in Scotland

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NOTE FOR CONSULTATION PROCESS

The Forensic Network Board is pleased to present this report for a consultation period from 8 May 2007 to 31 May 2007.

In order that the revised procedures outlined within the report are best suited to forensic services in Scotland there are three points that require particular consideration. Therefore if you intend to offer comments to the Network Board about this report it would be helpful if you give consideration to the following:

1. Is it necessary to have a separate Incident Review Procedure for Forensic Mental Health Services and if so how would it fit with generic incident review arrangements within Boards?

2. If it is determined that a separate Incident Review Procedure is required it is essential to define the reach of such a policy. There are three possible options:

   i. Patients on a restriction order
   ii. Additionally patients within recognized Forensic Mental Health Services (Therefore a list of recognized services would be required)
   iii. Additionally patients where following an incident are disposed of to Forensic Mental Health Services (therefore the type of incident determines the relevance of this Incident Review Policy)

3. Is there a need/benefit in having a structured Memorandum of Understanding as outlined in the section on Multi-Agency Working on page 22?

4. Should the Special Incident Review level of be included within the process or completely out with the Health Service?

Contents

Preamble

Membership of the Group

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Acknowledgements

The group would like to formally acknowledge the assistance received from The National Patient Safety Agency, London Development Centre and Professor Tony Maden for supplying a copy of his report, Review of Homicides by Patients with Severe Mental Illness, before it was published.

The group would also like to thank Mrs Sharon Bruce for assisting with meeting arrangements.

Terms of Reference

Formulate a set of definitions and a classification system covering all levels of serious incidents in forensic mental health services. The system should be multi axial covering the severity of event and the extent of contact with mental health services. It must also align with the national approach for incident reporting being taken forward by NHS Quality Improvement Scotland in collaboration with NHSScotland.

Develop a set of multi agency decision rules to enable the determination of the best level of investigation required.

Develop practical guidelines of the conduct of each different level of investigation.

Suggest indicators that could be used to determine whether investigations have had beneficial neutral or negative effects.

Identify training needs.

Summary of Work

Dr Crichton provided the group with a substantial briefing paper that was the framework for discussion at an initial meeting on 7 March 2006. This report was then drafted and reviewed by the group at a second meeting on 25 July 2006.

The report was submitted to the Forensic Network Advisory Board at its meeting in December 2006 and following some minor changes and consultation with Mental Welfare Commission and NHS Quality Improvement Scotland was considered again by the Forensic Network Board at its meeting in March 07. The report will be subject to a period of consultation before it contributes to Scottish Executive Policy.

1. Introduction

By its very nature forensic mental healthcare is prone to the occurrence of adverse events. As a leading forensic psychiatrist Dr Adrian Grounds (1995) commented, 'there is only one meaningful outcome in forensic psychiatry – silence – the absence of disaster'. Patients enter into forensic mental healthcare because of a criminal offence or violence, with a variable relationship between mental illness and the problematic behaviour. Much of the time whilst patients are actively unwell and following recovery, the ability to make morally bad choices is retained; the popular mad/bad dichotomy is false (Crichton 1997). A forensic service must manage the risks posed by its patient population, within its area of responsibility, expertise and law, and thus minimise the risk of adverse outcome. As there are perioperative deaths, even for routine surgical procedures, there will be patients who fail when tested out, or who will go on to seriously reoffend, despite optimal clinical management. The task then for services is to review the clinical care given and identify any lessons to be learnt when there is an adverse outcome. Currently there is a system of Critical Incident Review in Scotland but no system to collate or disseminate findings and the methodology variable.

1.1 Background

The management of adverse offences in forensic mental healthcare is a particularly sensitive and important topic. When an adverse offence occurs lessons need to be learned and in some cases they need to be seen to have been learned, particularly when a case attracts broad public concern. Guidance exists for the conduct of critical incident reviews in the *Risk Management* report (Mental Health Reference Group 2000). The Memorandum of Procedures (Scottish executive 2005) has reinforced the importance of this guidance in response to incidents involving restricted patients. The need to review this area was identified in the Care Standards report (Crichton 2005) commissioned by the Forensic Network.

The Care Standards report identified variation in how critical incident reviews were carried out. There was:

- variation in procedure and degree of independence of review team.
- no central collation or statistical analysis of findings and recommendations.
- no opportunity to disseminate important lessons to the body of forensic mental healthcare (apart from the very few reported by the Mental Welfare Commission).
- some confusion regarding the role of NHS Quality Improvement Scotland and the Mental Welfare Commission particularly in very serious cases.

The Forensic Network accepted the recommendation that a further expert working group should be convened to consider this matter more fully. This report will outline a proposal for reforming Critical Incident Reviews (CIRs) in Scotland. A particular influence in this paper is the work of the report of the Expert Committee on Proposals for responding to serious and untoward incidents in the Adult Mental Health Services (Health Advisory Service 1999). That report, which was submitted to ministers in England in 1999, was never published and John Crichton was a member of the expert group. In the English context the recommendations were superseded by the Chief Medical Officer, Sir Liam Donaldson's report, 'An Organisation with the Memory' and the establishment of the National Patient Safety Agency. In Scotland however, the report may still have practical utility.

This report outlines a proposal for reforming Critical Incident Reviews (CIRs) in Scotland.

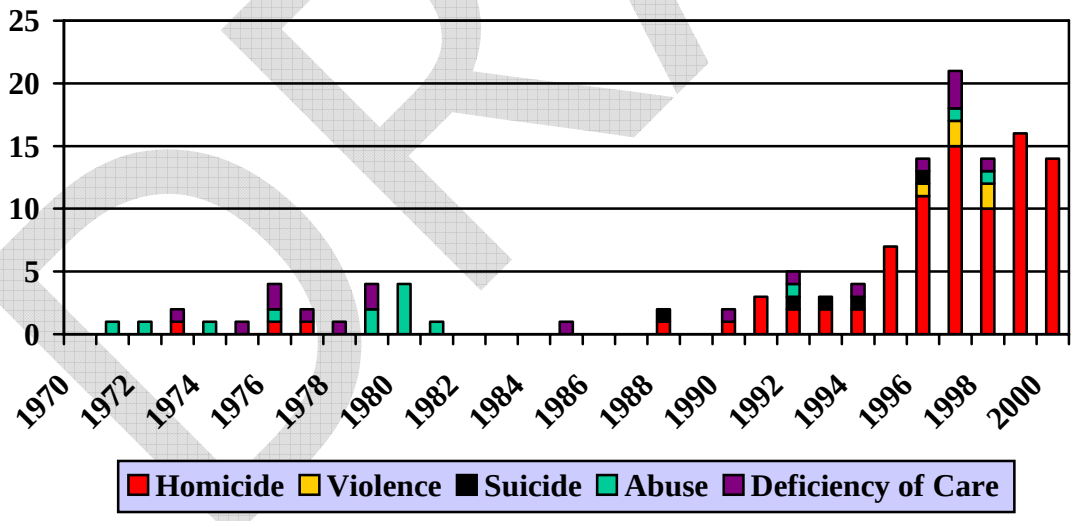
2. Literature Review

Inquiries are not new in mental health services; perhaps the earliest was in an inquiry into the misconduct of an attendant at the Royal Bethlehem Hospital (Bedlam) in London in the 15th Century. Parliamentary inquiries into the conditions of mad houses in the early part of the 19th Century led eventually to the county asylum act of 1840. In more recent years there has been a shift of focus away from inquiries investigating the over control of patients in abusive institutional settings in the 1960s to early 1980s to the under control of patients in the community involved with serious violence. Rose (1986) suggested that, "yesterday's scandals of the institution have already been replaced by today's scandals of the community". That was written in the context of increasing criticism of psychiatric care in the community and had followed a series of inquiries into restrictive and abusive practices in psychiatric institutions, mostly during the 1970s (Martin 1984).

During the accelerated hospital closure programme of the late 1980s (Jones 1993) such "scandals" became a focus of concern about the whole policy of care in the community. By the early 1990s there were already several external homicide inquiries about patients in the community either underway or planned (table 1). In 1993 the Westminster government announced a ten-point plan to meet concerns about community psychiatric care, which included an announcement that whenever a psychiatric patient committed homicide an independent inquiry should be held. This policy, Health Service Guidance (HSG(94)27) (Department of Health 1993), applies only to England (reproduced Appendix 1) and has been slightly modified (Department of Health 1995) since its introduction. Graph 1 shows the increased frequency of published UK psychiatric inquiries driven by the increase in homicide inquires since the introduction of HSG(94)27 until 2001. There are still institutional "scandals" and some deaths caused by psychiatric inpatients, but the bulk of the inquiries set up following HSG(94)27 have scrutinised death in the community caused by psychiatric patients.

Graph of the number of published UK Independent Inquires into Mental healthcare

Graph 1



In Scotland there have been comparatively a very small number of published inquiries. The Mental Welfare Commission has statutory authority to hold inquiries with certain judicial powers. The Commission has twice been asked, once by The Secretary of State and once by The Scottish Executive to hold inquiries which have then been published (McFadden and Ruddle) referred to below. One further inquiry about a homicide committed by a conditionally discharged restricted patient was published in March 2006 (The Report of Inquiry into the care and treatment of Mr L and Mr M). There was also an inquiry following the escape of two patients from The State Hospital in 1976, chaired by Sheriff Reid, and a summary of an Inquiry

published by Highland Health Board. These inquiries are discussed below. The Cullen Inquiry, which investigated the Dunblane tragedy, was not an inquiry into mental health services, although it considered psychiatric evidence, and is excluded.

In England, however, there is a level of unparalleled published independent scrutiny into psychiatric practice, but is it worthwhile? The characteristics and main recommendations of the HSG(94)27 inquiries up until summer 2000 are summarised below. Comparison will be made with Scotland, where only one similar inquiry has taken place over the same period of time, and with the national Confidential Inquiry into Suicides and Homicides, which has a UK remit. The future of homicide inquiries in the context of reform in the English NHS will be considered as there may be relevance to the development of inquiries in Scotland. Finally, there will be a brief description of the published psychiatric inquiries in Scotland, the role and development of Critical Incident Reviews.

The purpose of Homicide Inquiries and how they are received

At a simple level, the extract from HSG(94)27 (Appendix 1) outlines the purpose of homicide inquiries: to scrutinise the delivery of care when something has gone wrong and to make changes to avoid future repetition. The reality is more complex, with the victim's family, the perpetrator, individual professionals, health organisations, social services, criminal justice agencies and central government, all approaching an independent review from different perspectives.

At an early point in the history of HSG(94)27, the purpose of homicide inquiries was examined in an academic seminar connected to a homicide inquiry (Blom-Cooper *et al* 1996). The origins of this seminar are found in the professional response to an earlier inquiry, *The Falling Shadow* (Blom-Cooper *et al* 1995). That inquiry into an inpatient homicide was set up before HSG(94)27 but was published shortly after its introduction and became a target for professional anxieties about the new policy. *The Falling Shadow* was subject to great criticism: it was overly dramatic; it disclosed unnecessary confidential information; it was used as a vehicle for pre-existing opinions of the authors; it paid too little attention to hindsight bias; and it was too critical of individual professionals (for example Bynoe 1995, Chiswick 1995). The academic seminar was designed to examine these criticisms and other aspects of homicide inquiry; it was organised by Jill Peay who later edited the proceedings into a book, *Inquiries after Homicide* (Peay 1996).

Inquiries after Homicide remains one of the most helpful explorations of external homicide inquiries. One of the main themes was the purpose of inquiries. Blom-Cooper (1996) suggests the purpose is to establish the truth of what happened, how it happened and establish responsibility for what had occurred. From a professional perspective, Eastman, (1996a, 1996b), argues that the homicide inquiries should not focus on the potential failings of individual professionals, there are other routes to scrutinise professional competence, but on the wider organisational contributions to tragedy. The primary aim should be 'learning from experience' and a helpful health service model is that of clinical audit. This line of thought is in line with current literature on the need to look at 'systems failure' and broker a 'fair blame' or 'just' culture rather than apportion individual blame.

Several authors have criticised the lack of standard methodologies, the efficiency of inquiries and their subsequent impact on services (Buchanan 1999, Eastman 1995, 1996, Muijen 1997, Petch & Bradley 1997, Reith 1998). In contrast, the importance of an external review for the family of victim and perpetrator has been stressed (Murphy 1996, Reith 1998, Rock 1996). Grounds (1997) reflects on the earlier inquiries into psychiatric institutional failing and suggests that homicide inquiries may have a wider positive influence on psychiatric practice, perhaps securing resources and improving standards. Appleby *et al* (1997) have argued that the Confidential Inquiry into Suicides and Homicide meet many of the needs for review after a tragedy has occurred. One useful comparison is with child abuse inquiries and another contribution to *Inquiries after Homicide* explores this (Reder and Duncan 1996).

HSG(94)27 Inquiries

The policy itself does not stipulate what form of publication, if any, should be taken, although the *Building Bridges* clarification of the policy stated that "an undertaking, given at the start of the process, to publish the report enhances the credibility of the inquiry" (Department of Health 1995). Up until summer 2001 there were 76 published inquires investigating the circumstances of 78 perpetrators and 86 victims of homicide.

Procedural aspects
There is little guidance for those who commission inquiries or those who conduct them on what procedure to follow. Aspects of the procedure adopted by Ritchie (1994) have been utilised most often: hearings are in private; witnesses are asked to affirm the truth of testimony; and witnesses have the opportunity of challenging any criticism made about them.

To avoid contempt of Court, inquiries have waited until the conclusion of legal proceedings before their commencement. The average length of time between critical incident and publication is 26 months. In the interim an internal inquiry may have been completed and major deficiencies remedied. However, this delay between incident and recommendations to improve services is clearly problematic. There is even a risk that improvements in services are delayed whilst an inquiry report is awaited. Also prolonged is the stress of the personnel under scrutiny and victim's family.

HSG(94)27 inquiries have no statutory authority. They rely on the co-operation of agencies other than the sponsoring health authority and individual professionals. Occasionally this is not forthcoming, for example a General Practitioner in Keating *et al* (1997). Most crucially they depend on the perpetrator's consent to disclose confidential information, but only a third of inquiries clearly state that consent was obtained. This supports the view of Rees and Lillywhite (2000) that this issue is not properly addressed in many inquiries. In cases where consent has not been forthcoming inquiries have had difficulty in proceeding. In one published case, following an opinion from Queens Counsel, publication proceeded without consent with the justification of public interest (Eldergill *et al* 2001). When inquiries have had difficulty in obtaining documents and have sought statutory power, this has not been forthcoming. One problem for central government in giving an inquiry statutory powers is that the profile of the inquiry, especially in terms of its impact on central government policy, is increased.

The procedure adopted by Eldergill *et al* (2000a) is worthy of particular attention. The medical member, Dr Paul Bowden was a fierce critic of *The Falling Shadow*; his verbal presentation at the academic seminar day was not included in *Inquiries into Homicide*, partly because of its vitriolic style. The social work member, Dave Sheppard, had edited two volumes of compilations of inquiry reports (Sheppard 1996) and had provided a website cataloguing past and future inquiries (www.davesheppard.co.uk). Eldergill *et al* (2000a) stated a set of guiding principles which went on to be adopted in other inquiries chaired by Anselm Eldergill (Eldergill *et al* 2000b, 2001). In particular the principles ensure that disclosure of patient information is kept to a minimum and clear recommendations and agreed action plans from responsible agencies published. Individual practitioners are not singled out for criticism and questions of whether a homicide could have been predicted or not are avoided.

Characteristics of the critical incidents described in HSG94(27)

The characteristics of the homicides described by the HSG94(27) inquiries is summarised in Table 1. Notable is the number of inquiries which leave out important criminological data such as the method of homicide and the role of intoxication. The function of homicide inquiries is not to collect such information, which is much better presented in *Safer Services, National Confidential Inquiry into Suicide and Homicide by people with mental illness* (Confidential Inquiry 1999). Instead there is much more detailed examination of the service provided to perpetrators and their shortcomings. The Confidential Inquiry in contrast does not provide that level of detail to such an extent, the two methods of reviewing homicides are

complimentary; Confidential Inquiry is much better at presenting epidemiological data whilst the independent homicide inquiries are better at reviewing the state of mental health and allied services. From both approaches the conclusion that the pattern of homicide involving psychiatric patients closely mirrors that in those without mental health problems is confirmed. Most homicide victims know the perpetrator and many occur in a domestic setting.

Table 1: HSG(94)27 Inquiries – Summary of the critical incidents (up to July 2001)

Number of Perpetrators: 78		
Number of Victims: 86		
Number of:	Single Homicides: 72	
	Double Homicides: 4	
	Triple Homicides: 2	
Average Age of Perpetrator: 33		**Range**: 19 - 61
Primary Diagnosis:	Schizophrenia: 59%	Personality Disorder: 17%
	Mood Disorder: 10%	Drug Induced Psychosis: 5%
	Alcohol Problems: 5%	Learning Disability: 1%
	Head Injury: 1%	
Secondary Diagnosis:	Personality Disorder: 15%	Substance Abuse: 10%
	Alcohol Problems: 8%	Depression: 1%
	Learning Disability: 1%	Head Injury: 1%
Teritiary Diagnosis:	Substance Abuse: 12%	
	Alcohol Problems: 4%	
Method of Homicide:	Stabbing: 36%	Strangulation: 9%
	Fire: 8%	Blunt Instrument: 8%
	Battery: 5%	Car Driving: 5%
	Shooting: 2%	Other: 1%
	Unclear from inquiry report: 26%	

Location of Homicide:	Home of Victim & Perpetrator:34%	Home of Victim: 30%
	Public Place: 14%	Mental Health Community Facility: 6%
	Home of Perpetrator: 4%	Prison: 1%
	Hospital: 1%	Unclear from report: 11%
Intoxication at time of homicide:	Yes: 35%	No: 20%
	Unclear from inquiry report: 45%	
	Hospital Order with restrictions: 64%	Statutory Life: 18%
	Suicide: 7%	Discretionary Life: 4%
	Other Sentence: 4%	Probation: 3%
	Hybrid Hospital Order: 1%	

Victim Characteristics		
Number: 86		
Gender:	Male: 48%	Female: 52%
Average Age: 43	**Range**: 3 - 91	
Children: 8%		
Relationship to Perpetrator:	Parent: 21%	Wife, Partner, ex-Partner: 16%
	Stranger: 13%	Service User: 13%
	Neighbour: 11%	Other relative: 6%
	Other Friend: 5%	Own Child: 4%
	Professional: 4%	Landlord: 4%
	Other: 6%	

Recommendations from HSG94(27)

A crude content analysis of the published HSG94(27) inquiries reveals the thirty most frequently made recommendations in rank order (Table 2). This list was compiled after collecting the recommendations from the first ten HSG94(27) reports and making a list of all which occurred in more than one. This resulted in a list of 53 broad categories of recommendation and their presence was searched for in each of the 76 HSG94(27) inquiries. The results of the content analysis are unlikely to be surprising - if the care of 78 patients of similar age, diagnosis and background who had not killed were put under the same scrutiny how similar would the list of recommendations look? The suspicion is that many of the deficiencies identified in the homicide inquiries are symptomatic of wider problems in mental health services. It is difficult to identify particular areas of deficiency which would be specific to those patients who have killed other than perhaps risk assessment and management (Reed 1997).

Table 2

Frequency Rank Order of HSG(94)27 Inquiry Recommendations (up to July 2001)

		Percentage
1.	Improved use of Care Programme Approach	71%
2.	Better Risk Assessment/ Management	59%
3.	Better Interagency working/communication	55%
4.	Improved training	45%
5.	Better communication with General Practitioners	42%
6.	Improved multi-disciplinary working	38%
7.	Better note keeping	37%
8=	Better integration of notes	36%
8=	Improved internal incident reviews	36%
10=	Better liaison with family/carers	32%
10=	Better guidelines on the disclosure of confidential information	32%
12=	Increased resources	28%
12=	Improved role of key worker	28%
14.	Improved discharge planning	26%
15.	Better professional supervision (in general)	25%
16=	Improved residential provision	21%
16=	Better Police management of Mentally Disordered Offenders	21%
18.	That HSG(94)27 inquiries should be reformed	20%
19.	Better supervision of junior psychiatrists	18%
20=	Improvements in meeting patients' racial and cultural needs	17%
20=	Better facilities for dual substance misuse and psychotic patients	17%
20=	Better use of Audit	17%
23.	Better management of improvements in provision substance misuse	16%
24=	Improvements in psychotherapy provision	15%
24=	Better cover for absent staff	15%
24=	Improved contingency planning for discharged patients	15%
27.	Better communication from prison health care to other agencies	13%
28=	Better supervision of Community Psychiatric nurses	12%
28=	Improvements in assertive outreach	12%
30=	Improved Prison health care	11%
30=	Better diversion from custody	11%
30=	Better management of mentally disordered offenders by probation services	11%

3. Proposals for change in England

External homicide inquiries perform several functions, but central to their purpose in the health service is the review of health service provision. There have been many criticisms of homicide inquiries since the introduction of HSG(94)27 and a review of those inquiries reveal certain basic flaws in the current system. The Health Advisory Service made certain recommendations to Ministers in 2000 having convened an expert group, but their proposals were not acted on then partly because a wider review was underway in England reforming the reporting of adverse events in the NHS.

HAS2000 clarified that the key objectives of a psychiatric homicide review should be:

- the provision of information to relatives
- staff accountability – where negligence had occurred then this would be dealt with appropriately
- as part of the duty of public services to continually reappraise policies and procedures – to learn the lessons.

HAS2000 recommended that a new system of inquiry was created, which included all adverse incidents in mental health, and was overseen by a local multi-agency group. Depending on the seriousness of the incident there were recommended three levels of inquiry with increasing independence from the service providers and degree of scrutiny involved. To guide all inquiries a set of guiding principles were recommended, table 3:

Table 3

HAS 2000 Guiding Principles for mental health Inquiries
1. Clarity of purpose and method of investigation. 2. Sensitivity to the needs of families, carers, victims and other service users. 3. Appropriate membership and constitution 4. Timeliness and proportionality 5. Openness to external scrutiny 6. Appropriate safeguards and support to staff 7. Clarity and presentation of findings 8. Links with other agencies and sources of information 9. Accountability 10. Evaluation

Reform is therefore over-due. It is likely homicide inquiries in England will continue in some guise; the task is to learn from past inquiries and to create a fairer, efficient and worthwhile system of review.

Fairness

However informal or even-handed an inquiry board may be, a professional under scrutiny will feel under enormous pressure as their work is scrutinised. An important starting point is a clear statement about the purpose and guiding principles of any inquiry. The Eldergill principles helpfully state that the purpose of the inquiry is not to find individual blame. There is consensus that homicide inquiries are not the right arena to expose and address individual professional failings. Of course, as part of an inquiry individual failings as well as wider problems may be exposed. If that occurs there needs to be system whereby this is then dealt with by parallel, and distinctly separate, disciplinary procedures. Procedural fairness is therefore important and many inquiries have allowed a right of representation and the right to respond to any criticism. There needs however to be consistency about what fair procedure should be followed.

Fairness also extends to others who have an interest in an inquiry. Victims' families require special regard and support. Again guidelines and best practice need to be developed, perhaps in conjunction with the Zito Trust set up after the homicide of Jonathan Zito (Ritchie 1994). At a minimum, any inquiry must provide a person to liaise with a victim's family to provide information about the process, how the inquiry is progressing and to make sure the inquiry is including the questions that they think should be asked. In complex inquiries this latter role may require a lay advocate. Often the family of victim and perpetrator are one, but even if they are not the perpetrator's family will require similar support.

The perpetrator also requires to be dealt with fairly. There is inconsistent practice regarding whether the perpetrator is anonymised and how much personal history is disclosed. How can the balance of anonymity be right if twice the number of inquiries choose to anonymise professionals than perpetrators? The principle adopted by Eldergill *et al* (2000a, 2000b, 2001), which is not to disclose personal information unnecessarily, should be adopted as standard.

Currently, inquiries depend on the perpetrator consenting to obtain necessary records and in general publish confidential material. When consent has not been forthcoming inquiries have had considerable difficulty and in one case, as described above, disclosure of confidential information was made in the public interest against a perpetrator's wishes (Eldergill 2001). Notably, that inquiry had already chosen to limit the amount of personal information published.

It is unsatisfactory for homicide inquiries to rely on perpetrator co-operation. The current rules on disclosure and public interest require urgent robust clarification. This may require primary legislation for inquiries to have statutory powers as the Mental Welfare Commission does in Scotland. In any case it would seem to be good practice to limit the confidential information to be disclosed and to obtain co-operation from the perpetrator wherever possible. Such respect for confidentiality would also help give proper regard to the confidentiality of the dead; those perpetrators who have killed themselves prior to any inquiry.

Efficiency

External inquiries into homicide are estimated to cost up to £250,000 (Peay 1996), but in many cases are more modest. The page length of the inquiry report and number of recommendations perhaps crudely reflects the differing complexity and cost of inquiries; there is a wide variation. As there is no detailed guidance on homicide inquiries they have to work out their own procedure and methodology from scratch; perhaps following the procedure of other inquiries or relying on the experience of members of the panel who have been involved in previous inquiries. An overwhelming advantage can be seen for central organisation of external inquiries to ensure the competence of inquiry members, and the consistency and quality of methodology. A common approach and secretariat would save on costs. Such a body could choose what information to make public and combine the lessons from several inquiries into one publication. The emphasis for such a publication would be on useful information for service in general and not simply local issues.

It is clearly inefficient for different agencies to have different inquiries in place investigating the same situation. A new inquiry structure must have a remit to investigate multi-agency working and must have the authority to examine and then influence social services, criminal justice agencies as well as health. Several previous inquiries have had such an interagency foundation. However, as a standard, any new system of inquiry must have cross agency and cross boundary authority.

A structural weakness to current homicide inquiries is the delay between incident and publication. Although there may be legal reasons for such a delay, much work can still be accomplished before the conclusions of legal proceedings. Proper guidance needs to be developed in collaboration with the Crown Prosecution Service, Coroners and professional bodies to clarify what work can be done on an inquiry, which would not prejudice other proceedings. For an inquiry to be effective it must be timely and should keep to a clear

timetable. There should also be a mechanism for an inquiry to issue interim recommendations where urgent remedial action in required before the full inquiry is complete.

Are Inquiries Worthwhile?

There is no way to assess whether homicide inquiries have been successful in achieving what they set out to do. The inquiries themselves are not subject to audit. There continues to be no central collection of inquiry reports that can be referred to. Some inquiries recommend that the inquiry panel be reconvened to review progress on recommendations. It is unclear however whether that recommendation has been followed and what the follow up assessment has uncovered. In a new structure to homicide inquiries there needs to be a system of clear re-examination of services with the authority to oblige failing services to implement necessary changes.

The above suggestions resonate with the report *An Organisation with the Memory* (Donaldson 2000), which states: "the time is right for a fundamental rethinking of the way that the NHS approaches the challenge of learning from adverse healthcare events, [t]he NHS often fails to learn the lessons when things go wrong, and has an old fashioned approach to this area compared to some other sectors." The report suggests that the NHS should develop:

- unified mechanisms for reporting and analysing things when they go wrong;
- a more open culture in which errors or service failings can be reported and discussed;
- mechanisms for ensuring that where lessons are identified the necessary changes are put into practice;
- a much wider appreciation of the value of the system approach in preventing, analysing and learning from errors.

This approach is clearly one that needs to be applied to the area of external inquiries into homicide with the one caveat that there needs to be cross agency authority. Following *An Organisation with a Memory, Building a safer NHS for patients* (Department of Health 2001) the Westminster government undertook to implement a new system for learning from error and adverse events in the NHS. A new organisation, the National Patient Safety Agency (www.npsa.org.uk), was created in summer 2001 and was tasked with reform of external inquiries into homicide in England. Currently the NPSA is advocating the use of Root Cause Analysis and is piloting this method of review in several homicide inquiries. NHS Quality Improvement Scotland (www.nhshealthquality.org) has the remit for taking forward patient safety within NHSScotland and a working agreement has been established between the two organisations to ensure that patient safety lessons are shared across the UK.

4. Comparison with Scotland

The Mental Welfare Commission for Scotland has statutory powers to carry out investigations into cases where there may have been ill treatment, neglect or some other form of deficiency of care or treatment and also of any damage to or loss of property. The Commission can initiate such inquiries by itself or can be requested to do so by Scottish Ministers. The Commission is required to report the findings of its investigations to the relevant authorities, usually Health Boards, local authorities, the Health Department and to relevant regulatory and inspection bodies. Such inquiries usually will make a number of recommendations. Under the powers of the Mental Health (Scotland) Act 1984 one report of an inquiry requested by the then Secretary of State for Scotland was made public, in an anonomysed form. Since 1995 the Commission has carried out 28 significant investigations and had begun to publish anonomysed summary reports of its inquiries. The 2003 Act allows for the Commission to publish its inquiry reports and now all such reports will be made public. In 2005 the First Minister asked the Commission to carry out an inquiry into the care and treatment of Mr L and Mr M, published on 22 March 2006.

The inquiry report identified weaknesses in the management of risk and the systems of clinical governance and the requirements of the Memorandum of Procedure for Restricted Patients were found to be ineffective in addressing these weaknesses. The joint response from Scottish Executive, Greater Glasgow and Clyde Health Board and Glasgow Social Work made clear that the protection of the public is paramount and that steps will be taken to address the deficiencies identifies to ensure that the public can have confidence in the services. As a result of this particular inquiry The Forensic Network has been tasked with reviewing and revising the CPA Guidance for Restricted patients and the Risk Management Authority (RMA) have separately been invited to take forward work in relation to risk management.

As well as carrying out significant inquiries the Commission has historically asked services to notify it of serious incidents and of the suicides of people with a mental disorder. It is important to note that suicide or a significant incident such as a homicide in itself does not necessarily indicate any deficiency in care. Over time the Commission has encouraged the development of effective critical incident review processes in health services. While the Commission plans to continue to encourage the reporting of cases where there may have been deficiencies in care it does not think it appropriate that it is the body that has oversight of the processes of critical incident review. The Commission believes that that function would be better carried out by NHSQIS ensuring that services have high quality critical incident review policies and processes. In addition NHS Quality Improvement Scotland (NHSQIS) could provide a mechanism for ensuring that any service issues and learning points from individual cases are effectively shared across health services. The Commission will be publishing updated guidance on the reporting of cases where there may have been some form of deficiency of care later this year.

There has been one other Scottish published homicide inquiry involving psychiatric patients, which did not involve the Commission. Sheriff Reid chaired an inquiry following the escape of two patients from The State Hospital and the murder of a patient, a nurse and a police officer. This tragedy continues to evoke strong emotions despite the passage of time. Darjee and Crichton (2004) discuss its impact with particular reference to the detention of MDOs with a primary personality disorder in the Scottish setting.

Highland Health Board have also published the summary of an inquiry (Fraser *et al* 1997) following a serious assault on Rev John MacPherson, who received an extensive facial knife wound whilst conducting an outdoor Remembrance Sunday service. The inquiry made recommendations regarding effective discharge planning for those with complex needs and the adoption of the Care Programme Approach.

Critical Incident Reviews (CIRs)

The Mental Health Reference Group report *Risk Management* (2000), intended for general use in mental health services, makes explicit reference to the HSG (94) 27 Inquiries. A policy for CIRs was forwarded in appendix D of the report and is reproduced in this report in appendix 2; this was endorsed by HDL (2000) 16 as Scottish Executive policy. Further this policy is referred to in Chapter Six of the Memorandum of Procedures (MOP) for restricted patients.

All CIRs should be reported to MWC but there is a huge variation in quality of these reviews despite the guidance in their conduct and there is no system to collate findings or share good practice. For example resulting from a CIR at the Orchard Clinic all illicit drug urine specimens are observed. This intrusion was found to be necessary because of practices which had developed to avoid detection with false samples. Associated with that was bullying of patients to provide samples and deterioration of patients' mental state because of illicit drug use. The adverse incident which led to this recommendation was a restricted patient absconsion. What would be desirable is a system where the wider forensic community could learn from such investigations.

The Forensic Network could clearly have a role in monitoring CIRs but could also consider whether the CIR policy requires updating, perhaps drawing on the English experience of HSG (94)27, Route Cause Analysis (RCA) as a method of incident review and whether the role of MWC in conducting inquiries requires further clarification.

5. A Proposed Way Forward

Reviewing the literature, it emerges that the current practice in Scotland regarding CIR in forensic mental healthcare is unsatisfactory and that the recent experience in England prior to the creation of the National Patients Safety Agency (NPSA) is not one that should be copied. It is too early to judge whether the new systems of investigating incidents in mental healthcare created by the NPSA will prove successful. Proposed here is a new model of CIR modelled on the proposals from the HAS2000 report in 1999.

The group agreed that in order to give a true reflection of the change in policy and indeed to encourage services and staff to see CIRs as an opportunity to learn rather than as criticism that the policy should remove the word "critical" and be referred to in future as Incident Reviews (IRs).

It is important to define the reach of such an Incident Review policy in terms of the boundary for "Forensic" mental health services. The group suggest that there are three possible options for determining that a patient falls within the remit of this Incident Review Policy as part of Forensic Mental Health Services:

- Patients on a restriction order
- Additionally patients within recognised Forensic Mental Health Services (therefore a list of recognised services would be required)
- Additionally patients where following and incident are disposed of to Forensic Mental Health Services (therefore the type of incident determines the relevance of this Incident Review Policy)

The group recommend that this issue should be subject to wider consultation and therefore should form a specific question for consideration during the consultation period planned for this report. It is important to make sure that there is specific consultation with general adult psychiatric services.

The revised Incident Review policy would contain 5 elements:

1. A statement of the general principles which should underline good practice with regards to the investigation of any serious incident leading to an IR.
2. A description of the different levels of investigation suitable for different kinds of incident.
3. Guidance regarding the kinds of incident that might be most appropriately investigated at different levels.
4. An operational definition of the differences between each level of inquiry which could form the basis of an ordered instrument.
5. A flowchart illustrating how these different instruments are connected together.

<u>General Principles</u>

The key objectives of any Incident Review should be:

a) Reassurance for the public that systems are accountable and that where negligence has occurred, this will be identified and dealt with appropriately and transparently (but separately)
b) To ensure that public services and professionals continually examine their policies and procedures and "learn the lessons"
c) The provision of information to users, carers and victims

Key Principles

There are ten key principles which should guide Incident Reviews:

- Clarity of purpose and method of inquiry.
- Sensitivity to the needs of families, carers, victims and other service users.
- Appropriate membership and constitution.
- Timeliness and proportionality.
- Openness to external scrutiny.
- Appropriate safeguards and support for staff.
- Clarity and presentation of findings.
- Links with other agencies and sources of information.
- Accountability.
- Evaluation.

Although each of the principles is important in its own right the principles need to be read and considered together. The principles are operationalised in greater detail in relation to different kinds of investigation below.

Clarity of purpose and method of inquiry. All inquiries should have clear objectives and the terms that include, as a minimum, the assessment of the care and service provision of the person who is the main focus of the review. They should also cover the history of inter agency working and specific objectives for ensuring that lessons are learned. In short, the inquiry should specify what they will cover and how they will be achieved, including the agreed standards and any other evidence that will be used to assess the incident in question. In Scotland it will be expected that any inquiry will be undertaken in private, however in certain inquiries it will be appropriate for findings to be made public and in all inquiries it will be appropriate for central collation of findings and dissemination of best practice by the Forensic Network.

Sensitivity to the needs of families, carers, victims and other patients/service users. The needs of those people, especially family members most directly affected by an incident should be identified as one of the primary concerns of an inquiry. Families have often welcomed the independence of inquiries. In England sometimes such homicides inquiries have been the only source of information they have had about a tragedy. Following tragedy many can find the processes of inquiry that result, confusing and distressing. In England, inquiry panels have been distant and uncommunicative or there has been an over emphasis on the professional views of the case. In the context of an IR involving serious violence and homicide, relatives need to be kept informed throughout the process and those conducting the IR should ensure that specific contact is made as early as possible with families, both to give information and listen to their concerns.

Appropriate membership of an inquiry team. IRs need to be conducted by people with relevant expertise, ability and training to equip them to do the job sensitively and thoroughly. The chair and other members should therefore be selected for their general expertise and for specific skills relevant to the incident in question. The chair need not be a lawyer, although legal expertise may be valuable in a few special cases. It is important that there is independence between the IR team and the clinical team concerned. The degree of independence will vary according to the nature of the incident. For some incidents it may be necessary to use team members who are independent of the service rather than members of the same organisation. Also when considering the constitution of teams for standard IRs there needs to be an account of secretarial and administrative support.

Timeliness and proportionality. The scope and extent of the IR should vary according to the severity and complexity of the incident. The evidence of individual and or systems being at fault and the likelihood that new lessons will be learned. The inquiry should start as soon as possible, taking into account such matters as ongoing criminal proceedings and complete

within a predetermined timescale schedule. Within the overall timetable specific milestones should be made clear and communicated to all key participants. The final report should aim to be concise rather than over inclusive.

Openness to external scrutiny. Whatever the type or extent of IR there should be a point in the process at which there is the opportunity for external scrutiny. This is vital for the overall independence of the process. In a local IR this may simply mean that the findings are considered by an internal review team that has an external representative. In a more serious IR, all relevant evidence, findings and recommendations should be scrutinised by an appropriate multi agency group.

Appropriate safeguards and support for staff. All staff taking part in inquiries should be informed in advance about the process, how the evidence will be collected, how issues of confidentiality will be dealt with, what safeguards will be provided for those giving information and what mechanisms will enable them to respond to findings at a later date. Although inquiries should primarily be investigative and not disciplinary, staff should be informed in advance if their behaviour is likely to come under criticism. This would be good practice for any organisation, regardless of the level of inquiry. Employers should also be responsible for ensuring staff receive advice about representation. Staff should also be offered emotional help and support in coming to terms with the incident and their part in it. Finally they should be given feedback about the findings of the inquiry and subsequent action plans.

Clarity and presentation of the findings. There is a need for information to be clearly presented in a consistent and transparent structure with clear separation of facts and opinion. The basis for arriving at any conclusion should be stated and should be clearly linked to evidence presented in the text. Recommendations should also be clearly linked to conclusions and the report should include an action plan which can be implemented by local managers with explicit targets, timescales and indications of resources. Recommendations should also cover arrangements for further investigation and ongoing audit and review. A date for reviewing progress in implementing the recommendations should be included in the report.

Effective linkage with other services, agencies and other sources of information. There is a need for IRs to use information from other sources, both within and without agencies. There requires to be understanding between agencies regarding the sharing of confidential information for the purpose of the IR.

Accountability. Understanding what happened in an incident and why is the central task of any inquiry. The overriding focus should be upon improving the quality of the service. There is a need to separate disciplinary issues from the IR. In the past there has been an inherent tendency to underestimate structural and management issues, such as polices, procedures, supervision, staff support, training and resources.

The inquiry must therefore be primarily alert to system problems rather than individual faults. Any subsequent criticism of management issues must then be formulated in such a way that the implications and responsibility for remedial action are clear. This may include recommendations for corrective action at a number of different levels. There should be a mechanism for aggregating such recommendations and this could be done by the Forensic Network.

Evaluation. IRs themselves should be subject to regular evaluation and monitoring. This should include an assessment of whether the terms of reference and original objectives have been met. That the key participants feel the inquiry has been conducted in an open and honest manner and that the recommendations have been implemented and improvements to local services have occurred.

Level of Incident Review

Key to this proposal is the division of Incident Review (IR) between three levels of investigation. The first two are local, largely internal, with a degree of independence, depending on the nature of the incident. These IRs would be conducted essentially in private and would report in private. Although certain key data could be passed to the Forensic Network for statistical analysis. These first two levels could be called **Standard Incident Review** and **Enhanced Incident Review**.

Standard IR would be mainly internal to the particular organisation but involve other local agencies (e.g. Police or Local Authority) depending on the nature of the incident. The operation of a Standard IR would remain under the oversight of the clinical governance structures of the Health Boards. The Forensic Network would have responsibility to advise local managers on the terms of reference, conduct and composition of these inquiries if requested to do so, and also take an annual overview of the results in order to identify lessons which could be of use more broadly. The main aim of these inquiries would be to improve local services and such investigations would be common as now. One of the main outcomes would be adaptations to policies and procedures and there should be an expedited method of improving local policies and procedures following the recommendations of a Standard IR.

Enhanced IRs would take place under the oversight of the Forensic Network. These would deal with more serious incidents and the composition of the inquiry team needs to reflect a greater degree of independence than for standard IRs (e.g. greater involvement of a lay representative i.e. non executive member of the Health Board). The Forensic Network would have a role to advise local services on the appropriate level of inquiry for given incidents. The findings of all enhanced inquiries should be overseen by the Forensic Network who will report annually. One aim and purpose of enhanced IRs would be to identify multi agency issues regarding practice and service deliveries and ways of improving these. They will be relatively common e.g. 1 to 3 a year for a local forensic service.

The final level could be termed **Special Incident Review**. These would correspond to the kinds of processes currently carried out in the English homicide enquiries or carried out on a few occasions in Scotland by the MWC in the published reports referred to above. Special IRs would be a rare event and would be only undertaken if there was an overwhelming public interest or the possibility of learning major new lessons in terms of national policy. Special IRs could be conducted by the MWC and the Forensic Network could have a role in identifying cases which may be worthy for such a review. In practice the MWC themselves might also identify that an incident is worthy of such a review or there may be a referral from the Scottish Executive.

It is recommended that all three levels in an investigation share a common core set of auditable processes based on the generic principles described above. There should be no difference in the rigour, quality or consistency between different levels of inquiry despite the differences in the type of incidents concerned. An attempt to operationalise the detailed procedural differences between the different types of investigation is given below.

Table 4 below gives guidance as to the kind of incident that might be most appropriately investigated by the different types of investigation.

The suggestions are merely guidelines and not rigid decision rules. An element of discretion will be essential. It is expected the decision about most standard IRs will be taken by local management with occasional special reference to the Forensic Network for guidance. Enhanced IRs will involve the Forensic Network who on a few very special occasions will make reference to the MWC for a special IR.

Audit of Critical Incident Reviews

In the past four years there have been fifteen CIRs carried out in relation to restricted patients. Had this revised IR structure been in use during that period, 10 would have been Standard IRs, 4 Enhanced IRs and 1 Special IR. Since September 2003 The State Hospital has carried out a further 4 CIRs that do not relate to restricted patients. Of these 3 would have been Standard IRs and 1 would have been Enhanced IRs under this new process

The audit of Critical Incident Reviews prepared has highlighted a significant variation in the quality of inquiry and reporting across health boards. The variety of information sources and the format for inquiry, e.g. interviews, reading notes, group discussion appears in some cases to depend on the perceived seriousness of the incident. There is no standard format for conducting a review or preparing a report. The time taken to prepare a final report also varied widely: in a couple of cases the internal review process was completed 2 weeks after the incident took place compared with a time lag of 19 months in a case where an external review was commissioned. Where recommendations were made these often related to failures in systems and a lack of awareness on the part of staff as to the correct procedures to follow in the event of an incident. Changes to existing procedures for outings, ground parole and meals were also recommended to prevent further similar failings. Lastly, the audit made it clear that there is currently no central system in place for monitoring the effectiveness of CIRs, albeit that individual health boards will monitor their own area as part of clinical governance. The group recommends that there is a need for a more formal follow-up process.

Table 4

Type of Incident	**Low Security**	**Medium Security**	**High Security**
- Significant assault, injury to staff, service users, or other person in hospital or community	Standard IR	Standard IR	Standard IR
- Suicide of current in-patient (informal or detained)			
- Suicide of patient in the community known to secondary mental health services in the community (i.e. contact within last 12 months).			
- Potentially fatal self-injury, not resulting in death, for service user in recent contact (within last year) with specialist mental health services			
- Homicide committed by person in recent contact with secondary mental health services (in last year).	Enhanced IR	Enhanced IR	Enhanced IR
- Suicide by person in current contact with specialist mental health services (i.e. within last 12 months) if there is significant public interest *and*/or major local lessons to be learned.			
- Sudden death of current in-patient (other than suicide) if any of the following present: o *Control & restraint* o *High dosage of medication* o *Unusual combination of medications* o *Seclusion*			
- Homicide committed by person in recent contact (within last year) with specialist mental health services if there is a significant public interest in doing so *and*/or major national lessons to be learned.	Special IR	Special IR	Special IR
- Sudden Death of a patient (other than suicide)	Standard IR	Standard IR	Standard IR
- Absconsion	Standard IR	Standard IR	Enhanced IR
- Escape	Standard IR	Enhanced IR	Special IR
- Serious Breach of Security	Enhanced IR	Enhanced IR	Enhanced IR

Appendix 3 indicates how the principles outlined above could be operationalised by the different levels of inquiry.

Deciding the level of inquiry

A particular difficulty in this type of inquiry is the interplay between individual professional failings and system failures; this was a major topic of the Sir Liam Donaldson document "An Organisation with a Memory." The current consensus is that incident reviews must be separate from any disciplinary proceedings. The "Incident Decision Tree" from the National Patient Safety Agency (NPSA) is designed to help managers when considering these issues. It is available via the NPSA website (http://www.npsa.nhs.uk/health/resources/incident_decision_tree).

As mentioned above the guidelines above do not offer an exhaustive list of types of incidents and service managers will be required to use a significant amount of discretion to decide which level of inquiry is appropriate. The working group acknowledge that deciding a particular level does give some pre-cognition as to what the outcomes might be. The flowchart at appendix 4 offers advice on making decisions about the level of inquiry and the Forensic Network can provide advice to any service manager at any stage in the process.

Multi- Agency Working

It is particularly difficult in instances of adverse incidents to maintain effective liaison with other appropriate agencies that have an interest in investing and monitoring such occurrences. A Memorandum of Understanding may have to be developed between the NHSScotland, Crown Office (in both their roles as prosecutors and Fatal Accident Inquiries), the Police Force, Scottish Prison Service, Local Authorities and The Health and Safety Executive. Whilst the group recognises that the focus of such a Memorandum of Procedure extends beyond the range of forensic mental health services it recommends that this question be addressed during the consultation period.

Services should note that there may be circumstances when it is not possible to carry out an internal Incident Report as Procurators Fiscal occasionally request, in circumstances requiring a fatal accident inquiry, that no local inquiry is undertaken. In these circumstances services should follow the direction of the Procurator Fiscal and await the outcome of the FAI before deciding whether there is a need for another IR.

Training

The National Patient Safety Agency (NPSA) has developed a "Root Cause Analysis Tool Kit" which is an e-learning package that is accessible through their website, www.npsa.nhs.uk . This gives individuals a good understanding of the principles and practice of Root Cause Analysis and an opportunity to explore and practice the tools and techniques of investigation and analysis. NHS Quality Improvement Scotland has adopted this methodology and commissioned NPSA to deliver this RCA training for NHSScotland during 2006. A summary of the guide to Route Cause Analysis from the NPSA is attached at appendix 5.

In this context, the use of Root cause analysis is a retrospective review of a patient safety incident undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future.

Incident Review Reports
Incident Review Reports should have a basic level of consistency across Forensic Mental Health Services in Scotland, in so much as each should provide results within the following sections:

- Brief Description of the Incident
- Review Team Members
- Remit of the Review
- Review process
- Conclusions
- Recommendations

Given the nature of mentally disordered offenders and the importance of assessing and managing risk Incident Reports should not include all background information about patients, it is only necessary to include relevant antecedents and not a fully patient history. Each report should be anonomysed as standard.

Analysis of Incident Review Results
It is clear that although the numbers of Incident Reviews are few that there are always lessons to be learned from them. As Forensic Mental Health Services in Scotland grow over the next few years it is important that all services learn from each others experiences in this area. In order to achieve this it is necessary that the conclusions and recommendations for each Incident Review are collated and distributed throughout the relevant services. The group recommends that each Forensic Mental Health Service produces an annual report for the local Health Board Clinical Governance Committee, Scottish Executive Health Department and the Forensic Network. The Forensic Network will take on the role of collating all the analysis into a national report that to be shared with all forensic services throughout Scotland and published on the Forensic Network website.

In addition, in order that lessons can be learnt swiftly, the Forensic Network should devise a system for disseminating IR findings across services in a bulletin style, alerting services to situations that may require immediate alterations to practice.

Freedom of Information Requests
The Freedom of Information (Scotland) Act 2002 provides individuals with the right to request information from any organisation. In England information about particular Confidential Homicide Inquiries is exempt under section 40 of the Freedom of Information Act as it is categorised as “personal data.” The Data Protection Act of 1998 defines “personal data” which means data that relate to a living individual who can be identified from the data.

Legislation therefore provides a system for protecting personal identity however the group recommends that all Incident Review Reports should be anonomysed as standard as an added safeguard. These individual reports should remain confidential and therefore, we believe, exempt from Freedom of Information requests. The annual Health Board and Forensic Network reports should be published as public documents in the same way that Mental Welfare Commission reports are published currently.

6. A Scottish Pilot

It is appropriate that this report be subject to a consultation period and the group suggests this is carried out prior to a pilot period. The system will then, if successful, be rolled out to all forensic services in Scotland as part of Scottish Executive policy.

Whilst considering how best to improve the process of Incident Reviews it is not intended to increase the workload for services. The group recommends that a pilot should be set up involving the State Hospital, The Orchard Clinic and The Blair Unit based on the protocols outlined in this report. Each of these services will carry out Incident Reviews following this new policy for a period of six months after which time the Forensic Network will produce a comprehensive analysis of the lessons to be learnt that can be shared with other Forensic

Services. It is important that three services are involved in order to test out the system at different levels of security, high, medium and low.

Throughout the pilot it is recommended that incident review teams have the opportunity to comment on areas that worked well, areas that could benefit from changes or improvements and to give feedback to The Forensic Network on their overall experience of the process. This should be included

7. Conclusions and Recommendations

7.1 The current system of carrying out Critical Incident Reviews in Scotland is unsatisfactory.

7.2 Incident Reviews are of vital importance to Forensic Mental Health Services with the main focus being to share important lessons between services in order to provide improved patient care. The Forensic Network has provided guidance in terms of Secure Care Standards as part of HDL (2006) 48 and these must be reviewed regularly to ensure that lessons learnt from adverse incidents through Incident Reviews are shared throughout Scotland therefore providing the best care possible.

7.3 The new systems and role of the NPSA in Mental Health incident reporting in England have not been in place long enough to be subject to meaningful review of effectiveness. In any case whilst the system is helpful it is not possible to have a similar structure in Scotland at this time.

7.4 In order to give a true reflection of the change in policy and indeed to encourage services and staff to see CIRs as an opportunity to learn rather than criticise the process should be renamed, "Incident Review."

7.5 Wider consultation is needed to determine the reach of a revised Incident Review Policy in terms of "Forensic" Mental Health Services and this should form a specific question as part of the consultation process for this report.

7.6 The policy for Incident Reviews should be separated into three levels of investigation, Standard, Enhanced and Special Incident Reviews. All three levels should share a core set of auditable processes based on the generic principles. There should be no difference in the rigour, quality or consistency between different levels of investigation despite the differences in the type of incidents concerned.

7.7 Local services should develop their own Incident Review procedures taking cognisance of the 5 elements, general and key principles outlined in this report.

7.8 The guidelines in Table 4 are not rigid decision rules in deciding which level of inquiry is appropriate for particular adverse incidents. An element of discretion and professional judgement is essential.

7.9 A Memorandum of Understanding between NHSScotland, Crown Office, Scottish Prison Services, Local Authorities, The Police Force and the Health and Safety Executive may be helpful. Opinions from across services and agencies should be sought as part of the consultation process.

7.10 In order to meet the required standards for Incident Reviews and develop consistency of approach, it is important that managers and staff are supported in terms of training. The group recommends that the Root Cause Analysis Tool Kit, an e-learning package developed by the NPSA is a helpful introduction with step-by-step guidance. NHS Quality Improvement Scotland has a working agreement with NPSA that will facilitate this process.

7.11 It is important that as Forensic Mental Health Services in Scotland develop over the coming years each is able to learn from the experiences of the other in the true nature of a forensic network. Therefore each Forensic Mental Health Service should produce an annual report to their NHS Board Clinical Governance Committee, Scottish Executive Health Department and the Forensic Network. The Forensic Network will take on the role of collating all the analysis into a national report that will be shared with all forensic services throughout Scotland and published on the Forensic Network Website. NHS Quality Improvement Scotland will assist in the development of an external quality assurance process.

7.12 The Forensic Network should devise a system for disseminating IR findings across services in a bulletin style, alerting services to situations that may require immediate alterations to practice.

7.13 Incident Review Reports should be anonomysed as standard and remain confidential therefore, we believe, exempt from requests under Freedom of Information legislation. The annual Health Board and Forensic Network reports should be published as public documents in the same way that Mental Welfare Commission reports are published currently.

7.14 It is not expected that changes in the system will mean any significant increase in the amount of work involved in carrying out Incident Reviews, except perhaps in the production of Annual Reports. However this should not be an onerous task given the small numbers of Incident Reviews that are likely. In order to fully test the new system it is recommended that a six month pilot should be undertaken at The State Hospital, The Orchard Clinic and The Blair Unit. The Forensic Network should then produce a comprehensive analysis and share this with the forensic mental health services.

7.15 Whilst the remit of the group focussed on the procedures within Forensic Mental Health Services the model described may be helpful to other health services.

Appendix 1

Extract from NHS Executive HSG(94)27.

'If things go wrong

33. If a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event, action by local management must include:

- An immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the care programme approach. Where Court proceedings in relation to the incident have started or thought likely, legal advice should be sought with a view to ensuring that the investigation does not prejudice those proceedings;

- If the victim was a child, i.e. under 18 years of age, the report of the investigation should be forwarded the Area Child Protection Committee within 1 month of the incident;

- Incidents involving a death should be reported to the confidential inquiry into homicide and suicide by mentally ill people.

34. Additionally, after the completion of any legal proceedings it may be necessary to hold an independent inquiry. **In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved**. The only exception is where the victim is a child and it is considered that the report by the Area Child Protection Committee (see paragraph 33) fully covers the remit of an independent inquiry as set out below.

35. In setting up an independent inquiry the following points should be taken into account:

(i) **The remit of the inquiry** should encompass at least:

- the care the patient was receiving at the time of the incident;
- the suitability of that care in view of the patient's history and assess health and social needs;
- the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the exercise of professional judgement;
- the adequacy of the care plan and its monitoring by the key workers.

(ii) **Composition of the inquiry panel.** Consideration should be given to appointing a lawyer as chairman. Other members should include a psychiatrist and a senior social services manager and/or a senior nurse. No member of the panel should be employed by bodies responsible for the care of the patient;

(iii) **Distribution of the inquiry report**. Although it will not always be desirable for the final report to be made public, an undertaking should be given at the start of the inquiry that its main findings will be made available to interested parties.'

[Note: This guidance was subject to minor revision in 1995 by the Department of Health in *Building Bridges: a guide to arrangements for interagency working for the care and protection of severely mentally ill people* in particular financial prudence in the costing of any inquiry was stressed.]

Appendix 2

Mental Health Reference Group: Risk Management

APPENDIX D

Critical Incident Review

All organisations providing mental health care should have a procedure in place to review critical incidents. What is presented here clearly has a health bias. It is hoped that it can follow a template for others to modify and adapt for their own circumstances.

ALL MENTAL HEALTH SERVICE PROVIDERS

POLICY DOCUMENT - THE CONDUCT OF CRITICAL INCIDENT REVIEWS

1. Introduction

1.1 **Critical Incidents are defined as follows:**

a. Death of a resident in-patient or out-patient which is sudden or unexpected or where suicide is the most likely cause.

b. Homicide allegedly committed by a resident, in-patient or out-patient.

c. "Incidents", including those which might have resulted in suicide or homicide, episodes where there is evidence of serious intent of self-harm or violence to others or which led to injury or disability.

d. An event where an important policy, procedure, or practice was not followed by staff leading to a detriment or potential detriment of care - so called "near misses".

Reasons for Review

1.2 There are a number of reasons why it is essential that the circumstances of such incidents are reviewed by service managers, any clinical staff or others, including those service users involved. Most importantly any factors which could have prevented the incident should be identified so that steps can be taken to reduce future risk. "Near miss" events may not have had an obvious catastrophic outcome, but luck should play no part in service delivery; the effect on others may be considerable. It is equally essential that the impact on staff members and individuals using the service of the incident is identified and that appropriate support is made available. The Review should also allow the needs of others, for example, relatives or carers of the individual, to be identified and met.

1.3 A Critical Incident Review is not part of the disciplinary procedure. Any matter involving discipline should be dealt with separately altogether (see paragraph 5).

2. Procedure:

If any member of staff is made aware of a Critical Incident as defined above he/she should report this immediately to their line manager who, in turn, will make this information available to the service manager for mental health and the lead clinician. Trusts should establish a system for the confidential reporting of incidents.

2.1 The line manager will be responsible for arranging immediate support for the immediate patient group and any members of staff involved in the incident and for ensuring that all relevant persons are informed. If

there is any possibility that the event may be of interest to the media the on call general services' manager should be contacted.

2.3 On being advised of a Critical Incident the lead clinician in discussion with senior medical and nursing colleague will initiate a Review. The Review will be carried out by a senior member of staff from another part of the organisation. All available information will be taken into account as well as face-to-face contact with staff, workers from other agencies, individuals involved (accompanied by an advocate if necessary) and relatives/carers. Contact may be in a meeting or in one-to-one interviews. **The purpose of the Review is to establish matters of fact, not to attribute blame or responsibility.**

2.4 All patient records from all disciplines and including care plans must be passed onto the lead clinician immediately after the incident for safe keeping; they then will be passed onto the person carrying out the review.

2.5 The patient's RMO will inform the Procurator Fiscal of any sudden or unexpected death which falls within the categories listed in *Deaths in Hospital MEL(1996)*33.

2.6 The patient's RMO will notify the Mental Welfare Commission of the Incident and advise them that a follow-up report will be made available.

2.7 When the Review is complete a report should be made available to all relevant staff which must include the patient's General Practitioner. While the method and extent of the distribution should take account of the potential sensitivity of the information contained in the report, secrecy is not an option. The author of the report should convene a meeting of all those to whom it had been sent to discuss the contents and consider any implications. In particular, the Review should determine whether any aspect of patient care contributed to the incident and whether any recommendation should be made with regard to current clinical practice or policy.

2.8 A final report should then be prepared by the person leading the Review. This report should be forwarded to the Mental Welfare Commission and to the **Medical Director** of the Trust for consideration by the Clinical Governance Board.

3. Timescale:

3.1 Any member of staff made aware of a Critical Incident must report this to their line manager immediately.

3.2 If the line manager judges that there is any likelihood of media interest the on call general services manager must be advised immediately. The on call nurse manager and consultant psychiatrist should be informed immediately and the lead clinician and service manager advised of the Incident as soon as possible.

3.3 A Review should be completed within 4 weeks of the Critical Incident and the Multidisciplinary Meeting to consider its content should be completed within 6 weeks.

3.4 It is essential that the Review should involve affected patients, or carers, admitting an independent advocate if requested.

3.5 Wherever possible the Final Report should be available within 8 weeks.

4. Contents of Report:

4.1 The report should include the following factors, whatever the nature of the incident:

a. A brief background of the service users involved, including a brief psychiatric history, any relevant personal details, a description of the assessment of the individual's needs, the risk assessment and the diagnosis.

b. The care plan for the service user involved at the time of the incident, including an assessment of its relevance and the extent to which the planned care had been delivered to the user (and where relevant to other users of the Service).

c. Significant events in the period before the Critical Incident.

d. The service user's liability to detention under the Mental Health (Scotland) Act and, if voluntary, whether detention should have been considered.

e. If the service user was in hospital comment on the level of observation.

f. Where available the detailed circumstances of the incident.

g. Actions proposed by the Procurator Fiscal and any comments from the Mental Welfare Commission.

h. Significant outcomes of the review with particular comments on any evidence of substandard care or recommendations to be made with regard to changes in practice, training or communication or working environment, together with a timescale.

i. Possible contribution of substance or alcohol abuse.

4.2 Where the incident has involved suicide or other sudden death reference should be made to subsequent contact with the service user's family, and what support has been offered.

4.3 Whether appropriate expressions of regret and apologies have been made to the service user(s) and carers.

5. The organisation normally will not institute disciplinary proceedings against staff as the result of the findings of a critical incident review.

Exceptions are:

- where behaviour has occurred which may amount to a criminal offence;
- where a staff member has been involved in a second similar critical incident, showing no learning from the first;
- where it is found that a staff member has failed to report an incident which meets the definitions given in paragraph 1.1;
- where behaviour is reported which is well beyond the bounds of normal professional practice.

Appendix 3

Principles	Standard IR	Enhanced IR	Special IR
1. Clarity of Purpose & Methods of Investigation	• The aims and objectives are agreed and set out clearly in advance by the Health Board • Methods are clearly describes: e.g. interviewing staff, consultation of care notes, contact with victims, relatives etc (those affected) • Aims are clearly oriented around learning local lessons to improve practice.	• Terms of reference set out clearly in advance by the 'Forensic Network'. • Methods are clearly described: e.g. involvement with those affected. • Responsibilities of chair are clearly described by the Forensic Network, in relation to communication with staff and families. • Process will normally involve at least one visit to the site. • Aims are to identify lessons for improving local practice.	• Terms of reference set out clearly, in advance by MWC/ Scottish Exec on advice of Forensic Network. • Responsibilities of chair are clearly described. • Chair responsible for ensuring that all those likely to be involved know about the process and methods of inquiry, including those affected. • Process will normally involve more than one visit to the site. • Aims to identify lessons which have national policy significance.
2. Sensitivity to needs of families, carers, victims and other service users	• Chair to identify a member if the review team to have responsibility for liaising with families and victims. • Decisions over whether or not to involve families are recorded, with reasons given (e.g. not available, patient refuses consent, etc.)	• Families, carers, & victims are informed verbally and in writing before the inquiry begins. • Chair identifies a 'link person' to provide information for families etc. during the process. • 'Link person' required to keep notes of contacts, specifically relatives concerns.	• Families, carers and victims informed verbally and in writing before the inquiry begins. • Chair to ensure that local agencies appoint a 'link person' for families etc., which is communicated to all those involved. • 'Link person' required to make regular contact before, during and after the inquiry. • Contacts to be recorded, specifically relatives concerns.
3. Appropriate Membership & Constitution	• Review team to consist of maximum of 2-3 people.	• Panel to consist of 3 members. • Chair is appointed	• Panel to consist of maximum of 4 members.

	• Usually at least 2 senior clinicians from different professional backgrounds.	by the Forensic Network. • Chair is independent of service concerned, but may be from another local agency • Most panel members to have some mental health expertise. • Majority of panel members are independent of service concerned, although there may be some cases where all members are independent.	• Independent chair appointed by MWC • All members of panel to be independent of local services concerned. • Panel should contain at least one lay member. • All members to have some mental health knowledge or experience.
4. Openness to External Scrutiny	• Objectives are agreed in advance • Recommendations are shared with partner agencies before finalised. • Recommendations and action plan presented to local clinical governance group and those affected. • Local Health Boards should produce an annual report including number of incident reviews, nature and summary of action. This should be copied to Health Board Clinical Governance Committee, SEHD and The Forensic Network	• Lay person sometimes appointed to inquiry panels. • The recommendations and action plan are scrutinised by the Forensic Network. • Forensic Network to produce an annual summary of all 3 types of inquiries.	• Lay person always appointed to inquiry panels. • Copies of conclusions, recommendations and action plan are sent to Scottish Executive. • Audits of the recommendations and action plan for all Special IRs inquiries. • Copies available for consultation by researchers, professional bodies, etc.
5. Proportionality & Timelines	• should aim to begin within 4 weeks of the incident and report within 8 weeks. • The length of report should be not more than 2500 words.	• Investigation should begin **6-12** weeks of incident (legal constraints permitting) and report within **12-24** weeks. • Overall length of the report not more than 10,000 words.	• Inquiry should aim to begin within **3 months** of incident (legal constraints permitting) and report within **12 months**. • Overall length of the report should not exceed 25,000

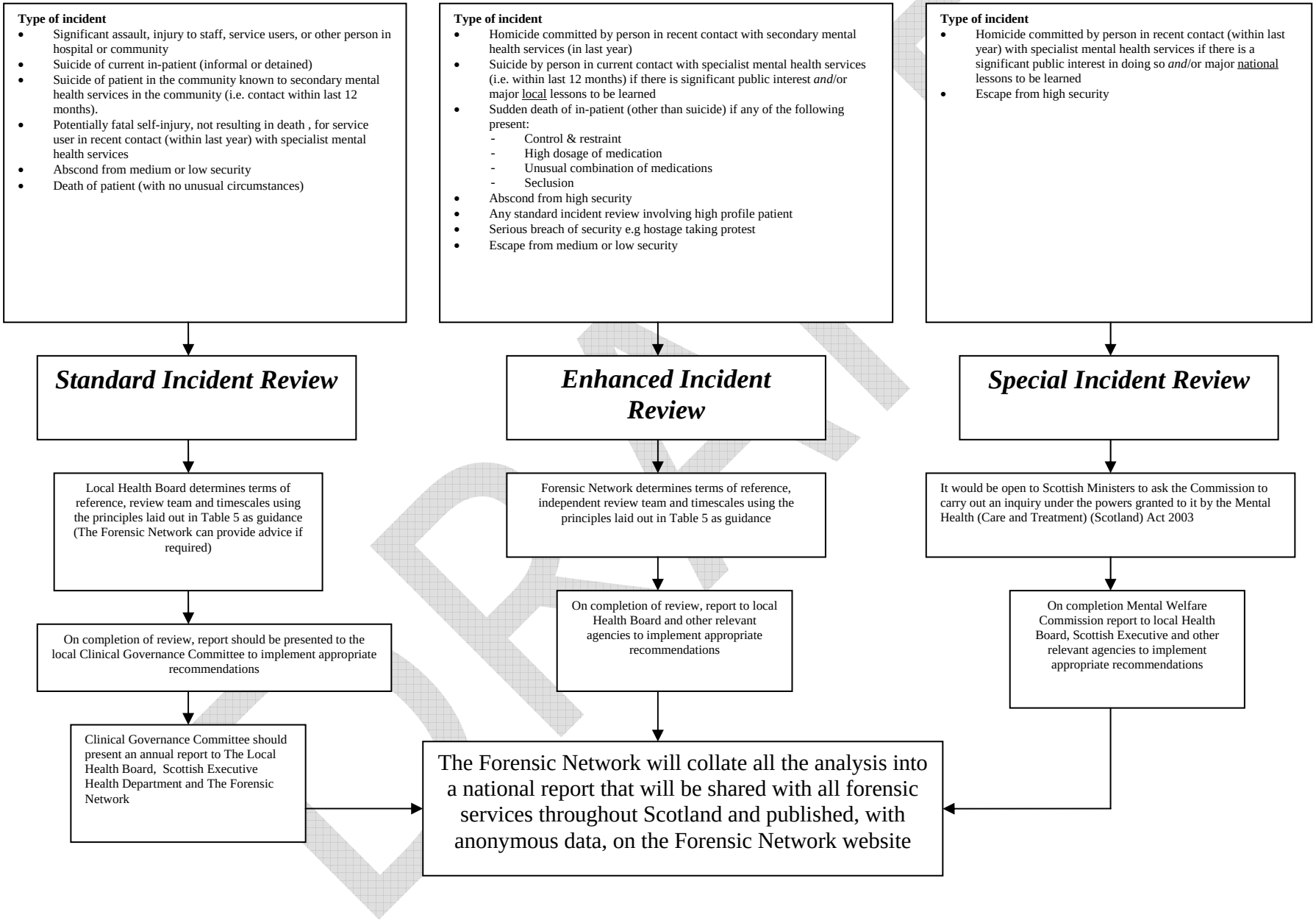
			words.
6. Appropriate Safeguards & Support for Staff	• Chairs of review teams to ensure all staff likely to be involved are informed in advance about the process and methods of review. • Staff are offered counselling and support. • Staff are clear about personal and professional responsibilities regarding the disclosure of information (e.g. local policies, implications of disclosure and non disclosure).	• Chair to ensure that local service managers inform all staff who are likely to be involved, in advance. • Staff to have copies of the terms of reference for the inquiry. • Local service managers are responsible for offering and providing counselling and support to staff involved in the incident. • Staff are clear about personal and professional responsibilities and the implications of disclosure and non disclosure. • Chair to ensure that local staff are informed if the recommendations and action plan following an inquiry.	• Chair to ensure that local service managers inform all staff who are likely to be involved in advance. • Staff to have copies of terms of reference for the inquiry. • Local service managers are responsible for offering and providing counselling and support to staff involved in the incident. • Staff are clear about personal and professional responsibilities and the implications of disclosure and non disclosure. • Chair to ensure that local staff are informed of the recommendations and action plan following an inquiry.
7. Clarity & Presentation of Findings	• Information is clearly presented in text with clear internal structure. • There is a clear separation of ‘fact’ from ‘opinion’ in the text. • Where conclusions are stated, the relative ‘strength’ of the evidence is acknowledged. • Conclusions are clearly linked to textual ‘evidence’. • Any recommendations presented are clearly linked to	• Information is clearly presented in text with clear internal structure. • There is a clear separation of ‘fact’ from ‘opinion’ in the text. • Where conclusions are stated, the relative ‘strength’ of the evidence is acknowledged. • Conclusions are clearly linked to textual ‘evidence’. • Any recommendations presented are clearly linked to	• Information is clearly presented in text with clear internal structure. • There is a clear separation of ‘fact’ from ‘opinion’ in the text. • Where conclusions are stated, the relative ‘strength’ of the evidence is acknowledged. • Conclusions are clearly linked to textual ‘evidence’. • Any recommendations presented are clearly linked to

	conclusions. • Recommendations contain an explicit 'action plan' with a timescale and an indication of who is responsible.	conclusions. • Recommendations contain an explicit 'action plan' with a timescale and an indication of who is responsible.	conclusions. • Recommendations contain an explicit 'action plan' with a timescale and an indication of who is responsible.
8. Links with other services/agencies and sources of information	• Reporting links to all services concerned through local clinical governance arrangements. • There are links with local (and joint) training structures to implement improvements.	• Reporting links with all relevant agencies through the Forensic Network.	• Reporting links with MWC, Scottish Executive and Forensic Network • Reporting links with national policy and training bodies (e.g. professional bodies; NES, QIS etc.)
9. Accountability	• Clear distinction made between 'individual' and 'system deficiencies'. • If decision taken to name individuals, clear justification given. • If 'system' faults then clear indication given of appropriate remedial action (e.g. targeted audit, changes in policy and/or procedure, training initiatives).	• Clear distinction made between 'individual' and 'system deficiencies'. • If decision taken to name individuals, clear justification given. • If 'system' faults, then clear indication given of appropriate <u>local</u> measures (e.g. undergoing training, improvement of joint working). • Recommendations that do have a national bearing are drawn out.	• Clear distinction made between 'individual' and 'system deficiencies'. • If decision taken to name individuals, clear justification given. • If 'system' faults, then clear indications given as to changes in <u>national</u> policy, (implications for national training etc.) and guidance for local services involved.
10.Evaluation	• Terms of reference and recommendations of each investigation to be reviewed every six months as part of clinical governance arrangements. • Dissemination of findings, report and outcomes is reviewed.	• Forensic Network to produce annual summaries of the objectives, terms of reference and the recommendations and action plans of <u>all</u> IRs undertaken. • Forensic Network to propose local improvement targets and/or	• Forensic Network to conduct audits of recommendations of all special inquiries, one year after submission the findings of which are shared with all relevant agencies. • Dissemination and outcomes are

		audit programmes. • Panels for enhanced IRs to reconvene after one year, to review implantation and produce report on progress to the Forensic Network and local agencies (not > than 1500 words. • Dissemination of findings, report and outcomes is reviewed.	reviewed.

APPENDIX 5

INCIDENT REVIEW PROCESS FLOWCHART



APPENDIX 5

Exploring Incidents – Improving Safety
A Summary of the guide to Root Cause Analysis from the NPSA

Introduction

The National Patient Safety Agency (NPSA) is committed to improving patient safety by promoting active learning at all levels across the NHS. It believes that learning can best be encouraged by:

- developing a supportive and open culture and
- ensuring that there are robust and proven tools available to staff to learn from incidents and near misses.

In order to develop ways of minimising risk to patients in future, we need to understand the true causes of patient safety incidents. The NPSA is reliant on the efforts of NHS staff in developing this understanding and has therefore created the e-learning package to help in the task ahead.

This summary pack is designed to give the reader an overview of the content of the e-learning package developed by the NPSA. It is not a substitute for the e-learning programme. However, this guide provides an overview of the key issues, theory and practice, which will help when undertaking a root cause analysis.

Aims

The information provided will enable you to gain an overview of:

- what the Root Cause Analysis (RCA) process is
- the tools and techniques used to undertake a RCA.

Further information

For further information about how to access the learning programme, please contact the NPSA.

Structure

The e-learning package comprises six modules:

1. Introduction
2. Why Things Go Wrong
3. Getting Started
4. Gathering Information
5. Analysing Information
6. Generating Solutions

The programme is supported by a Resource Centre which contains downloadable documents in the following sections:

- tools
- templates
- guidance
- glossary
- case studies
- references
- assessment

The Glossary and References are reference documents you may wish to refer to at any time. There is a version number on each of these documents and you can find out from the NPSA when new versions have been released by the NPSA.

This pack sets out a summary of the modules in the e-learning programme, together with an indication of the specific Resource Centre documents which may be relevant or helpful.

Module 1 Introduction

Summary

The e-learning package can give you a good understanding of the principles and practice of Root Cause Analysis and an opportunity to explore and practice the tools and techniques of investigation and analysis. It will also help you to identify how you can pursue further knowledge, experience and formal assessment in this field.

The NPSA is keen to promote learning at all levels - nationally, locally and organisationally within the NHS. Much information from RCAs will be shared through the NPSA but above all please remember that these methods should be used to support learning wherever you see the opportunity.

It is essential that organisations learn from patient safety incidents and make changes in practices and procedures to prevent them happening again.

What is a Root Cause?

The root or fundamental issues, is the earliest point at which action could have been taken that would have reduced the chance of the incident happening.

What is Root Cause Analysis?

Is a methodology that enables you to ask the questions "How" and "Why" in a structured and objective way to reveal all the influencing and causal factors that have led to a patient safety incident. The aim is to learn how to prevent similar incidents happening again, not to apply blame.

The process for undertaking a RCA enables a structured approach to investigating incidents, which supports analysis of systems, rather than focussing on individuals. This approach will also support the identification of effective solutions to problems. It involves all levels of staff in identifying causes and solutions, promoting a positive attitude to the management of incidents and moving towards a fair and learning culture.

There will usually be a Facilitator who co-ordinates a RCA. Other people may be involved as members of the team gathering and exploring information about an incident. The people who were actually involved in the incident may also be part of the process, for example, by being interviewed.

It is also important to consider how patients and their families may be involved in the process.

Resource Centre Documents

Glossary

Module 2 Why things go wrong

Summary

There has been a lot of work and research into why accidents happen and into the background to incidents in healthcare.

Most failures fall into one of two categories:

- Care Delivery Problem (CDP) A problem related to direct care giving
- Service Delivery Problem (SDP) Acts or omissions not associated with direct care giving.

When barriers fail, an accident is possible. There are four types of barriers:

- physical
- natural (time and distance placement)
- human action
- administrative

Human errors can lead to accidents: these are active failures.

Mistakes can be grouped into three categories:

- skill based
- rule based
- knowledge based

Violations

- routine
- reasoned
- reckless and malicious

It is important to consider the contributory factors which may have had an influence on an incident. The NPSA Contributory Factors Framework uses nine categories to help in the analysis of problems. Each category can be broken down into a further 15-30 components

Resource Centre Documents

Glossary

Guidance: *Introduction to Human Theory*

Guidance: *Contributory Factors Framework Checklist*

Module 3 Getting Started

Summary

This module deals with:

- classifying incidents
- commissioning reviews
- setting up the team
- scoping the incident
- setting out the “route map” for a RCA.

Each organisation will have a system for classifying incidents. Examples of classification categories are:

- death
- severe harm
- moderate harm
- low harm
- no harm.

Reviews of the more serious patient safety incidents are commissioned by the Trust.

Other triggers for a causal analysis include frequently occurring and local issues.

The review Facilitator will need to decide who to involve in the team and how to go about scoping the incident for review. This will depend on the nature and healthcare setting of the incident. In general, the following guidelines are helpful:

Acute Care episodes - examine the complete care episode

Community-based episodes and in environments of long-term care – start data collection at the time of the incident and work backwards until enough information has been gathered to enable the issues to be identified and explored fully.

The RCA process consists of six main activities:

- data gathering
- information mapping
- identifying problems
- analysing problems for contributory factors
- agreeing the root causes
- recommendations and reporting

Module 4 Gathering and Mapping Information

Summary

The first task in an RCA review is to gather information and establish a chronology of events. Information should be gathered about:

- what happened
- the site and/or equipment
- policy and guidelines
- patient's notes and other documentation.

Interviewing people involved will be critical to this part of the process and interviewers need to be aware of how to elicit information effectively and sensitively from people.

Once the information has been gathered, it has to be ordered – or mapped - in a useful way. Tools to enable you to do this include:

- Narrative Chronology
- Timeline
- Tabular Timeline
- Time-Person Grid.

The application of each of these will depend on circumstances.

A Multi-Professional Review meeting may be organised by the Facilitator to help to identify the key problems (Care Delivery Problems or Service Delivery Problems) that emerge.

There are a number of tools which can be used to help the team identify the CDPs and SDPs that occurred. These include the following and are explored in greater detail in the next Module.

- Brainstorming
- Brainwriting
- Nominal Group Technique
- Change Analysis
- Barrier Analysis.

There are case studies in the Resource Centre which illustrate how the various tools and techniques referred to here are used in practice.

Resource Centre Documents

Guidance: *Data Collection; Site Visits; Undertaking an Investigative Interview; Witness Statements; Multi-Professional Review*
Tools: *Narrative Chronology; Timeline; Tabular Timeline; Time Person Grid; Tool Matrix*
Case Studies.

Module 5 Analysing Information

Summary

Once data has been collected and mapped and problems have been identified and clarified it is necessary to:

- prioritise problems and issues for analysis
- identify contributory factors
- choose appropriate causal analysis tools
- agree root causes.

The Multi-Professional Review Team will need to prioritise the identified problems before analysing them. There are tools which can help with this task, including:

- Nominal Group Technique
- Brainstorming
- Brainwriting

They then need to analyse each problem for its contributory factors and to consider whether contributory factors were influencing or causal. The tools which can help at this stage include:

- Brainstorming
- Brainwriting
- Fishbone diagram
- Five Why technique
- Barrier Analysis

There are case studies in the Resource Centre which illustrate how the various tools and techniques referred to here are used in practice.

The team should now have identified the fundamental issues or root causes which need to be addressed.

Resource Centre Documents

Guidance: *Multi-Professional Reviews; Contributory Factors Classification System*

Tools: *Barrier Analysis*; *Brainstorming; Brainwriting; Five Whys; Representing Contributory Factors;Tool Matrix*

Case Studies

Module 6 Generating Solutions

Summary

The final module of the programme looks at:

- failsafe evaluation
- generating solutions
- reporting recommendations.

It is important the lessons learned from the RCA can be used to improve patient safety.

The Multi-Professional team will need to consider whom to involve in making recommendations and to be aware of the wider implications of actually putting recommendations in place. These may involve considering cost implications, impact on other parts of the organisation and ensuring that action plans are part of the overall risk management programme on the organisation.

The strengths and weaknesses of control measures need to be examined in order to understand what new measures might work best. Conducting a failsafe evaluation of existing and recommended barriers or control measures is therefore helpful. Understanding the inherent strengths and weaknesses of different types of control measure or barrier is essential to this process.

Understanding why things go wrong is fundamental to making improvements in healthcare. Many of the people who have used root cause analysis have found it an invaluable help in identifying the true causes of problems and the best solutions to prevent incidents from happening in future.

The case studies in the Resource Centre illustrate how the issues referred to here can be tackled in practice.

Resource Centre Documents

Tools: *Barrier Analysis*

Case Studies