The Regulation and Quality Improvement Authority

GAIN
GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

A Project Examining Learning Arising from Serious Adverse Incidents Involving Suicide, Homicide and Serious Self Harm

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and projects are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement, and to protect the public interest.

Our reports are submitted to the Department of Health and are available on the RQIA website at www.rqia.org.uk.

Guidelines and Audit Implementation Network

On 1 April 2015, the responsibility of the Guidelines and Audit Implementation Network (GAIN) transferred to RQIA.

GAIN is committed to supporting the delivery of effective clinical audit and guideline development across the Health & Social Care Community in Northern Ireland as a key component of its arrangements for supporting the development and maintenance of high quality patient-centred services.

GAIN is also committed to assessing and improving the quality of patient care through robust and effective clinical audit by undertaking regional and national clinical audit projects.

This report relates to a joint project undertaken by RQIA and GAIN designed to examine different approaches and methodologies for identifying learning from serious adverse incidents (SAIs), involving suicide, homicide and serious self-harm.

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[1] http://www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

1. Introduction and Background

In a letter dated 9 April 2014, the Chief Medical Officer, DoH, stated the vast majority of patients, clients and their families using health and social care services have a positive experience and receive a high quality service. Outcomes for patients and clients are improving on an ongoing basis, despite what can be a very challenging environment in terms of demographic change, new technologies and treatments, rising public expectations and finance.

However, amongst the millions of interactions between Health and Social Care (HSC) Trusts, patients, clients and families there are some cases where outcomes are not as initially planned or expected, or the quality of care falls below the standard which any of us would wish or expect. An important aspect of the quality of services being provided is how organisations and the people working within them respond in these instances.

In a letter, dated 31 July 2015, Deputy Chief Medical Officer, Dr Paddy Woods commissioned a project from GAIN, to examine different approaches and methodologies for identifying learning from serious adverse incidents (SAIs), involving suicide, homicide and serious self-harm

This project was convened in October 2015, at which time the procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013) was operational. This document has been prepared based on the requirements of that procedure.

As documented in the project brief any circulars, guidance, standards, reviews and reports which arise during the course of this project will not be assessed as part of this project but may be highlighted for consideration in the future. Therefore it is noted that during the life of the project, in November 2016, an updated procedure for the Reporting and Follow up of Serious Adverse Incidents was issued by the HSC Board.

The main changes to the procedure are outlined below; however sufficient time has not yet elapsed to determine if these changes are making a significant impact on the learning related to suicide, homicide and serious self-harm or on the conclusions or recommendations contained within this report.

- The revised process requires reporting organisations to quality assure the robustness of level 1 SEA Reviews prior to submission to the HSC Board and provides additional guidance on the use of an ‘incident debrief’ for each level of SAI review.
- In line with DoH circular HSC(SQSD) 56/16 (Never Events), the current SAI notification form has been revised to enable reporting organisations to identify relevant SAIs as a Never Event and confirm that service users/family/carers have been informed.
- The checklist for Engagement/Communication with Service Users/Family/Carers following an SAI has been updated to reflect where relevant, the service user/family carer has been advised:
    - the SAI is a never event; and
    - if a case has been referred to the Coroner, where the reporting organisation had a statutory duty to do so.

In addition the guidance has been revised to reflect:

- the term 'SAI Review' (this has also been reflected throughout the revised procedure);
- a service user/family's right to contact the Northern Ireland Public Services Ombudsman (NIPSO) where they are dissatisfied with the HSC organisation's attempts to resolve their concerns following a SAI review; and
- the engagement leaflet has been updated to reflect the organisation's responsibility to advise the service user/family/carer of a Never Event.

- The Report on Falls Resulting in Moderate to Service Harm was issued in March 2016. As a result, a new process has been developed, with phased implementation, which enables Trusts to undertake a timely local post falls review, and report the learning from these incidents to the Regional Falls Group, rather than being reported routinely as SAIs.
- In addition to the above, all other changes to the process, previously communicated to Arm's Length Bodies (ALBs) since October 2013, were incorporated within this review.

1.1 Suicide, Homicide and Serious Self-Harm in Northern Ireland

Suicide

In 2015 there were 15,678 deaths registered in NI; of these 268 were suicides, which represents a decrease from 303 in 2013[2]. Just over three quarters (207) of suicides in 2015 were men. In February 2016, it was reported that, for the second year in a row, Northern Ireland had the highest suicide rate in the United Kingdom[3].

During 2015 there were 16.5 suicides registered per 100,000 of the population in Northern Ireland, according to the Office for National Statistics. Scotland had the second-highest rate at 15.5, followed by 10.3 in England and 9.2 in Wales.

Trends in statistics for the years 1999 – 2003 showed[4]:

- More males die as a result of suicide than in transport accidents.
- More males die through suicide than as a result of either accidental falls or poisoning.
- More females die as a result of suicide than in transport accidents but fewer die as a result of suicide than from other external causes and accidental falls.
- Incidents of suicide were most common in those aged between 25 to 35 years.
- Suicide rates tended to be higher in urban than in rural areas.

Research would tell us that we need to see a greater focus at both local and regional levels on the coordination and prioritisation of suicide prevention activity, especially in areas with high levels of socio-economic deprivation[5].

[2] http://www.nisra.gov.uk/demography/default.asp31.htm
[3] Irish News, 5 February 2016: http://www.irishnews.com/news/2016/02/05/news/ni-suicide-rate-higher-than-south-and-britain-for-second-year-406825/
[4] http://www.stampoutsuicide.org.uk/locational-info/northern-ireland/

We know that good collaboration between different sectors and agencies is vital to reduce suicide. The causes of suicide are complex and we need to encourage people to seek help before they reach a crisis point.

Homicide

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (July 2015) reports that in the period 2003-2013, there were 217 homicide convictions in Northern Ireland, an average of 20 a year[6]. During this period, 27 people convicted of homicide (12% of the total sample) were confirmed as having been patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 2 per year. There were 28 victims.

Serious Self Harm

In February 2015, the Northern Ireland Registry of Self-Harm published its second annual report presenting an analysis of the incidence of self-harm presentations to the 12 Emergency Departments (EDs) across Northern Ireland[7].

Recently there has been a concerted effort to increase understanding of the issues represented in data, and perhaps more importantly, what can be done to raise greater awareness about the issue of self-harm, supporting carers and families and informing professionals working in this field in both the community and statutory sectors.

The summarised key findings of this report are that between April 2013 and March 2015:

- There were 8,453 self-harm presentations to EDs in Northern Ireland, involving 5,983 persons.
- Overall, there was an even balance of male and female presentations.
- The majority of people presented on just one occasion.
- One fifth of people presented with self-harm on more than one occasion during the 12 month period.
- In total 127 people accounted for 1,160 presentations during 2013/15, each presenting 5 or more times.
- The rate of repetition of self-harm was 20% for males and 19% for females.
- Persons aged 15-29 accounted for almost half of all self-harm presentations.
- Drug overdose was the most common method of self-harm accounting for almost three quarters of presentations, followed by self-cutting which was involved in almost a quarter of presentations.
- Although rare as a sole method of self-harm, alcohol was involved in almost half of the total presentations.

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[5] http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf

[6] http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015Bookmarked3.pdf

[7] http://www.publichealth.hscni.net/sites/default/files/Annual%202013%2014%20Report%20NIRSH_0.pdf

1.2 Terms of Reference

The terms of reference for this project, agreed by RQIA/GAIN with the DoH were:

1. To assess the effectiveness of existing tools and processes used to identify learning from individual SAIs involving suicide, homicide and serious self-harm[8], including the degree of patient/family involvement.
2. To review the present approaches and methodologies for identifying and evaluating organisational and regional learning from SAIs involving suicide, homicide and serious self-harm. This will include looking at actions arising from these SAIs and dissemination of learning.
3. To examine good practice elsewhere in the UK and internationally in relation to the assessment of SAIs involving suicide, homicide and serious self-harm.
4. To develop a revised methodology for the investigation of deaths involving suicide, homicide and, where appropriate, cases of serious self-harm, which will include:
    - Identification of learning;
    - Dissemination of learning;
    - Improved service user participation;
    - A mechanism whereby cases that require further investigation may be referred to an appropriate independent person or group; and
    - A process for ongoing oversight, review/audit of the learning arising from SAIs involving suicide, homicide or self-harm.
5. To establish linkages, where appropriate, with existing programmes and systems in Northern Ireland and nationally.

1.3 Methodology

The aims of the project were to:

- review different approaches and methodologies for identifying learning from SAIs, involving suicide, homicide and serious self-harm, taking account of good practice elsewhere in the UK and internationally;
- assess existing methodologies to review learning from SAIs.

This project was managed using the PRINCE2 project management approach. All planning, decisions and actions were appropriately recorded and managed within acceptable timescales.

Generally the work undertaken was grouped into the following stages:

- Initiation
- Design
- Fieldwork
- Reporting
- Closure and Evaluation

[8] Defined As: Those self-harm cases which were reported as a SAI by Trusts

As set out in Dr Woods' letter the project was carried out in partnership with the HSC Board, the Public Health Agency (PHA) and the six HSC Trusts. To take the project forward, a multi-organisational Project Board was established, with membership drawn from relevant organisations, GAIN and RQIA. In addition to this a Project Team was also established to take forward a number of individual work streams.

2. Reporting and Follow up of Serious Adverse Incidents in Northern Ireland

Commissioners and providers of health and social care in Northern Ireland wish to ensure that when a serious incident occurs, there is a systematic process in place for identification of learning which will assist with safeguarding service users, staff and members of the public, as well as property, resources and reputation. One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from SAIs.

2.1 Current Reporting Procedures

The current procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013) was developed by the HSC Board in conjunction with other HSC organisations. This procedure aims to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies. The procedure also takes account of the independent sector, where it provides services on behalf of the HSC.

The current HSC definition of an adverse incident is:

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[9] arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The current criteria used to determine whether or not an adverse incident constitutes an SAI are attached at Appendix 1 and guidance on timescales for the completion of SAI investigations is attached at Appendix 2.

SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review. There are 3 levels of investigation:

- Level 1 Investigation: Significant Event Audit (SEA)
- Level 2 Investigation: Root Cause Analysis (RCA)
- Level 3 Investigation: Independent Investigation

2.2 Involvement of Service Users/Relatives/Carers in Investigations

The current procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013) outlines that investigation teams should provide an opportunity for the service users/relatives/carers to contribute to the investigation, as necessary.

The level of involvement clearly depends on the nature of the SAI and the service users/relatives/ carers willingness to be involved. Teams involved in the investigation of SAIs should ensure sensitivity to the needs of the service user/relatives/carers involved in the SAI and agree appropriate communication arrangements.

[9] Source: DHSSPS How to classify adverse incidents and risk guidance 2006 www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

In April 2014 a group comprising HSC Board, the PHA, Patient Client Council (PCC) and RQIA representatives was established to develop guidance for HSC organisations on engagement with patients, clients and families as part of the SAI process. The guidance, issued in February 2015, is informed by the National Patient Safety Agency (NPSA) 'Being Open' framework (2009)[10] and the Health Service Executive – Open Disclosure National Guidelines (2013)[11]. It refers to the principles of being open with service users, carers and families and specifically highlights the various stages of engagement from recognition that an SAI has occurred, to the conclusion of the process.

To support the engagement process, an SAI leaflet has been designed for organisations to give to service users, family and carers prior to any initial discussion regarding the SAI.

2.3 HSC Board Overview of the Management of Serious Adverse Incidents

SAIs are reported to the HSC Board (Regional Reporting System) within 72 hours, via a central email account linked to the HSC Board's Governance Team and immediately logged onto the Datix system. On receipt of an SAI report, the HSC Board allocates a Designated Reporting Officer (DRO) to each SAI, who is responsible for the review of investigation/review reports completed by trusts.

The HSC Board, working closely with the PHA, is responsible for identifying and disseminating regional learning as part of its assurance role in relation to SAIs, complaints and patient client and experience. It does this via a number of groups as outlined below:

Quality Safety and Experience (QSE) Group – this multi-disciplinary group meets on a monthly basis to consider learning, patterns/trends, themes or areas of concern from all sources of safety and quality information received by the HSC Board and PHA and agrees appropriate actions to be taken.

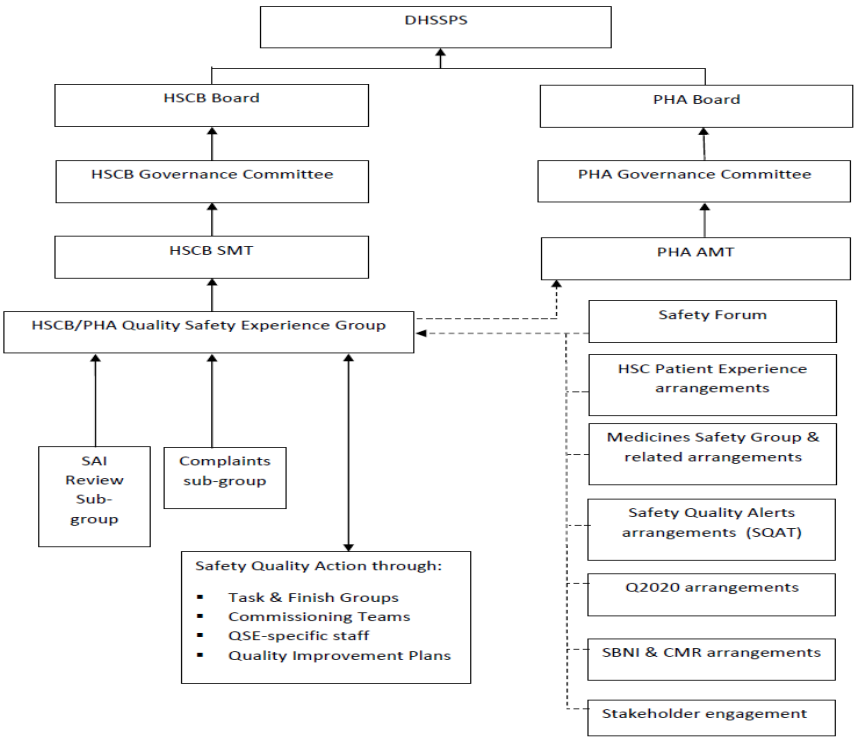
Regional SAI Review Subgroup – a multi-disciplinary group that meets on a monthly basis. The group reports to, and supports the work of, the QSE Group. Membership includes representatives from relevant directorates within the HSC Board and the PHA.

Safety Quality and Alert Team (SQAT) – a multi-disciplinary group that meets fortnightly. The team is responsible for overseeing the implementation and assurance of Regional Learning / Reminder Letters and Guidance issued by HSC Board/PHA and other organisations.

A further series of **Individual Professional Groups** review reports and/or seek further professional advice and identify themes. Where assurance arrangements are required from trusts, the **SQA Team** oversees this function.

In addition to the above, the HSC Board Senior Management Team receives and considers all SAIs on a weekly basis.

[10] http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726
[11] http://www.hse.ie/opendisclosure/



Upon completion of an SAI investigation/review, the final report is submitted to the DRO. If the DRO (in conjunction with other officers or RQIA) is satisfied that the review is robust and is content with checklist, the final report will be shared with the relevant Professional Group and the SAI will be closed.

If learning has been identified by the DRO or the Professional Group, a learning submission form will be issued and completed by the DRO and forward to the SAI Review Sub Group. Where the DRO has identified learning, but there is no specific professional group, the Governance Team will provide the DRO with a learning submission form for completion and onward referral to the SAI Review Sub Group. At this point the SAI is closed on Datix and the reporting organisation is informed.

If the DRO is not satisfied that the review has been robust, they will request additional information from the reporting organisation, along with associated timescales for receipt of a response.

Typical queries raised by DROs are:

- queries regarding membership of review teams;
- queries on the care provided/timeliness of care;
- queries on the engagement checklist; and
- requesting action plans.

During this time the DRO may also choose to seek other professional advice from staff within the PHA, HSC Board and RQIA.
This engagement will continue until the DRO is satisfied with the SAI review and the associated family engagement checklist. The SAI remains open throughout this continued engagement.

2.4 Mechanisms in place for Learning

Learning opportunities arising from SAIs can be identified in a number of ways; by the reporting organisation, DROs, Professional Groups, the Regional SAI Review Sub Group or QSE Group.

All identified learning is reviewed for approval by the Regional SAI Review Group. Learning submission forms are then referred to the QSE Group and learning actions are agreed, depending on the type of learning identified.

Dissemination can be done in a number of ways:

- Reminder of Best Practice notices.
- Learning Letters (identified by the SAI Review Group, approved by the Quality Safety and Experience Group (QSE) issued and assurance provided by the Safety and Quality Alerts team (SQAT).
- 'Learning Matters' newsletter (SAI articles identified by the SAI Review Group)
- Thematic Reviews (identified by the SAI review Group and approved by QSE; assurance on any actions provided by SQAT).
- Bi-annual Learning Report (produced by the SAI Review Group / approved by QSE/Senior Management Team and ultimately the Board).

Where actions for implementation are identified, these can be progressed by:

- an existing work stream or established group;
- undertaking a thematic review; and
- establishing a task and finish group.

When it is necessary to inform other statutory bodies of learning, the HSC Board/PHA may choose to refer to another regulatory body or to commission or organise a training event/workshop.

It should be noted that when urgent/immediate learning is identified by the DRO, this is taken forward in conjunction with the relevant professional Director and the Governance Team to ensure that this is disseminated in a timely and appropriate manner.

Data on the SAIs closed during the period 1 April – 30 September 2016, showed that none of the 81 SAIs closed relating to the Mental Health Programme of Care had generated any regional learning. In comparison, in the Acute Programme of Care 55 SAIs were closed and regional learning was agreed in 11 of these, representing 20% of the overall total.

It must be noted that the identification of regional learning, in relation to some of the SAIs noted above, may be still under consideration at a professional group which may result in a higher number of SAIs with regional learning agreed at a later stage. There may also be local learning being taken forward in relation to the above SAIs which has not been accounted for in these figures.

Over the past number of years there has been the following 2 thematic reviews undertaken with Mental Health SAIs:

1. Thematic Review of Mental Health Serious Adverse Incident Reports relating to Patient Suicides; and
2. Audit of the use of Landline and Mobile answering and Messaging Machines in Mental Health Services.'

3. HSC Trust Procedures for the Management of Serious Adverse Incidents involving Suicide, Homicide and Serious Self-harm

As part of this project, we explored the current operation of the SAI procedure within each trust, focusing on the current processes in place for the reporting, investigation and sharing the learning from SAIs, related to suicide, homicide and serious self-harm. The information in section 3 of this report represents the views expressed by trusts.

3.1 Reporting SAIs related to Suicide, Homicide and Serious Self Harm

The procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013) details the criteria used to determine whether or not an adverse incident constitutes an SAI. Trusts were asked if they had any difficulties in identifying incidents which meet these criteria e.g. serious self-harm type incidents.

Each trust, with the exception of the Belfast Trust, has local guidance to help with the classification of SAIs, based on regional SAI reporting guidance. However, concerns were raised around the lack of specific guidance on the classification of serious self-harm and presently defining what does and does not constitute '*attempted suicide'* and the seriousness of '*self-harm'* is subjective and open to interpretation.

In statistics provided by the HSC Board, it was noted that in 2013/14 there were only 4 SAIs reported in relation to self-harm, while in 2014/15 this number increased to 17. Despite the small increase, these figures would seem to reflect an under-reporting in this area.

In the main trusts are prompt in their notification of SAIs, however, on occasions trusts may delay/defer reporting an incident as an SAI while they seek additional information, to determine if reporting criteria have been met; however this is not described as a routine or frequent practice. Delays can also occur when an unexpected/unexplained death occurs in the community, as initial information gathering can take more time.

The requirement to report SAIs within 72 hours can result in a greater tendency to de-escalate SAIs, rather than delay reporting until cause of death is confirmed.

3.2 The Investigation Process

The SAI procedure states that SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

For Level 1 investigations- membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved.

For Level 2 investigations- the level of investigation undertaken will determine the degree of leadership, overview and strategic review required.

A core investigation team should comprise a minimum of 3 people of appropriate seniority and objectivity. Investigation teams should be multidisciplinary and should have no conflict of interest in the incident concerned. Investigations should have a chairperson who should be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. The chair should not have been involved in the direct care or treatment of the individual, or be responsible for the service area under investigation.

For Level 3 investigations- the same principles as Level 2 investigations apply; however team membership must be agreed between the reporting organisation and the HSC Board/PHA/DRO prior to the investigation commencing.

All trusts are operating within these guidelines; however they did note that it can be difficult to convene panels within a timely manner and that in some cases, while the chair is independent of the service area, the level of independence may still be considered questionable.

Trusts were asked if, at the outset of the investigation, the investigating officer would usually identify if an appropriate clinical diagnosis has been made and this appears to be variable across each of the trusts. Two HSC trusts confirmed that diagnosis is considered as part of the review, while 2 others reported that the investigation will not usually identify if an appropriate clinical diagnosis has been made. In the final trust the approach varies across review panels/investigating officers and as a result, confirmation of an appropriate diagnosis would not be made in all cases.

In addition to this, trusts were asked if investigations would routinely identify and examine the appropriateness of the clinical treatment and the associated care plan for the individual diagnosis. In the main, all trusts reported that the appropriateness of the clinical treatment and the associated care plan would be discussed/examined as part of the investigation, particularly in the more recent reviews. Where issues in relation to treatment and care are identified, these will be included in the investigation report and, when appropriate, factored into recommendations.

All trusts agreed that the current investigation process has the potential for the identification of learning in relation to the individual and to their case management/treatment. However, some weaknesses were noted, particularly in relation to adopting an RCA approach which can often fail to identify a 'root cause' rather than focusing on the contributory factors that could potentially strengthen care delivery. It was reiterated that the current SAI process can be labour intensive and difficult and there is a strong sense that inputs are disproportionate to outcomes or output. Trusts also identified that any investigation into practice has the potential to cause some level of anxiety for the staff member(s) involved in the case.

In relation to the timescales for investigation of SAIs involving suicide, homicide and serious self-harm, the majority of trusts expressed difficulties with the timeframe for review investigations. They acknowledged the need to complete reports in a timely manner, mindful of the individual needs of families involved, to ensure the application of learning; however they identified a number of issues which can contribute to delays:

- Difficulties in engaging with families and staff sensitively immediately after a suicide; the appropriateness and timeliness of their interaction must be considered and can often extend the time it takes to complete the process.
- The volume of currently reported cases puts excessive strain on the workforce.
- Difficulties engaging with the necessary clinical staff due to their existing diary commitments, prearranged leave or sick leave.
- On occasions, when a number of reviews run concurrently, the availability of clinicians to attend reviews can be limited by competing priorities.
- Other investigatory processes e.g. Police Service of Northern Ireland (PSNI) involvement may delay the start of the SAI process.

On completion of an investigation, all trusts have a process in place to review the quality of the final SAI report, prior to submission to the HSC Board.

On receipt of an SAI notification, the HSC Board allocates a DRO to each SAI, who is then responsible for the review of investigation/review reports completed by trusts.

Trusts' views of the usefulness of the DRO input were variable. Overall, trusts reported that the DRO offers an independent and regional view on the final report. However, it was noted by some that the DRO's intervention has added a layer of bureaucracy to the investigation process, which may at times detract from a service manager's productivity.

Most of the communication from the DRO is forwarded by email and at times this can become protracted. It tends to be most constructive when the DRO and chair of the review communicate directly and discuss specific queries in a timely way, to avoid any misinterpretation. There were concerns raised around the timeliness and content of the contact and the number of issues raised. The request for comments can often come at a later stage when the SAI report may have already progressed through the courts system/inquest.

On occasions, where there have been additional queries raised by RQIA separate from the DRO, there has been confusion. There have been times when RQIA and the DRO have contacted trusts separately with separate/same queries. However this appears to have been resolved, with the DRO now being the sole conduit for any such queries.

In relation to SAIs involving suicide it was noted that, due to the complexity of the case, it is often difficult to accurately contextualise the individual's level of engagement with services, social and therapeutic relationships and the logic of the decision-making process that occurs in real time. Due to these difficulties, the comments received back via the DRO can at times appear over-simplistic and challenging and the comments, at times, may not clearly relate to day-to-day operational practice.

It was suggested that more flexibility is required in each investigation, dependent on the nature of the incident itself. Some trusts felt that a discussion between the review team chair and the DRO prior to the investigation starting may reduce the number of queries later.

3.3 Family Engagement

The current procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013) indicates that investigation teams should provide an opportunity for the service users/relatives/carers to contribute to the investigation, as necessary.

Normally, at the time of the SAI the trust will make contact with the family to advise them of the SAI. This contact could be via the team leader from the area where the SAI has occurred, the key worker, the consultant or in the case of the Northern Ireland Ambulance Service (NIAS) their senior operational staff. During this initial contact, in cases where the service user has died, the trust may offer the family immediate care and support, for example a referral to the various suicide liaison services provided by the trusts. Where the service user is alive, consent will be sought to inform and engage with their family.

Trusts will then issue a letter to the family expressing condolences and again offering support. The letter will also advise the family/next of kin about the SAI review process and will invite them to become involved or to comment on the care their loved one received. The family is provided with a contact name within the trust should they wish to make contact. If families choose to become involved in the process, they are offered various options to do this. For example, they may be invited to meet with members of the review team, or to liaise by telephone or in writing. Trusts will facilitate whichever option is chosen.

During the investigation, the family is provided with the opportunity to comment on the care their relative received; if the family is agreeable, their comments are then included in the final investigation report. Draft SAI reports are shared with families, providing them with an opportunity to read the report prior to it being finalised.

All trusts were keen to express that all communication regarding an SAI and the investigatory process is carried out in a sensitive and timely manner.

3.4 Sharing the Learning

Within Mental Health services it would be unusual for learning to have wider application across the entire trust; however when it is appropriate to do so, all trusts have mechanisms to facilitate this. Each trust uses their internal learning alert systems and/or newsletters which are communicated to all staff electronically.

All trusts had systems in place for the dissemination of identified local learning within local units/hospitals. In the main, dissemination is facilitated through trust governance processes and line management structures, cascaded via heads of service, professional leads and team and ward managers. In one trust the chair of the review is required to meet in person with each team involved in the care of the patient; this provides an opportunity for reflective discussion and to answer any queries in relation to how the panel reached its conclusions.

When a trust completes an investigation, they are able to flag up issues which they feel should be identified for wider regional learning; any such issues can be identified as a recommendation within the SAI investigation report which is then forwarded to the HSC Board. However trusts reported that sometimes there is no feedback from the HSC Board to explain why regional learning/actions identified in final report are not taken forward. This can be difficult for trusts particularly when families ask for this information.

When regional learning is identified by the HSC Board, this is disseminated to trusts. All such notifications from the HSC Board are received via a central point in trust governance departments, with the exception of the NIAS which receives these via their Medical Directorate.

When received by trust governance departments, regional learning notifications are cascaded electronically to staff, via existing individual trust governance structures; for example they would be issued to directors, assistant directors, senior managers, clinical leads and team leaders. This information is then disseminated further to all frontline staff using mechanisms such as team meetings, email notification, notice boards etc.

3.5 Outcomes

All trusts reported that, where learning has been identified, they have mechanisms in place to provide assurances in relation to implementation and effectiveness of actions taken via their existing governance structures. Where required, this assurance will be reported upwards to Trust Board level.

3.6 General Observations

In general, trusts identified a number of strengths of the current SAI reporting and learning system. Overall, the system in theory seems to support the process for notification of an SAI, completion of investigations and involvement of service users/families. Trusts reported that the current process is an open process which is clearly defined and provides a structure for the review of SAIs. Appropriate family involvement enriches the quality of the review and facilitates learning that can really make a difference from a service user perspective.

The system provides a very effective process for the investigation of complex cases. There is local/team involvement in the investigation and the process allows for areas of good practice to be highlighted; the end product is comprehensively reviewed and staff are made aware of issues arising. Where appropriate, the system also facilitates the dissemination of regional learning.

However trusts also identified a number of weaknesses within the current arrangements. These are outlined below:

- The process is labour intensive and process driven and the input is disproportionate to the outcomes for most SAIs apart from the complex cases.
- There were concerns about the reporting criteria/thresholds for SAIs.
- The interface for inquiry between the HSC Board/RQIA and trusts could be improved to support a quality improvement/learning culture.
- Clarity is required on the most appropriate investigation methodology to use.

- There are difficulties in obtaining external independent chairs for level 3 reviews.
- The process doesn't support trust collaboration in relation to interface SAIs.
- The independence of the investigation process can be questionable.
- The current timeframes for investigation are difficult to manage particularly when dealing with families who have suffered a loss.
- Staff, who have been involved in an SAI and the subsequent investigation, sometimes feel there is an element of blame and feel anxious about involvement in the process.
- While the system does allow for the sharing of regional learning, it can at times be weak and some reportable SAIs tend to result in consistently similar recommendations.
- The entire process is not appropriately resourced.

Trusts reflected that the current processes for the investigation of incidents involving suicide, homicide and serious self-harm seem too inflexible with regard to determining the level of investigation needed. SAIs can be very labour intensive for the level of learning that is extracted. Trusts feel there is a need to have a more proportionate and flexible approach to reporting and investigation and that specifically, SAIs related to suicide may benefit from having their own process.

Frequently, it is the same learning themes which are being identified. Issues in mental health cases tend to be more systemic as opposed to incidents where there has been tangible errors/learning. It is therefore very difficult to identify and determine the overall effectiveness/impact of remedial actions taken as a result of reviews. This is particularly relevant for SAIs where there has been death by suicide.

Learning involves often low level causal and process factors that, when updated or changed, have a very limited impact on future events. In order to achieve more effective learning, a trust wide or regional overview of this may be required, which could be achieved via a process of thematic review.

Trusts felt the HSC Board should reconsider the regional reporting criteria in relation to incidents involving suicide, homicide and serious self-harm. If this is modified the HSC Board should ensure there is clarity for trusts about which incidents should be reported/investigated.

One possible improvement could be the transfer of the management of Level 1 Investigation: Significant Event Audit (SEA) to trust level. This would result in the learning potentially being timelier and more meaningful.

In addition to this, trusts could be provided with more autonomy in determining what is reported and how the investigation should be managed. For example, for SEAs there is often little in the way of new learning, therefore a more refined process of review involving the multidisciplinary team may be more appropriate.

While the current SAI process always seeks to identify learning, in the case of most SAIs involving death by suicide or serious self-harm, the reality is that there tends to be few significant or far reaching recommendations which impact at a programme or organisational level.

One trust further identified a potential level of danger in making even minor changes to organisational practice on the basis of findings in every SAI case. It was suggested that such incidents may benefit from thematic review rather than individual SAI investigations, as recommendations arising from thematic reviews would ensure a stronger evidence base for changing practice. However, it is acknowledged that this form of review would not meet the needs of the families and their search for answers. Any such change would therefore need to be given further consideration.

In relation to more complex SAIs there is often more opportunity to identify learning and such cases would benefit from more intensive investigation. In such cases, which could be termed as 'organisationally complex', the existing SAI process may be considered to be entirely appropriate.

Overall it was felt that the system could be significantly improved by supporting a more collaborative approach that focuses on quality improvement programmes rather than investigation. There is probably little 'new' learning to be extracted from some mental health related incidents; however adopting a strengths based approach that seeks to support quality improvement initiatives could fundamentally reframe the current approach toward the learning culture that will better support safer services.

Trusts reflected that the use of RCA and the language regarding 'investigation' creates and subtext of blame and fault finding. It was felt that any movement away from this would improve the development of a learning culture.

It was suggested that a regional pool of external chairs, who have expertise in investigatory methodologies, is established.

4. Learning from adverse events through reporting and review: A national framework for Scotland

4.1 A National Approach to Learning

As part of the fieldwork for this project, several representatives from the Project Board visited Health Improvement Scotland (HIS), to examine the systems it has in place for the reporting of adverse incidents and how learning is achieved, specifically in relation to suicide events.

This aim of health and social care services in Scotland is to provide high quality care that is safe, effective and person-centred[12]. The national framework document is intended to support health and care providers to effectively manage adverse events and drive improvements in care across Scotland. When an adverse event occurs, this is regarded as an opportunity to learn and to improve, in order to increase the safety of the care system for everyone. Therefore the aims of the national approach to learning from adverse events are to:

- Learn locally and nationally to make service improvements that enhance the safety of the care system for everyone.
- Support adverse event management in a timely and effective manner.
- Provide a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland.
- Present an approach that allows reflective review of events which can be adapted to different settings.
- Provide national resources to develop the skills, culture and systems required to effectively learn from adverse events to improve services across Scotland.

The national approach seeks to ensure that no matter where an adverse event occurs:

- the affected person receives the same high quality response;
- any staff involved are treated in a consistent manner;
- the event is reviewed in a similar way; and
- learning is shared and implemented across the organisation and more widely to improve the quality of services.

The scope includes all events that could have caused, or did result in, harm to people or groups of people. This includes harm to patients and service users, as well as harm to staff.

The NHS Scotland Knowledge Network provides comprehensive access to a wealth of resources on all aspects of health and social care. The portals available have been specifically tailored to inform practice and personal professional development. They contain a selection of information and tools in a single subject area.

12 http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx

In addition there is access to a number of communities where staff can work collaboratively with others, share resources and discuss topics of common interest. One of these relates specifically to suicide.

4.2 The Suicide Reporting and Learning System

In Scotland it is recognised that sadly, some people in contact with mental health services do complete suicide. The numbers are small, but the effects are devastating for relatives, friends and the staff involved. When a suicide takes place, NHS boards need to understand what happened and learn from any lessons identified. The lessons learned are important to improve services and help staff recognise where risk exists.

Suicide reviews are the way that NHS boards and their mental health services analyse what happened and identify areas where improvements may be made, to make things safer for other people at risk.

All NHS boards are required to report to HIS any suspected suicide of a person who has been in touch with mental health services 12 months prior to the death. Each NHS board has a key contact that is responsible for submitting notifications and completed review reports to the Suicide Reporting and Learning System (SRLS).

The SRLS aims to assist NHS boards to improve the way that suicide reviews are carried out and to help to reduce risk. It aims to do this by:

- improving the effectiveness of suicide reviews;
- sharing lessons learned nationally from suicide reviews;
- promoting the sharing of experiences and peer support among mental health services;
- analysing and providing commentary on the suicide reports received; and
- ensuring that the Mental Welfare Commission (MWC) has been notified of relevant cases where further investigation may be required.

If a suicide review is required, this will be carried out by the relevant NHS board.

4.3 Suicide Reviews

The purpose of a suicide review is to help all mental health staff, both clinical and managerial, improve the service for others by:

- recognising where risk can be reduced;
- identifying where clinical practice and service improvements can be made; and
- sharing good practice found during reviews.

The suicide review team will produce a report with their findings and any recommendations for action by doing the following:

- operating in an open and transparent way;
- speaking to all the relevant people who had been in contact with the person in the period of time being examined;

- engaging with family and carers to make sure they are included in an objective assessment of the circumstances of the death;
- gathering and scrutinising the relevant information about the care, treatment and contacts the person had with mental health services;
- assessing the use of interventions made;
- recognising if there have been significant unmet needs as a result of insufficient resources;
- recognising good practice that should be shared with other parts of the mental health service, other services and NHS boards;
- identifying lessons that will help improve services and reduce risk for other people;
- referring any concerns about individual clinical performance to managers to be dealt with through clinical supervisory arrangements or, in very rare circumstances, disciplinary proceedings; and
- making clear recommendations for action to be taken forward by managers and clinical governance leads within the NHS board.

4.4 Action Planning and Service Improvement

Regardless of the effort made to carry out an effective review and identify areas for improvement, nothing is gained from the exercise if the lessons learned are not effectively converted into improvements that will help provide a better and safer service.

While there may be different approaches within mental health services throughout Scotland, they all share the same principles in relation to ensuring effective learning. However, the biggest barrier to effective change is often at the point of converting learning into improvement. Once learning has been identified, those lessons must be converted into real, sustainable change that will improve the service.

A learning summary is a useful tool to monitor the actions from a suicide review and evaluate the service improvements that have been made. It can also be helpful to share learning summaries with families and carers to show how the review process has made a real difference.

An improvement plan sets out how each recommendation from the review will be monitored, measured and shared. The plan must include responsible owners, timescales for delivery and review dates. The format of improvement plans will vary but they should be set out in a clear and accessible manner, as follows:

- There should be a clear improvement plan which sets out how each action will be monitored, implemented and measured.
- The improvement plan should be agreed by all relevant members of staff.
- The improvement plan should identify responsible owners, timescales for delivery and review dates.
- Where a recommendation, and subsequent action, is directly related to a concern raised by family members or carers this must be made clear.
- The outcome of the improvement plan should be shared with all those involved in the suicide review and the person's care, including family members and carers where appropriate.

- All suicide review improvement plans should be locally owned and monitored through defined governance processes. Timescales for completion of actions should be regularly reviewed and rationales for exceptions documented.
- The local policy should outline which group or committee is responsible for monitoring and embedding the improvement plan, to ensure that learning has been shared and implemented.
- Thematic learning should be collated to inform wider service and organisational improvement plans.

In addition to this, it is recognised that effective communication with those people who have been involved in the person's care and the suicide review, not only spreads learning; it also helps to promote a positive attitude to reviews and consequently to a safer service.

4.5 Mechanisms for Sharing Learning

Lessons learned may be about factors directly related to the completed suicide being reviewed or they may be about wider clinical and service issues, not directly related to the suicide or they may be about sharing any good practice identified in the review.

Completed suicide review reports are progressed through agreed local clinical governance and management arrangements, and submitted to HIS. HIS's Clinical Advisor reviews the submitted reports and identifies national learning points, which are then shared through the Suicide Review Community of Practice website.

The Clinical Advisor may identify issues with the NHS board's arrangements for carrying out a suicide review and this is brought to the attention of NHS boards. This HIS scrutiny process will identify areas for improvement with the suicide review process and/or recommendations; these will be detailed in an email to the identified NHS board contact for action. Acknowledgement of receipt is requested within 1 week. Learning points are then agreed with the NHS board and are shared via the Suicide Review Community of Practice website.

If the NHS board is not in agreement with the issues raised through this feedback process, the case will be reviewed by an HIS Mental Health Advisor. If agreement is not reached, the issues will be escalated to the Suicide Reporting System Management Group for resolution. After a period of 3 months, HIS will follow this up with the NHS board to determine improvement and gather learning. Learning points are then shared via the Suicide Review Community of Practice website.

Ultimately, HIS liaises with the reporting NHS board to support the implementation of recommendations and actions that come out of the suicide review.

If the Clinical Advisor identifies issues with an individual service user's care or welfare, an MWC notification process is followed. If it is not clear from the report, the Clinical Advisor will contact the relevant NHS board to establish if it has:

- notified the MWC of the case;
- informed the family and carers that the MWC has been notified and why; and
- passed on the family and carers' contact details to the MWC.

The MWC will review the clinical issues and inform HIS of any further action taken. In order to facilitate learning and knowledge sharing, HIS will share this information through the SRLS.

4.6 The Suicide Review Team Network

The Suicide Review Team Network was set up with a view to building a 'community of practice' in order to share knowledge across organisational boundaries and facilitate and enable sharing of experiences, lessons, challenges and solutions. The network aims to do this by:

- providing support, advice and guidance for suicide review teams;
- finding common principles to support an effective system; and
- providing a forum for the exchange of ideas and best practice.

The network meets twice a year and is attended by:

- NHS board Suicide Review Co-ordinators and other staff involved in the review of suicides locally;
- The HIS Suicide Reporting and Learning System Project Team; and
- Representatives from the MWC, Procurator Fiscal Office, NHS Health Choose Life team, Scottish Prison Service and Police Scotland.

Members of the network can view previous minutes and associated papers by logging onto the Network's secure information pages.

4.7 Improvement Programmes

The Suicide Review Team Network is currently working with the Scottish Patient Safety Programme (Mental Health) and 3 NHS boards to facilitate improvement programmes to improve both adverse event reviews and the resulting mental health service improvement. This is designed to support NHS boards to translate learning from adverse event reviews into service improvement, focusing on the key clinical areas detailed in the Suicide Prevention Strategy commitment.

It is planned to test this improvement approach to ascertain if it will support NHS boards to make mental health services safer for people at risk of suicide. Each participating NHS board has provided an SBAR (Situation, Background, Assessment, Recommendation) outlining their improvement programme. The network plans to provide updates on progress as these programmes continue to develop.

5. Wales: The National Reporting and Learning System (NRLS)

5.1 Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011 (Version 3: November 2013)

The Project Board reviewed the current system for incident reporting in Wales. Putting Things Right was established to review the existing processes for the raising, investigation of and learning from concerns[13]. The aim is to provide a single, more integrated and supportive process for people to raise concerns which:

- is easier for people to access;
- people can trust to deliver a fair outcome;
- recognises a person's individual needs (language, support, etc.);
- is fair in the way it treats people and staff;
- makes the best use of time and resources; and
- pitches investigations at the right level of detail for the issue being looked at; and
- can show that lessons have been learned.

The benefits of the approach adopted in these arrangements include:

- learning from concerns leads to better quality and standard of care;
- reduced incidence of similar issues arising again;
- improved patient safety;
- better experience for people wishing to raise a concern;
- reduced number of concerns that are escalated;
- better focus of specialist advice;
- potential reduction in the cost of legal fees; and
- increased public confidence in the services provided by the NHS.

Section 9 of the guidance is aimed specifically at the reporting arrangements for concerns which are patient safety serious incidents (referred to as serious incidents). A serious incident[14] is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following;

- unexpected or avoidable death or severe harm of 1 or more patients, staff or members of the public;
- a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population; allegations, or incidents, of physical abuse and sexual assault or abuse; and/or

[13] http://www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

[14] National Framework for Reporting and Learning from Serious Incidents Requiring Investigation NPSA 2010

- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Examples of serious incidents that must be reported to the Welsh Government include:

- Suspected suicide/unexpected death of mental health patient (including community and in-patient services); and
- Self-Harm incidents categorised as 'severe' under the *Grading Framework for dealing with Concerns*[15]**.**

Within 1 working day of receipt of a serious incident form, the Welsh Government will issue an email acknowledgement which includes an initial incident grading together with a timescale to submit a completed investigation.

All serious incidents are subject to an RCA investigation. Once this is completed and approved by the relevant organisational committee, an incident closure summary is completed. This must include findings, recommendations and learning identified for the organisation. In exceptional circumstances a copy of the investigation report may be requested. Closure summaries are expected to be submitted within a timescale of 3 or 6 months as specified. Particular attention should be afforded to ensuring 'never events' are investigated in a timely manner.

The outcome of any investigation must be used to maximise opportunities for learning, quality improvement and improving patient safety. This should be a key element in any overall attempts to reduce adverse events and avoidable harm to patients/service users. As well as local learning, organisations are expected to contribute to the wider opportunities for shared learning. This should be identified when completing the incident closure form.

Issues and learning arising from incidents will be considered at the National Quality and Safety Forum; in order to determine any action required, particularly at a national level. Regular reports will also be compiled for the Director General/Chief Executive NHS Wales and the executive team, to help inform policy development and priorities.

5.2 Homicide Reviews

Health Improvement Wales (HIW) is also commissioned to undertake independent external reviews, when an adult known to mental health services in the previous 12 months, commits the homicide of another adult. This is to ensure that any lessons that might be learned are identified and acted upon. The terms of reference for such reviews are to:

- Consider the care provided to the perpetrator as far back as his/her first contact with health and social care services.
- Provide an understanding and background to the fatal incident that occurred.
- Review the decisions made in relation to the care of the perpetrator.
- Identify any change or changes in the perpetrator's behaviour and presentation.

[15] http://www.wales.nhs.uk/sitesplus/documents/862/514-Gradingframeworkfordealingwithallconcerns.pdf

- Evaluate the adequacy of any related risk assessments and actions taken leading up to the incident.
- Produce a report detailing relevant findings and setting out recommendations for improvement.
- Work with key stakeholders to develop an action plan(s) to ensure lessons are learned from the case.

5.3 Patient Safety Solutions

The Welsh Government now leads the vital role of identifying any significant safety risks and concerns and developing Patient Safety Solutions (Solutions) at a national level for issue to the NHS in Wales[16]. These Solutions are informed by a number of patient safety information sources, networks and organisations working in partnership to identify and address potential patient safety risk. NHS Wales Solutions are to be developed and issued in two formats:

ALERT: This requires prompt action with a specified implementation date to address high risks/significant safety problems.

NOTICE: This is issued to ensure that organisations and all relevant healthcare staff are made aware of potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas, and take immediate action. This stage 'warns' organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action. Notices may be re-issued as an Alert, if increased risk or further action is identified/required.

NHS organisations are now required to comply with specific Solutions or actions to mitigate the risk in line with the Patient Safety Solution by the specified deadline.

Solutions are issued by Welsh Government through the Public Health Alerts System. NHS organisations must ensure they are 'solution ready' and that they have systems in place to receive and manage alerts from the Welsh Government. Organisations must ensure that areas of non-compliance are being monitored and reported at board level including mitigation to manage the risk. The board must ensure that they have a robust system in place to assure themselves that progress is being achieved against compliance with Solutions. Risk registers should be integral to capturing areas of concern relating to the management of Solutions, so that decision-making at Board level is based on a balanced and well informed assessment of risk from the relevant service areas.

Organisations are required to confirm that they have achieved compliance by the date stated on the Solution. Each NHS organisation must identify 1 designated lead that will be providing Solutions compliance status for their organisation. They act as the point of contact and will receive a compliance status request for each Solution from the Delivery Unit prior to the return date stated on the Solution.

[16] http://www.patientsafety.wales.nhs.uk/safety-solutions

The designated lead will be required to state the compliance position of the NHS organisation as compliant, non-compliant or not applicable. Compliance will be monitored through the Welsh Government Quality and Safety systems.

6. Staff Engagement

As part of this project, the Project Board felt it was important to capture the views of frontline staff who have been involved in the SAI investigation process and to engage with them directly, in order to discuss the current processes and also the processes in place for the dissemination of learning. A series of semi-structured interviews were held with staff across each of the trusts and included a session with staff from Prison Healthcare.

Focus groups were well attended and included representation from medical staff, both senior and junior, team leaders, nursing staff, social workers and investigating officers or case review officers. Some staff had been directly involved in SAI investigations, whilst others' experience came from the investigating officer role. Some staff had never been involved in an SAI but they were able to share their views on their understanding of the process and the dissemination of learning. The views of staff across all trusts are presented collectively in the following section.

6.1 Reporting SAIs related to Suicide, Homicide and Serious self-harm

On the whole, staff who attended the focus groups were aware of the requirements of the SAI reporting procedure. Issues were raised in relation to the reporting criteria for SAIs, with a number of staff highlighting a feeling of dissatisfaction that all suicides are automatically reported as an SAI. There were also concerns around reporting cases of suspected suicide where the cause of death is not clear at the time of reporting. Staff mentioned that starting an investigation before the cause of death is confirmed can cause unnecessary stress for staff. Some staff felt that perhaps a decision should not be made until the inquest confirms suicide and others did indicate that they have delayed or deferred reporting in some cases, while additional information is sought. The majority of staff had issues with the investigation timescales. It was felt that a more timely review of incidents could be achieved by local review.

It was evident that the perception of the culture around SAIs is varied. Some staff felt that the culture was much more focused on learning rather than blame, whereas others felt it was still very much focused on blame. Some staff felt that the mandatory reporting of all suicides as an SAI contributes towards a feeling of blame. There were mixed views when asked if there was any fear attached to this process and a number of staff indicated a feeling of apprehension and anxiety, not with regard to the actual reporting of the SAI but in relation to the subsequent investigation.

The management of SAIs in a prison setting is very different to that of trusts and when the new guidance was issued in 2013, there were concerns raised about the application of this to the prison setting. Staff described a number of difficulties around the reporting criteria which were described as very subjective. It was also noted that the reporting criteria relate specifically to incidents occurring in a healthcare setting; however staff felt that the prison is not a healthcare setting and therefore this criterion should not be applicable to prison healthcare. Staff felt they need to be able to apply a level of judgement on what is reported, but the current criteria do not support them to do this.

Despite the difficulties, governance staff felt that prison healthcare does promote reporting in a positive way, emphasising the potential for learning, however this has resulted in increased reporting which in turn has led to a backlog in dealing with these; they are not being completed within required timeframes.

6.2 The Investigation Process

The current investigation process for these SAIs follows a model where investigations are conducted by an investigation panel. Panels are drawn from staff as appropriate, but usually would include a chair, a nurse, a social worker and an independent psychiatrist. Staff directly involved in the SAI are asked to provide reports/statements to the panel and GPs are also usually asked to provide a report from the primary care perspective. The panel will then complete their investigation and produce a final report. There were mixed opinions regarding the staff involvement in this process. Some staff felt that it was appropriate whilst others felt there should be more direct involvement of the care team. It was felt that the current process does not support reflective practice.

All staff spoken to felt that all incidents have potential for learning. Staff feel that when an incident occurs, it is important for them to review what has happened and identify if they could have done things differently; however this needs to be in a balanced way. It was felt that whilst all suicides are investigated as an SAI under the current process, not all investigations actually generate real, high quality learning. It was reported that the angst around the investigation process can reduce the opportunity for learning.

Staff felt that the SAI process is driven by the requirement to identify recommendations/ improvement, and that the process is often scrutinising practice that is not actually relevant to the outcome. It was noted that there is often good practice identified which would be beneficial to share, but that this is often overlooked.

Some staff felt that suicides should be taken out of the SAI process, and that reviews of suicide could potentially be more profitably undertaken by the local team involved in the care. It was however noted that there would need to be a mechanism in place for escalation of concerns identified if this was the case.

In relation to terminology, some staff felt that ‘serious adverse incident’ and ‘investigation’ are not appropriate terminologies to use for the review of events around a suicide. Staff felt that whilst this terminology does describe what is happening, its use infers that someone has done something wrong, fostering a view that there is blame attached to the SAI.

It was highlighted that there can be difficulties in relation to the 12 week timeframe for completion of the investigation, and some staff also highlighted difficulties in the 5 week timeframe for the completion of an SEA investigation. Delays can be exacerbated by DRO queries which can often be quite complex and can tend to be outside the scope of the incident/review. The requirement to address the DRO queries can lead to multiple drafts of the final report, and this can be very frustrating for staff trying to work within the 12 week timeframe. In addition to this, DRO queries can often come late on in the process, after the investigation and report has been completed.

In the prison setting SAIs are subject to a heightened level of scrutiny from a number of organisations including:

- Prisoner Ombudsman;
- Independent Monitoring Board;
- RQIA; and
- Criminal Justice Inspectorate.

The ombudsman investigation is a very detailed clinical/forensic investigation, using external expertise carried out by a fully resourced and dedicated investigation team which has access to a wider range of information. Staff perceived it as a risk to run multiple investigative processes in tandem with each other, and also identified that this increases demands on staff to produce witness statements, etc.

6.3 Support for Staff

Staff reported that, as a practitioner, the suicide of someone in your care is devastating and such an event causes upset and anxiety for staff members involved in their care. Support for staff is essential, particularly as clinicians and other staff can perceive that they are under attack from the investigation process.

It was felt that, in the main, trusts have progressed in ensuring that investigations are seen in a culture of learning rather than attributing blame; however it was felt that this is not always the attitude of other external bodies. An investigation may not uncover any deficiencies in practice or care, but regardless it is still difficult for staff and they felt that this impact on the professionals involved is often overlooked. Some staff described feeling 'persecuted' by the system and questioned why such events are automatically classified as an SAI. Staff reported that the investigation process can create a sense of fear, vulnerability and is a stressful experience often associated with loss of sleep and emotional reactions. Staff emphasised the importance of ensuring that the focus is on the SAI and not the practitioner; at present staff can feel that they are the ones under investigation rather than the incident itself.

Staff described a need to take a positive risk-taking approach to care and that this needs to be done in a balanced way. However, when an SAI then occurs this can lead to a fear of blame; it can erode their confidence and they can become more risk-averse. Staff also described a heightening in this anxiety due to the awareness that despite being an internal report, it may well be shared with the coroner's court, and indeed they may also be called to give evidence in person.

Those who are managing investigations emphasised the importance of ensuring that staff feel supported and felt that it would be much better if the investigation could be undertaken with a positive approach to primarily determine what went well. It was suggested that one way to do this would be to change the terminology to 'learning review' rather than investigation.

6.4 Family Involvement

While all staff expressed that learning can be gained from family involvement in SAI investigations, they did describe mixed experiences of this in practice.

Some families do not want to be involved at all, while others are grateful for the opportunity to participate. Experiences for families will vary, and their experience of the process is often affected by how they have viewed the service, treatment and care of their relative.

On occasions, staff felt that the purpose of the SAI process is not always fully understood by families. It needs to be clear that it is a process to facilitate learning, and not about fault-finding. It is about understanding what has happened and how to learn from this, including the identification and sharing of good practice. Staff felt it would be helpful if the terminology could be changed to 'learning review' as current terminology can foster the view that there is blame attached to the incident, which subsequently leads to raised anxiety for both the family and staff.

All staff mentioned the timing requirements of an SAI investigation and the difficulties this can pose when engaging with families. It was noted that family engagement is expected to take place during the bereavement process and this can be difficult for all involved. Staff felt that very often the family can contribute towards the development of a much deeper understanding of the incident; however it was felt that the timescales involved to approach families can diminish this opportunity for learning, as they may not yet be ready to engage when approached.

Staff described other difficulties in engaging with families, particularly when prior relationships with the service user were poor and for investigations within Prison Healthcare, difficulties with family engagement can be further exacerbated. Staff reported that it can be difficult to identify who should be involved and if there are multiple family members this can prove difficult for staff to manage, especially if there is conflict between these members. On some occasions there may be little to gain from family involvement, for example where the family has had a very limited relationship with the service user.

In general, staff felt there could be a better way to review these SAIs which might include the ability to address the emotional needs of staff and families. One possible approach suggested was for the trust to conduct a timely internal review of the incident, initially without involvement of families. Leaning arising from family engagement could then come later. This would recognise that some families may need longer to grieve and to come to terms with the situation. Staff felt that the families themselves should be the ones to guide timescales for their own involvement.

6.5 Sharing the Learning

As already noted, all staff spoken to felt that all incidents have the potential for learning; however it was felt that under the current process not all investigations actually generate real, high quality learning. Staff felt that this was the primary problem, rather than how the learning is shared.

Most of the staff felt that investigations or 'learning reviews' should be based on a model of reflective practice, focusing on the identification and sharing of good practice. Any reflective process needs to look at the multiple factors that may have contributed to a person taking their own life; it is not just the care provided by the HSC that is a factor in this.

All staff are keen to learn and to promote this whatever way they can and several trusts are piloting a 'reflection template'; this is a PHA/Safety Forum/Mental Health Collaborative initiative.

Within trusts, there are processes in place within individual teams and opportunities to share learning; however the difficultly is achieving real, tangible learning. Staff do have time to discuss learning, via governance meeting and in their teams, however they again stressed that it needs to be valuable learning and include a focus on good practice.

Where learning is identified and shared across trusts, some staff mentioned that they only receive the recommendations from each report, but that they felt it would be more useful to receive the full report and the background to the event. Staff indicated that better feedback helps teams to understand the context/origins of the recommendations and can help when they need to implement associated actions.

One possible approach discussed for an improved model is that suicides are reviewed in the mortality and morbidity (M&M) process. Staff who voiced this opinion felt that the M&M process or a similar reflective process would provide real opportunity for the identification of learning. Staff felt that another potential way to achieve higher quality learning is through thematic review. It was felt that this can be more effective in identifying trends (and therefore learning) rather than solely looking at incidents on an individual case by case basis.

Similar to trusts, prison healthcare noted that sometimes the same recommendations come up time and time again; these can be focused on issues that often have no real bearing on the incident. It was also interesting to note that SAIs in prison rarely generate learning that is applicable outside of the prison setting.

6.6 Outcomes and Follow up

In the main, staff across all trusts indicated that, when SAI reports are shared, they do review the outcomes and think about their own practice.

Staff directly involved in the investigation will have sight of the final report for factual accuracy checking. Almost all staff who had been involved in an SAI investigation had received the final report, although some described a time lag between being involved in the investigation and receiving the final report.

Staff felt that within their teams, they do have time available to reflect on learning and to discuss the required actions. It is usually a standing item on the agenda for team meetings.

6.7 General Observations

Everyone, including the individual service user, has roles and responsibilities in their care. It is extremely difficult to identify any single contributing factor when a suicide occurs. It was felt that within a clinical setting, the cause of an unexpected death can be much easier to determine.

Staff noted that there could be the potential for outcomes to be different if there were infinite resources and joined up services across Northern Ireland. At present there is not and it was felt that it needs to be recognised that staff are working within the context of what is available.

Trusts often deliver similar services in different ways and within different structures, yet it was felt that the SAI process seems to assume these are standardised. This can make the sharing of learning difficult to apply in other trusts and even within different departments within the individual trusts. This particularly comes to the fore in cross trust investigations.

It was interesting to note that some of the recommendations from SAI investigations can require additional resources to implement, but that this is not always forthcoming, making action difficult.

It was interesting to note that prison healthcare faces unique challenges and that there is a need to be pragmatic about how any revised process is applied in prisons. In relation to 'deaths in custody' the trust currently reviews the health care provision only.

It is the statutory duty of the Prisoner Ombudsman to investigate such events, conducting a detailed forensic investigation using external expertise carried out by a fully resourced and dedicated investigation team. This comprehensive investigation usually involves interviews with Northern Ireland Office prison staff, other relevant prisoners, transcripts of telephone calls, access to CCTV and access to all NIPS information systems. It usually also encompasses interviewing health care staff and the final report can make recommendations relating to health care provision.

Within this context, it becomes apparent that the internal trust review is limited and often bereft of the full details of the prisoner's life within prison, his/her activities and relationships both within and outside of prison.

6.8 Views of the Designated Reporting Officers (DROs)

In addition to the staff engagement within trusts, the Project Manager met with the DROs, based within the HSC Board, with responsibility for SAIs arising within Mental Health Services. At the outset the DROs expressed disappointment that the scope of the project did not extend to examining learning from the wider numbers of suicide, not just those which were in touch with mental health services.

The DROs are now focusing more on the investigation process, challenging the trusts and asking why the same issues are identified repeatedly; the aim of this is to improve learning and consequently frontline practice. There is an identified need to involve families more in practice and to build better relationships during care and treatment; this in turn will foster better, more open, relationships in the event of an SAI occurring. In view of this there is work ongoing on the mental health documentation, including the addition of fields to record continuous contact with families; this is to ensure family involvement is appropriate.

DROs are keen to ensure that the SAI process does not undermine the other good work that is going on in trusts; they recognise that there is currently a fatigue with the SAI process. The increasing numbers of SAIs reported has led to a reduction in the quality of investigation, which has become a task and finish piece of work with the opportunities for reflection being overlooked. Currently, SAI investigations focus on the end result when, in fact, it can sometimes be an accumulation of factors/events that have led up to an incident and often learning is not apparent in individual events but does improve when you examine an accumulation of trends/events i.e. thematic review. The current process has created an industry that, in turn, is creating risk.

In order to reverse this, there is a need to be more discerning in what is reviewed and how it is reviewed. There is a general consensus that trusts should only conduct an in depth review when the incident really warrants this. One suggestion was that the reporting criteria should be linked back to the original definition which was ‘patients who have a diagnosis under the mental health order’, as this would exclude a number of existing SAIs.

7. Service User Engagement

When an SAI occurs it is investigated by healthcare staff; however service users/relatives/carers should also be given the opportunity to be involved in the investigation process. As part of this project, the Project Board felt it was important to capture the views of service users particularly in relation to their involvement and the subsequent identification of learning. After an initial approach made via voluntary agencies it became apparent that there were difficulties in speaking directly to families due to a number of issues e.g. confidentiality, risk of re-traumatising families and intrusion during their grieving period. It became clear that the best way to secure their views was via a series of meetings with organisations who could represent the views of service users/ families involved in investigations arising from suicide.

We met with a small number of voluntary agencies across Northern Ireland, and their views are presented collectively below.

At the outset, a number of the agencies felt it is important to note that a considerable number of people who self-harm or who complete suicide are not in contact with mental health services as they may not have had a mental health diagnosis and that these incidents are not included in the scope of this project.

In relation to family participation in the SAI investigation, the initial approach and offer to become involved can be poorly timed. It is normally made quite soon after the event, at a time when the family is still in the early stages of grief. Making an approach at this time can be counterproductive as families are not in a position to make clearly informed decisions about being involved in the investigation process. In view of this, there needs to be flexibility in the process, to ensure that it is accessible to everyone in a timeframe that suits their own individual needs.

Those who have become involved reported mixed experiences, ranging across the spectrum of positive to negative. It was reported that some families felt that the process was very helpful, in allowing them an opportunity to understand the history of the treatment and care provided and the response/actions of the patient. On the other hand, some experiences had been described as difficult, challenging, unhelpful and belittling. It is often difficult for families to accept all of the information being given; it should also be noted that it can often be very distressing for families.

In the past, family representatives were asked to attend an SAI review meeting but more recently, families are being asked to provide written statements to the investigation panel. When asked to provide a statement, it is difficult for families to think of every detail that they would like to be considered as part of the investigation; this is often in their opinion due to the timing of the approach and the lack of guidance to support them. This format also removes the opportunity for two-way engagement, additional questioning and clarification. It was noted that some families would prefer to discuss the incident with the staff directly involved in treatment and care rather than submitting a statement to a panel of strangers.

It was recognised that investigations can take a long time to complete and in such cases trusts must recognise the importance of keeping families informed about any delays. One organisation said that the process is so difficult and protracted that families often 'give up,' disengaging before receiving the final report.

Organisations were asked if they or the families who they work with have any thoughts around the terminology used, particularly the use of 'serious adverse incident' and 'investigation'. While the majority of organisations felt that this terminology can have a negative connotation, some felt that it is important to describe exactly what it the process entails. Organisations emphasised the importance of using language and terminology tailored to the needs of the individual situation and ensuring that families clearly understand the purpose of the investigation.

When an investigation/review completes, families are provided with a copy of the final report, if they request this. It was noted that the language used in reports can be very technical and that it can be difficult for families to understand. In addition, the content of the report can include new information, that families were previously unaware of, and this can often be quite distressing. It was reported that the recommendations made, often did not seem to reflect the severity of the incident itself.

The main criticism of the entire process is the follow up; families do not see the 'loop being closed'. It was reported that families are often unclear of the contribution they have made and while they see the recommendations they are not kept appraised of the follow through actions. Some families would be very keen to see if recommendations are implemented.

In summary the key issues raised focused on:

- The importance of including family in the review of incidents.
- The need for flexibility in the process to ensure that it is accessible to everyone in a time that suits their own individual needs.
- Families should be given a choice of options by which they can engage in the investigation process and they should be provided with adequate support and guidance to allow them to get the best from their contribution.
- When investigations are delayed, the family should be kept informed of the delay and the anticipated timescales for completion.
- Final reports should be less technical and more user friendly.
- Trusts should offer a further meeting with the family, to review and explain the content of the report when necessary.
- There should be a mechanism for families who request follow up/updates to be provided with updates on the implementation of recommendations.

It was interesting that one organisation expressed an interest in 'Psychological Autopsy'. The principles of this would see a wider net cast in terms of investigation i.e. it would not be confirmed to staff and families, it would allow for other significant figures to become involved e.g. teachers, voluntary agencies, work colleagues, etc. There could be potential uses for this in the investigation and learning for all suicides; this process could be conducted by an independent panel and could include review of all suicides not only those that are in contact with mental health services.

8. GAIN Exploratory Audit

As part of this project an exploratory audit involving 10 SAI reports was undertaken. The criterion for selection of the 10 reports was an outcome of death by suicide within the 2014/15 calendar year.

To assist in the recording of information, 2 data collection proformas were developed based on the Level 1 and Level 2 report templates found within Procedure for the Reporting and Follow up of Serious Adverse Incidents HSC Board 2013 guidance (revised October 2015) [17]. Three key areas were identified for review:

- administrative quality (focusing on the completion & information within the SAI report template);
- clinical review (focusing on clinical diagnosis, appropriate treatment); and
- learning identified.

In total, 5 Level 1 and 5 Level 2 reports were selected for review. It should be noted that there was no SAI Level 2 report available from the Belfast Trust in the timeframe selected; as an alternative a Level 2 from 2013/14 was reviewed.

Overall, in relation to administrative quality, the Level 1 and 2 report templates were not utilised by all trusts. While each report was designated with a unique ID, personal identifiable information was also often included in the final report. It was also noted that the chronological information provided within the report was often too in-depth and duplicated.

The information within the reports did not include a rationale explaining why a Level 1 or 2 investigation was deemed as the appropriate level for the investigation, and the reports often lacked sufficient detail to establish if appropriate staff were involved or to ascertain independence of the Chairperson.

In relation to the clinical review, this assessment was carried out by an Independent Psychiatrist. On 3 occasions it was observed that the decision-making process in Level 1 reports could be challenged, given the case history provided.

When opportunities for learning were considered, it was observed that often reports reflected on the appropriateness of procedures carried out prior to the event/incident rather than using the review of the incident as an opportunity to identify or reflect on possible local or regional learning.

Finally, it was noted that, when present, recommendations within reports often lacked the minimum standards for action plans outlined in Appendix 8 of the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

[17] http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-followup-of-Serious-Adverse-Incidents.pdf

This states that action plans must define:

- who has agreed the action plan;
- who will monitor the implementation of the action plan;
- how often the action plan will be reviewed; and
- who will sign off the action plan when all actions have been completed.

In the main, the findings of the audit support the key issues uncovered by the fieldwork, in particular with regard to the issues around timing, application of thresholds and the lack of tangible learning emerging. It was noted that the outcomes of reviews often result in vague recommendations and/or learning being identified for the sake of learning.

9. Conclusions and Recommendations

This project assessed the effectiveness of existing tools and processes used to identify learning from individual SAIs involving suicide, homicide and serious self-harm[18], including the degree of patient/family involvement. It included the examination of practice elsewhere in the UK in relation to the assessment of SAIs involving suicide, homicide and serious self-harm. The overall aim was to develop a revised methodology for the investigation of deaths involving suicide, homicide and, where appropriate, cases of serious self-harm.

Having completed a literature review of the systems in place in both Scotland and Wales, it was agreed that representatives of the Project Board would visit HIS to look at the systems in place for the investigation and learning from SAIs. While the Scottish model was interesting the team were keen to note that much of the work in relation to incident reporting and investigation is comparable to that in Northern Ireland. HIS did emphasise that the focus of their system was on learning not blame; a culture which they worked very hard to cultivate. It was noted that investigations also pay particular attention to contributory factors in each case. The mechanisms for online sharing of learning were of particular interest to the representatives of the Project Board, however it was noted that the model in Scotland has not yet been evaluated for effectiveness and that HIS cannot be assured that this is being accessed by staff on the frontline.

Locally, this project found a number of key issues uncovered by the fieldwork, which have been documented throughout this report; in particular the issues related to the timing of SAI investigations, application of thresholds for investigation and subsequent reporting, and the lack of tangible learning.

It emerged that, particularly for incidents arising from suicide, the outcomes of reviews often result in vague recommendations and/or some learning being identified simply to demonstrate the process had an outcome.

It was noted that trusts have been moving the focus of SAI investigations towards the differences that could be made in clinical care and treatment of an individual and there have been moves to pitch investigations at a more appropriate level. However, despite this, there are still differences in expectations for incident investigation and the consistency can vary across trusts.

Overall, this project concluded that incidents arising from suicide, homicide and serious self-harm must be considered individually.

Homicide:

Although these are relatively small in number they are significant events for all those involved, including families. The subsequent investigation will include a number of agencies external to health and social care. In view of this the Project Board concluded that these incidents do benefit from a more intensive investigation and that in such cases, the existing SAI process may be considered to be entirely appropriate.

[18] Defined As: Those self-harm cases which were reported as an SAI by Trusts

The Project Board recommends that:

Recommendation 1: The reporting arrangements and criteria for incidents involving homicide should remain unchanged and these should continue to be reported via the existing SAI process.

Serious Self-Harm:

In relation to the reporting and investigation of serious self-harm incidents there were a number of recurring themes arising, including confusion as to the definition of serious self-harm and the application of differing thresholds across and within trusts. Statistics provided by the HSC Board showed that in 2013/14 there were only 4 SAIs related to serious self-harm reported and while in 2014/15 this number increased to 17, it was concluded that a level of subjectivity has resulted in under-reporting of serious self-harm incidents as SAIs. In view of this the Project Board recommends that:

Recommendation 2: Incidents of self-harm should be taken out of the SAI reporting system and reviewed at trust level, ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

However, this approach must allow discretion to report an incident as an SAI when the trust deems it necessary to do so.

It was noted that, outside of the SAI reporting process, all inpatient self-harm incidents should continue to be reported to the Mental Health and Learning Disability Team in RQIA.

Suicide:

In relation to suicide it was immediately recognised that the incidents reviewed under the SAI process equate to around 25% of all suicides occurring in Northern Ireland. The Project Board agreed that very valuable learning could be achieved from a review of the other 75% of cases which do not fall under the remit of health and social care, and noted that a lot of work has been undertaken since the publication of the first Protect Life Strategy in October 2006 including the further publication of the Protect Life: A Shared Vision, Northern Ireland Suicide Prevention Strategy (2012-2014)[19].

In recognition of the fact that the health service alone cannot resolve all the associated causal factors and therefore action across government and across all sectors will be necessary to address the issues that impact negatively on mental wellbeing and which increase the risk of suicide in our communities, the Project Board endorses this wider pro-active work to support suicide prevention.

Fieldwork involving those SAIs in relation to suicide identified a significant number of issues with the current reporting and learning system.

[19] http://www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/Protect-Life-A-Shared-Vision-The-Northern-Ireland-Suicide-Prevention-Strategy-2012-March-2014.pdf

These are not listed in detail but did include:

- Use of the term investigation should be reconsidered.
- Timescales for investigation are difficult to comply with.
- Investigation is very labour intensive and process driven.
- RCA is often not the best process to deliver learning.
- Unease for staff and blame culture.
- Timeliness and content of DRO input.
- Learning not being identified.
- Feeling of SAI fatigue.

It was emphasised that progress could be made if there was an agreed approach where all suicide investigations were conducted internally at trust level unless it was apparent that the situation very clearly merited a more detailed review.

Within the HSC, there is a definite requirement to review all suicides ensuring that service users/relatives/carers are given the opportunity to be involved in this process. It was noted that, if responsibility for review of suicide passed completely to the trusts then it would be at their discretion when and how best to involve families in the process. Arrangements for family engagement can therefore be flexible to ensure that it is accessible to everyone in a time that suits their own individual needs.

In view of this the Project Board recommends that:

Recommendation 3: Incidents related to suicide should be taken out of the SAI reporting system. Trusts must continue to review suicides, using an appropriate level of review with discretion to escalate, as an SAI, when the trust deems it necessary to do so; ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

Suicides that occur within an inpatient setting/trust facility must continue to be reported using the SAI reporting and learning system.

It was obvious during this process that there was great variation in the process/methods /people used by trusts to investigate incidents involving suicide. If the onus for further investigation of these incidents passes to trusts, the Project Board considered that further work was required to develop a more standardised regional process for trusts to follow in these cases. Consideration should also be given to renaming the process to avoid the perceived difficulties involved with the term serious adverse incident investigation.

With respect to suicide and self-harm within Prison Healthcare the same principles should apply as to that suggested for mental health services, however the regional approach should give consideration to the unique position within Prison Healthcare which in relation to ‘deaths in custody’ the trust currently reviews the health care provision only.

Recommendation 4: A task and finish group should be established, with oversight provided by the Department of Health, to develop a standardised process for trusts to follow, for review of the suicide of an individual known to mental health services, that occurs outside an inpatient setting/trust facility and has not been escalated as an SAI.

The task and finish group should include the 6 HSC trusts and the commissioner. The group should give consideration to the following, not exclusive, points:

- Regional agreement on the level of review for suicide to be undertaken at local level.
- A quality assurance framework for decision-making in relation to suicides which do require an SAI investigation.
- Ensuring the process allows discretion to report an incident as an SAI when the trust deems it necessary to do so.
- Setting a deadline for the timescale for family engagement which will include timescales for provision of feedback.
- Consideration of a system/centralised forum for oversight and ongoing quality assurance and consistency of local reviews of suicide including a mechanism for sharing learning regionally when necessary to do so.

Finally, the Project Board noted that as the aim of the SAI process is first and foremost to identify learning in order to drive up standards and improve quality within the HSC, the proposals as presented are done so with the aim of achieving a more effective learning environment that supports reflective practice.

Serious Adverse Incident: Reporting Criteria (as at 1 February 2016)

The following criteria determine whether or not an adverse incident constitutes an SAI.

- Serious injury to, or the unexpected/unexplained death of:
    - a service user (including those events which should be reviewed through a significant event audit)
    - a staff member in the course of their work
    - a member of the public whilst visiting a HSC facility;
- Unexpected serious risk to a service user and/or staff member and/or member of the public;
- Unexpected or significant threat to provide service and/or maintain business continuity;
- Serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- Serious self-harm or serious assault *(including homicide and sexual assaults*)
    - on other service users,
    - on staff, or,
    - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- Suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- Serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS AN SAI.

Serious Adverse Incident Investigations

Level 1 Investigation: Significant Event Audit (SEA)

Most SAI notifications will enter the investigation process at this level and an SEA will immediately be undertaken to:

- assess why and what has happened;
- agree follow up actions; and
- identify learning.

If it is determined this level of investigation is sufficient, an SEA report will be completed and sent to the HSC Board within 5 weeks (6 weeks by exception) of the SAI being reported.

If the SEA determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a Level 2 or 3 investigation. In this instance the SEA report will still be forwarded to the HSC Board within 5 weeks (6 weeks by exception) of the SAI being reported with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 investigations.

Level 2 Investigation: Root Cause Analysis (RCA)

When a Level 2 or 3 investigation is instigated immediately following notification of an SAI, the reporting organisation will inform the HSC Board within 5 weeks, of the Terms of Reference and Membership of the Investigation Team. A final report must be submitted to the HSC Board either within 12 weeks from the date the incident was discovered or within 12 weeks from the date of the SEA.

In most circumstances, all timescales for submission of RCA investigation reports must be adhered to. However, it is acknowledged, by exception, there may be occasions where an investigation is particularly complex. In these instances the reporting organisation may request one extension to the normal timescale i.e. 12 weeks from timescale for submission of SEA report. This request must be approved by the Designated Review Officer (DRO) and should be requested when submitting the SEA report.

Level 3 Investigation: Independent Investigation

Level 3 investigations will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice; and
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred. The timescales for reporting will be agreed by the HSC Board/PHA Designated Review Officer (DRO) at the outset.

Membership of the Project Board

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