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Duty of Candour Policy

G109 Governance Policies

September 2024

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1. Introduction
   1. MHA is committed to delivering safe and effective care to all people using our services. When things go wrong the effects of harming a person can have devastating emotional and physical consequence for the person, their families/representatives, and carers. It can also be distressing for the professionals involved.
   2. MHA believes in a culture of honesty and transparency. Therefore, this document not only details our commitment to being open with the people that we serve but also sets out our duty to be aware of and comply with legislative requirements.
2. Scope and Purpose
   1. In complying with the Duty of Candour the primary concern is to ensure that people we support, and their families are told about the incident, receive appropriate apologies, are involved in any investigation, and are provided with support from a named colleague.
   2. A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. In many cases it is the lack of a timely apology that pushes people to take legal action. To fulfil the duty of candour, you must apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened.

Saying sorry is:

* + Always the right thing to do
  + Not an admission of liability
  + Acknowledges that something could have gone better
  + The first step to learning from what happened and preventing it recurring.”

This will enable all MHA to:

* + Maintain positive relationships with people we support and their relatives
  + Reassure individuals that lessons learned will help prevent the incident recurring
  + Maintain a constructive and non-punitive approach to safety incidents
  + Meet its obligations to all stakeholders by being open and honest about safety incidents
  + Meet its contractual and statutory obligations

Legislative requirement for England and Wales

* 1. England - Duty of Candour; Regulation 20, Health and Care Social Care Act 2008, Regulated Activities.
  2. Wales – Duty of Candour; Regulation 13, The Regulation and Inspection of Social care (Wales) Act 2016.

**Note**: England and Wales all have comparable requirements. Colleagues must refer to the actual document texts for specific expectations. Explicit differentials are identified in this document.

1. Definitions of Harm
   1. These definitions are common to all types of service. These definitions of harm are aligned to CQC’s [notification system for reporting deaths](https://www.cqc.org.uk/notifications) [and serious injuries.](https://www.cqc.org.uk/notifications)
   2. The **Duty of Candour** applies to incidents that result in –

| Term | Definition |
| --- | --- |
| **Moderate Harm** | Harm that requires a moderate increase in treatment and a significant but **not a permanent harm**. A moderate increase in treatment means an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area.  *e.g., an individual is given someone else's medication. The medication is stronger than their own and they suffer prolonged drowsiness for a week and need frequent observation of their respiratory rate.* |
| **Severe Harm** | **Permanent** lessening of bodily, sensory, motor, psychological or intellectual functions, including removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to the natural course of the service user’s illness or underlying condition.  *e.g., Colleagues find an individual who has fallen, they are conscious but lying awkwardly, with a twisted leg that is clearly fractured and twisted. Colleagues move the individual to help them get comfy. After this the person is unable to move their limbs, and later investigations identify that they have a spinal fracture and spinal cord damage. The individual is left with long-term paralysis from the waist down.* |
| **Moderate Increase in Treatment** | An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care). |
| **Prolonged Pain** | Pain which an individual has experienced, or is likely to experience, for a continuous period of at least 28 days. |
| **Prolonged Psychological Harm** | Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days. |

1. Duty of Candour: Notifiable Safety Incidents

Care Quality Commission (England)

* + 1. The duty of candour requires registered providers and registered managers (known as ‘registered persons’) to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines ‘[notifiable safety incidents](https://www.cqc.org.uk/node/3712)’ and specifies how registered persons must apply the duty of candour if these incidents occur.
    2. A notifiable safety incident must meet all 3 of the following criteria:
  + It must have been unintended or unexpected.
  + It must have occurred during the provision of a regulated activity.
  + In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

If any of these three criteria are not met, it is not a notifiable safety incident (but remember that the overarching duty of candour, to be open and transparent, always applies)

* + 1. Paragraph 9 of [Regulation 20 d](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation)efines the harms for all regulated services. The definition states that - In the reasonable opinion of a healthcare professional, appears to have resulted in, or requires treatment to prevent
  + The death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
  + The person experiencing a sensory, motor, or intellectual impairment that has lasted, or is likely to last, for a continuous period of at least 28 days
  + Changes to the structure of the person's body
  + The person experiencing prolonged pain or prolonged psychological harm, or
  + A shorter life expectancy for the person using the service.

Care Inspectorate Wales

* + 1. Care Inspectorate Wales do not require separate ‘duty of candour’ notifications; however, notifications must be submitted in accordance with Schedule 3, Regulation 30.
    2. With regard to duty of candour Regulation 13 requires that:

The service provider must act in an open and transparent way with the following:

1. Individuals who are receiving care and support
2. Any representatives of those individuals, and
3. In the case of a child who is provided with accommodation, the placing authority.
   * 1. Guidance relating to Regulation 13 and notifications listed in Schedule 3, Regulation 30 can be located within [The Regulation and Inspection of Social Care (Wales) Act 2016 Statutory Guidance.](https://www.gov.wales/sites/default/files/publications/2024-03/guidance-for-care-home-and-domiciliary-suppliers-2024.pdf)
     2. This guidance should be read in conjunction with:
   * [The Code of Professional Practice for Social Care Wales](https://socialcare.wales/cms-assets/documents/Code-of-Professional-Practice-for-Social-Care-web-version.pdf)
   * [The Social Care Manager Practice Guidance Wales](https://socialcare.wales/cms-assets/documents/The-social-care-manager-April-2017.pdf)
4. Never Events or Near Misses
   1. In addition to levels of harm all MHA colleagues have a responsibility to report any ‘Never Events’
   2. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
   3. Each Never Event type has the potential to cause serious harm or death. However, serious harm or death is not required to have happened because of a specific incident occurrence for that incident to be categorised as a Never Event. Any incident of this nature must be immediately escalated.
   4. A register of Never Events within MHA will be kept by the quality improvement team along with any learning from such incidents / events.
   5. Refer to appendix 2 – Never Event examples.
5. Duty of Candour Implementation Procedures
   1. Refer to appendices for flowchart and example letters.

Applying the Principles

* + 1. Candour (honesty) is a process NOT an event, it should be on going and is about being open about all aspects of care and support an individual has received, including when things go wrong.
    2. When an individual is affected by a safety incident, which may include a mistake that has been made or something that has happened unexpectedly MHA have a duty to:
  + Be open and inform individuals, their families and relevant representatives
  + Explain what has happened and answer any questions
  + Apologise – this is not an admittance of liability
  + Find out what happened
  + Learn from any mistakes or omissions to avoid recurrence

| **Task** | **Expected Actions** |
| --- | --- |
| **Reporting an incident** | * MHA expects colleagues to immediately **report and escalate** events that appear to have caused moderate / severe harm or death * Refer to MHA’s Incident Response and Escalation Policy and Adult Safeguarding Policy * All incidents to be reported on RADAR and notified to CQC (England) * Submit notifications in accordance with Schedule 3, Regulation 30.   (Wales)   * Occasionally an incident may not be discovered at the time it happens. If an incident has occurred Duty of candour requirements must be considered. |
| **Informing the person**  **(Verbal)** | * A sincere verbal apology must be made to the individual, their family and relevant representatives. Reasonable support must be provided * The nature of the incident will determine who talks to the person or their representative – for example, doctor or other professional. * If the ‘notifier’ is to be an MHA colleague, the manager must discuss this with the area manager or regional director and follow the escalation policy. * Any updates regarding verbal apologies or contact with families or representatives must be added to the incident report on RADAR |
| **Letter of Apology** | * A verbal apology must be followed by a written notification or apology **Within 10 days** of the incident * The written apology must include clarification that the letter has been made in accordance with the Duty of Candour requirements, if applicable informing of any timescales for investigation any further communication * A copy of the written apology should be uploaded to RADAR |
| **Investigation** | * An investigation into the incident must be progressed to determine why the incident happened with an explanation of events and circumstances which resulted in the incident, including any identified learning * The individual and their respective families or representatives should be kept informed of any progress, especially if expected timescales are likely to exceed those agreed within the apology letter * If the incident is not being investigated as a ‘serious’ incident the investigation should be concluded within **28 days** with a report provided outlining an explanation of events and circumstances * **All Final reports must be reviewed and agreed by the Regional Director or Associate Operations Director dependent on the severity of the incident.**   **NOTE** – Any external investigations i.e., Police, may impact on MHA’s internal investigation timeframes |
| **Conclusion** | * Final reports must be reviewed and approved (as above) for release and suitably redacted if required * Approved Final reports must be shared with the individual and/or the relevant representative with a copy made available in a suitable manner i.e., email or printed copy. * The individual and their relevant representatives must be provided with an opportunity to discuss the findings. * All communication must be documented and included in the RADAR report, including a copy of the CQC/CIW notifications |

1. Special Considerations

When an individual dies

* + 1. When an incident has resulted in an individual death it is crucial that communication remains sensitive, empathic and open taking into consideration the individual circumstances of the event and the timing when discussing with families and representatives
    2. An incident that results in an individual death must be reported and investigated as a Serious Incident
    3. The open discussion and investigation usually occur prior to any Coroner’s inquest; however, it may be necessary to decide to wait for the outcome of Coroner’s inquest before holding open discussions.
    4. In some cases, the events of an individual’s death may include a police enquiry. Where possible this should not prevent an open meeting or discussion with families or representatives. It will be important to only offer and communicate only facts known at the time. Further guidance must be sought from a senior manager and MHA’s Safeguarding Lead.

Individuals who may lack capacity

* + 1. Where possible the individual will be involved in all communication about the incident. If appropriate assistance from an advocate should be explored and made available.
    2. Some individuals may have conditions which limit their ability to understand what is or what has happened. If they have a representative legally authorised under ‘Lasting Power of Attorney’ or ‘Deputy of the Court of Protection’ clarity regarding their authority must be confirmed prior to any discussions.

Safeguarding

* + 1. Colleagues must consult the relevant safeguarding authority for guidance on reporting and adhere to MHA’s Adult Safeguarding Policy. Further Guidance is available from MHA’s Safeguarding Lead and associated guidance on the intranet [Connect with Safeguarding.](https://intranet.mha.org.uk/Interact/Pages/Section/Default.aspx?Section=8337)

Individuals with different language or cultural considerations

* + 1. Consider the need for translation, advocacy services and cultural needs when discussion are to be arranged. Some individuals may prefer discussions with people of the same gender, which must be taking into account when planning any meetings or discussions regarding incidents or events.

Activating Duty of Candour

* + 1. Organisations (as responsible persons) must activate the duty of candour procedure as soon as reasonably practicable after becoming aware that:
  + An unintended or unexpected incident occurred during the provision of the health, social care or social work service provided by the organisation as the responsible person.
  + In the reasonable opinion of a registered health professional not involved in the incident:

1. That incident appears to have resulted in or could result in any of the outcomes mentioned below; and
2. That the outcome directly relates to the incident rather than to the natural course of the persons illness or underlying condition
3. Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| **Home/Scheme Manager** | * Comply with this policy and associated procedures * Report incidents in accordance with MHA’s safeguarding and incident reporting procedures. * Ensure that incidents, including Near Miss incidents are reported via the RADAR system as soon as possible following an incident. * Retain records of cases where a response has been provided to a notifiable safety incident. If the incident also meets the notification thresholds should be reported through the regulators notification system. * Ensure lessons learned are cascaded to relevant colleagues through discussion at team meetings, training and education sessions, newsletters, and posters.   Responding to a serious incident:   * Attend the scene of an incident where required * Ensure all immediate necessary actions to preserve safety have been taken * Ensure the family or representative of any person who has been harmed has been informed * Must inform the appropriate Senior Manager (Area Manager / Senior Manager on Call) * Must discuss with the appropriate Senior Manager any resource implications or business continuity issues * Might consider contacting the PR Manager or ask their immediate manager to do so and discuss any possible media issues or concerns * Seek guidance from MHA’s safeguarding lead. * Must contact relevant external agencies (e.g., Police, LA Safeguarding) |
| **Area Manager / On Call Manager** | * Must escalate to Regional Director, Head of Housing, Head of MHA Communities in accordance with the Incident Response and Escalation Policy * Escalate serious incidents to the Director on Call (Out of hours) * Provide support, advice and any additional resource to the Home or Scheme Manager where needed |
| **Regional Director, Head of Housing, Head of Communities** | * Confirm all immediate measures have been completed * Confirms that an Incident meets the criteria for a Serious Incident * Takes a co-ordinating role ensuring all key people involved are kept informed of the progress of the incident investigation * Must inform the Associate Director of Operations * Must ensure that MHA’s Safeguarding Lead are consulted where there is a safeguarding incident. * Must identify a colleague as key communicator with the person harmed and their family or representative. |
| **People Team** | * Provision of support to the manager, offering advice with regard to the application of procedure where appropriate. * Advise on both support and reassurance, and advice on formal processes, where required |
| **Safeguarding Lead** | * Responsible for ensuring the reporting framework for Safeguarding operates and supports the incident reporting policy * All Safeguarding incidents must be reviewed and escalated in accordance with external Safeguarding procedures * Providing reports to relevant groups, internal and external, as required and actively co-ordinates investigations where safeguarding has been identified |
| **MHA Colleagues and Volunteers** | * Report all incidents and near misses (where intervention has prevented harm to individuals or colleagues) * Ensure the details of any incident are contemporaneously and objectively reported in the individual’s record. * Raise any concerns about situations that led to, or could lead to, an incident or a near miss with their line manager * Actively participate in any subsequent incident investigation such as: providing a written account of the incident; attending fact-finding and feedback meetings, as required * Attend a Coroner’s inquest on behalf of the MHA if called to do so |

1. Training and Monitoring
   1. Detailed instructions on Incident reporting using the RADAR system can be located on MHA’s intranet and Learning Zone [MHA Connect](https://intranet.mha.org.uk/)
   2. All those formally required to assume on-call responsibilities must be confident and competent to do so. Different categories of such roles will be identified, and appropriate information and training made available to all relevant staff to achieve this.
   3. System data is available for monitoring and analysis and is routinely monitored to identify themes, patterns, and risks.
   4. Procedures within this policy will be monitored through MHA’s Quality Governance and risk framework including regulatory compliance.
2. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Each colleague’s line manager must ensure that all teams are aware of their roles, responsibilities.
   3. This policy will be available to the people we support and their representatives in alternate formats, as required.
   4. Any review of this policy will include consultation with our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.
   5. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)
3. Equality Impact Assessment (EIA)
   1. MHA aim to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.
   2. It reflects the provisions of legislation, Human Rights, and the Equality Act 2010 to promote equal opportunities for all.
   3. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.
   4. For access to the EIA, contact [policies@mha.org.uk](mailto:policies@mha.org.uk)
4. Resources
   1. MHA policy documents, procedures, and guidance
   * Incident response and Escalation Policy
   * Adults Safeguarding Policy and Safeguarding Risk Matrix
   * Complaints Policy
   * Coroners Referrals and Inquest Policy
   * Fraud Prevention Policy and Response Plan
   * Incident Management and Investigation Protocol
   * Information Governance Policies and Procedures
   * Quality Review Group Terms Of Reference
   * Quality Governance Group Terms of Reference
   * Risk Management Policy
   * Whistleblowing Policy
   * [Duty of Candour Toolbox Talk](https://intranet.mha.org.uk/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=Duty+of+Candour+Toolbox+Talk.docx&fileguid=770210d2-8af8-4e58-b0dc-ca5685530fba)
   1. External Resources
   * [The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – regulation 20](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour)
   * [The Regulation and Inspection of social care (Wales) Act 2016 - Statutory Guidance](https://www.gov.wales/sites/default/files/publications/2024-03/guidance-for-care-home-and-domiciliary-suppliers-2024.pdf)
   * [CQC guidance on notifications for non-NHS providers](http://www.cqc.org.uk/content/notifications-non-nhs-trust-providers)
   * [Charity Commission Guidance](http://www.charitycommission.gov.uk/detailed-guidance/)
   * [Never Events List](http://www.england.nhs.uk/wp-content/uploads/2013/12/nev-ev-list-1314-clar.pdf)
   * [Patient Safety Incident Response Framework (PSIRF) NHS](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/)
   * [NHS Wales Patient Safety Incidents](https://du.nhs.wales/patient-safety-wales/patient-safety-incidents/)
   * [Wales - Never Events List](https://du.nhs.wales/files/incidents/supporting-section-1-never-events-list-pdf/)
5. Version Control

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Version Date | Revision Description / Summary of Changes | Author and Review Panel | Next Review Date |
| 12 | September 2024 | Transferred to standard template  Removed reference to Scotland, included additional information for Wales  Updated MHA documents and external resources | Head of Standards & Policy  Safeguarding Lead | September 2026 |

1. Appendices
   * Appendix 1 – Duty of Candour Implementation Flowchart
   * Appendix 2 – Never Event Examples
   * Appendix 3 – Letter 1 example
   * Appendix 4 – Letter 2 example
   * Appendix 5 – Letter 3 example

Appendix 1 – Duty of Candour Implementation Flowchart

Appendix 2 – Never Event Examples

The following are examples of Never Events that have occurred elsewhere. Any incident of this nature must be immediately escalated. A register of Never Events within MHA will be monitored through the Quality Governance Group (QGG) with any learning from such incidents / events

For service in Wales refer to [Wales - Never Events List](https://du.nhs.wales/files/incidents/supporting-section-1-never-events-list-pdf/)

| Never Event | Guidance |
| --- | --- |
| 1. **Medication** | |
| **Wrong route administration of medication**  The person receives the following:   * Oral / enteral medication or feed / flush administered by any parenteral route | [Recommendations from NPSA alerts - relevant for Never Events](https://www.england.nhs.uk/wp-content/uploads/2020/11/Recommendations-from-NPSA-alerts-that-remain-relevant-to-NEs-FINAL.pdf) Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, (2007) |
| **Overdose of Insulin due to abbreviations or incorrect device**  Overdose refers to when:   * a person is given a 10-fold or greater overdose of insulin because the words ‘unit’ or ‘international units’ are abbreviated. * a healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin * a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle. | [Recommendations from NPSA alerts - relevant for Never Events](https://www.england.nhs.uk/wp-content/uploads/2020/11/Recommendations-from-NPSA-alerts-that-remain-relevant-to-NEs-FINAL.pdf)  Rapid response report – Safer administration of insulin, (2010)  Patient Safety Alert – [Risk of severe harm and death due to withdrawing insulin from pen devices](https://www.england.nhs.uk/2016/11/risk-severe-harm-and-death-withdrawing-insulin-pen-devices/) (2016) |
| **Overdose of methotrexate for non-cancer treatment**   * a person is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose | [Recommendations from NPSA alerts - relevant for Never Events](https://www.england.nhs.uk/wp-content/uploads/2020/11/Recommendations-from-NPSA-alerts-that-remain-relevant-to-NEs-FINAL.pdf)  Patient Safety Alert – Improving compliance with oral methotrexate guidelines (2006) |
| **2. Falls from poorly restricted windows** | |
| * It applies to windows *within reach*. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited / fallen from without needing to move furniture or use tools to assist in climbing out of the window. * It includes where a person deliberately or accidentally falls from a window where a restrictor has been fitted but previously damaged or disabled but does not include events where a person deliberately disables a restrictor or breaks the window immediately before the fall. * Includes where people are able to deliberately disable or overcomes a window restrictor by hand or using commonly available flat-bladed instruments, or the ‘key’ provided, or by some other means. | [Falls from windows or balconies in health and social care](https://www.hse.gov.uk/pubns/hsis5.pdf)  [Health building note 00-10 Part D Windows and associated hardware](https://www.england.nhs.uk/wp-content/uploads/2021/05/20131223_HBN_00-10_PartD_FINAL_published_version.pdf) |
| **3. Bedrails** | |
| **Chest or neck entrapment in bedrails**  Entrapment of chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance | [Bed rails: management and safe use (2023)](https://www.gov.uk/guidance/bed-rails-management-and-safe-use) |
| **4. Nasogastric tubes** | |
| **Misplaced nasogastric tubes**  Misplacement of a nasogastric or orogastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration. | [Patient Safety Alert - Nasogastric tube misplacement: risk of death and severe harm](https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient_Safety_Alert_Stage_2_-_NG_tube_resource_set.pdf)  [NHS Improvement Initial placement checks for Nasogastric tubes](https://www.england.nhs.uk/wp-content/uploads/2016/07/Resource_set_-_Initial_placement_checks_for_NG_tubes_1.pdf) |
| **5. Scalding** | |
| Person scalded by water used for washing/bathing, or personal comfort or therapeutic warming e.g., hot water bottles  Excludes scalds from water being used for purposes other than washing/bathing (e.g., from kettles). | [HSE - managing risks from hot water and surfaces in social care](https://www.hse.gov.uk/pubns/hsis6.pdf)  [HSE - Scalding and Burning](https://www.hse.gov.uk/healthservices/scalding-burning.htm)  [HSE - Health and Safety in Care Homes](https://www.hse.gov.uk/pubns/books/hsg220.htm) |

## 

Appendix 3 - Example Letter 1 – within 10 days following verbal apology use MHA letter heading

***Written notification/apology***

***Example 1***

*Letter of apology to be written after a safety incident where an individual has suffered*

***moderate or more severe harm****.*

*Letter to be written within 10 working days of the incident and after the individual has been verbally informed that the circumstances and events of the incident are being investigated.*

Dear XXX

Thank you for taking the time to talk *with me/my colleague* regarding *XX (e.g., your father’s* *fall on 23rd June and subsequent fractured hip)*.

I would like to express my sincere apologies that this event occurred while *XX* was in our care and want to assure you that we will be investigating this incident to understand how this happened and whether there is anything that we could do differently in future to stop this happening to anyone else.

MHA are committed to being open when events such as this happen, and I will write to you again within the next XX weeks *(i.e. 10 working days after the investigation has been completed)* once the findings of the investigation are known.

Once you have received our investigation findings, we would welcome the opportunity to meet with you again to discuss the findings more personally and answer any questions that you may have.

In the meantime, should you have any questions please don’t hesitate to contact me on XXX

Yours sincerely

*Manager name/designation*

Appendix 4 - Example letter 2 – Conclusion & investigation report

use MHA letter heading

***Conclusion of investigation / offering copy of report / offering to meet***

***Example 2***

*Letter written at conclusion of the investigation within agreed timescales and reflecting agreements that have been reached with the individual/relevant person, for example the individual may have requested to receive the complete investigation report, requested a meeting, requested a summary only.*

Dear XXX

As agreed during our discussion on X and subsequent letter on X, we have investigated the incident concerning your X (*e.g., father*).

Please find enclosed a copy of the investigation report.

Once you have had an opportunity to read the report, and should you find it helpful, we would be pleased to arrange a time to meet with you to talk through the findings and to answer any questions you may have. If this is something that you would find helpful, please let me know.

I hope that the investigation and the findings help to assure you that we have taken appropriate steps to understand why this incident happened and to identify any lessons that may need to be learnt to help prevent a similar incident happening again.

Should you have any questions please don’t hesitate to contact me on XXX

Yours sincerely

*Manager name/designation*

Appendix 5 - Example Letter 3 – Investigation Summary

use MHA letter heading

***Example 3***

*Letter written at conclusion of the investigation within agreed timescales and reflecting agreements that have been reached with the individual/relevant person, for example the individual* *may have requested to receive a summary of the investigation findings.*

Dear XXX

As agreed during our discussion on X and subsequent letter on X, we have investigated the incident concerning your X (*e.g., father*).

Please find below a summary of the investigation findings:

Description:

*(Enter text/concise summary of incident being investigation)*

Immediate action taken:

*(Enter text/concise summary of actions taken immediately after the incident – could be presented as* *bullet points or short paragraph)*

Investigation findings:

*(Enter text/concise summary of findings – Why incident occurred? Root cause identified through* *investigation)*

Lessons learned:

*(Enter text/concise summary of what will be done differently/ what investigation identified)*

How the lessons learned will be shared across the Charity

*(Enter text/concise summary giving assurance of how learning will be communicated)*

I trust that the actions we have taken help to assure you that appropriate steps have been taken to identify care and support issues relevant to the incident, and that recommendations for action have been prioritised.

Yours sincerely

*Manager name and designation*