Background to the duty of candour

Guidance updated 30 June 2022

The changes clarify how you should apply the term "unexpected or unintended" to decide if something qualifies as a notifiable safety incident or not.

See updated pages:

- **Notifable safety incidents**
- **Examples of notifiable safety incidents**

Until 2014 there was no legal duty on care providers to share information with the people who had been harmed, or their families.

The tragic case of Robbie Powell and the perseverance of his parents through the UK courts and then the European Court of Human Rights exposed the absence of this legal duty.

In 2013, the Francis Inquiry also found serious failings in openness and transparency at Mid Staffordshire NHS Foundation Trust:

“The way in which the Trust handled the matter can be viewed as an object lesson in how the tragedy of an avoidable death can be exacerbated by inappropriate handling of the case. It demonstrates the sad fact that, for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism.” (Francis Inquiry into the failings at Mid-Staffordshire NHS Foundation Trust, 2013)

The Francis Inquiry recommended that a statutory duty of candour be introduced for all health and care providers, in addition to the existing professional duty of candour and the requirement for candour in the NHS standard contract.

This statutory duty of candour was brought into law in 2014 for NHS Trusts and 2015 for all other providers and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture. It is so fundamentally linked to concepts of openness and transparency that often the policies and procedures related to it have come to be known by staff by other names, for example, “Being Open”, “Saying Sorry”, and “Just Culture”.