What you must do when you discover a notifiable safety incident

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**

You must start the specific procedure laid out in the duty of candour regulation 'as soon as reasonably practicable'.

We will always expect to see providers acting promptly as soon as a notifiable safety incident has been discovered.

The 'registered person' is responsible for carrying out, or delegating the responsibility for carrying out, the duty and must liaise with the 'relevant person'.

The ‘registered person’ is the registered manager or the registered provider. If you do not need to have a registered manager, such as NHS Trusts, responsibility sits with the leaders of the organisation.

The relevant person is either the person who was harmed or someone acting lawfully on their behalf.

Someone may act on the behalf of the person who was harmed if:

- the person has died
- is under 16 and not competent to make decisions about their care or the consequences of the incident
- is over 16 and lacking mental capacity.

This is in accordance with the Mental Capacity Act 2005.

The regulation states that you must:

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.
2. Apologise.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

The purpose of these meetings and communications is to share whatever is known about the incident truthfully, openly and with compassion and support. The person who was harmed has a right to understand what has happened to them. The meeting is not about trying to apportion blame, and in any case, it is likely that investigations will still be underway at this point.

People are sometimes uncertain about how to apologise when an incident is still being investigated. But from the start, simple straightforward expressions of sorrow and regret can and should be made for the harm the person has suffered.

Throughout the process you must give 'reasonable support' to the relevant person, both in relation to the incident itself and when communicating with them about the incident.

'Reasonable support' will vary with every situation, but could include, for example:

- environmental adjustments for someone who has a physical disability
- an interpreter for someone who does not speak English well
- information in accessible formats
- signposting to mental health services
- the support of an advocate
- drawing their attention to other sources of independent help and advice such as AvMA (Action against Medical Accidents) or Cruse Bereavement Care.

If the relevant person consents, we would expect to see that you have involved family members and carers in any discussions. It is about taking reasonable steps to make sure you communicate in a way that is as accessible and supportive as possible.

You must keep your own clear records of cases where you have responded to notifiable safety incidents. It may be that the incident also meets the notification thresholds and if so should be reported through the STEIS and NRLS/PSIMS systems or the CQC notification system dependent on care sector.

If the relevant person cannot be, or refuses to be, contacted, you may not be able to carry out paragraphs 2 to 4 of the regulation (the parts relating to notifiable safety incidents), but must keep a written record of all attempts to make contact. You must still report the incident through the appropriate notifications system and investigate it in order to prevent harm occurring to others.