London Ambulance Service
NHS Trust

Serious Untoward Incidents Policy

For Use By: All Staff

Introduction

For the purpose of this procedure, a Serious Untoward Incident (SUI) is defined as:

- an event during which the actions or omissions of London Ambulance Service NHS Trust (LAS) personnel may have contributed to the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS.

- an event involving the LAS which may produce significant legal, media or other interest which, if not properly managed, may result in loss of the Trust's reputation or assets.

- an event during which the death, injury or illness of one or more patients, members of the public, members of staff or persons working on behalf of the LAS may have resulted from a delay in dispatching appropriate LAS resources, or where a delay may have been a contributory factor in those outcomes.

- When a potential SUI is reported the recipient must dispatch all information to the Complaints Manager/ Director of Operations/ Medical Director

- The above group review the information and conduct a risk assessment of the incident (using the Risk Reporting and Assessment Procedure)

- A decision is then made on whether to recommend that the incident be classified and dealt with as an SUI or not.

- A record must be kept of all the factors considered in determining whether or not an incident is classified as an SUI. This record must be maintained by the Complaints Manager.

This policy applies to all LAS staff and it requires them to report any potential serious untoward incident according to the guidance set out below.

The LAS is committed to cooperating fully with external agencies when they are reviewing any adverse incident and will share information with them, providing that relevant statutory responsibilities (Data Protection, Freedom of Information Acts etc.) are met. The LAS will also

involve and include other agencies in SUI investigations as appropriate. e.g. if an LAS employee reports a criminal offence has occurred during the incident then the Police will be contacted immediately.

Objectives

The purpose of this document is to describe a procedure that, when followed, will allow the LAS and its staff to:

1. Understand what constitutes an SUI and be provided with guidance on how to deal with these potentially stressful events.

2. Respond quickly and positively to an incident, mitigating the consequences and provide evidence that its main concern is for the wellbeing and best interests of patients, staff and those working on behalf of the LAS.

3. Take a consistent approach to the management of such incidents.

4. An SUI investigation should not be confused with an investigation conducted under the LAS Disciplinary Procedure. If, as a consequence of the SUI investigation, a disciplinary issue is discovered, a separate investigation, conducted in accordance with the LAS Disciplinary Procedure, will take place. In the event of a disciplinary investigation, all due care will be taken to avoid unnecessarily approaching patients, carers or members of the public for information relating to the incident which has already been obtained previously by the LAS.

5. Apply this procedure in an open and transparent way.

6. Involve and fully inform stakeholders, staff, other organisations/professionals, patients and their families, in line with Department of Health guidance on best practice.

7. Deal with cases where poor practice is identified as a contributory factor in a sensitive and fair manner in accordance with the Trust's workforce policies.

8. Consider the individual needs of staff, patients, their relatives and carers within the wider system, particularly regarding their cultural and/or religious needs.

9. Learn from all incidents and prevent recurrence as far as possible.

10. Address the lessons to be learnt from such incidents from both operational and organisational perspectives, recognising that the majority of incidents in health care occur because of failure in systems rather than individual practice alone.

Audit

The Trust will know that this procedure has been effectively implemented when:

- Full compliance with policy has been achieved and has been evidenced through use of the audit tool and audit standards in **Appendix 1.**
- It is demonstrated that contributory factors in an SUI are identified, action taken and recommendations are communicated, implemented and reviewed in accordance with the Trust's Risk Management Policy
- In those cases where disciplinary action is used it is apparent that gross negligence has been found -
- There is evidence of patient / public involvement
- There is evidence that the support offered reasonably met everyone's needs including cultural and religious requirements.

The LAS commits to monitor full compliance with this procedure and the routine achievement of the above objectives to ensure that the audit cycle is completed every time an SUI is declared. The methodology and standards for the audit are included in **Appendix 1**. The purpose of the audit is to ensure that lessons have been learned and patient care has been improved as a direct outcome of a SUI investigation.

Procedure

Following declaration of an SUI all identified personnel will be informed within 24 hours of the incident occurring, where contactable; the matter will be followed up by a full incident review.

The LAS is committed to being open with patients who have been unintentionally harmed. Being open involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and reassuring patients/carers that lessons learned will help prevent a similar incident recurring.

The LAS policy of Being Open has been developed in line with the National Patient Safety Agency's national 'Being Open' Policy that was launched in September 2005. The LAS Policy of Being Open must be read in conjunction with the LAS SUI Policy..

1.0 Reporting of Incidents Identified by Operational Staff

1.1 It is vital that in the event of an adverse incident that meets the above criteria, an appropriate Senior Manager is alerted accordingly. Crucial to the effective management of an adverse incident is speed of communication.

1.2 The decision to declare an SUI and apply the procedure to an incident will be made by the Chief Executive Officer (CEO) or another Executive Director and/or the Director of Operations and/or the Medical Director within 24 hours of it being reported. The

requirements of the SUI guidance issued by the Strategic NHS Authority for London must be met during the process of every SUI – see **Appendix 2**. The Director of Communications will be informed if the procedure is invoked.

2.0 Reporting of Incidents by Other Means

2.1 Information regarding incidents may come from various sources. When the SUI criteria applies to an incident that is reported through an internal source such as an enquiry made to the Patient Advice & Liaison Service (PALS), a complaint to the Complaints Manager, or notification of a 'problematic' coroner's inquest to Legal Services, the CEO and /or Director of Operations and / or the Medical Director must be notified accordingly.

2.2 The Communications Directorate, Legal Services, PALS & Complaints should all be simultaneously informed when an SUI is declared to enable a consistency of approach to enquiries from interested parties and avoid any duplication of investigation.

2.3 In the case of the Emergency Operations Centre (EOC), if an incident becomes apparent as it occurs, EOC must record all relevant details of the incident on the Call Receipt Form (AS1), using the electronic call log. If there is no pre-existing CAD log for the incident, one should be created. All decisions and records of who is informed about the incident and by whom must be recorded in the log. The Senior Operations Officer should inform the duty 'Silver' (Site managers) of any incident that they believe may constitute an SUI and a decision made whether to inform the duty 'Gold' (senior manager responsible).

3.0 Management of the Incident

3.1 The CEO/Director of Operations delegates the authority to the Complaints Manager to ensure the SUI investigation is conducted in a manner that is fully compliant with the SUI Policy.

3.2 The CEO/Director of operations will delegate the appointment of a Case Manager as appropriate.

3.3 As soon as possible a SUI Group consisting of the CEO and / or the Director of Operations, the Director of Communications, the Medical Director or their representatives and any other persons invited by the Group must be organised. The group will meet and be facilitated by the Case Manager. It will monitor developments, maintain a strategic overview and enable the specific management of the review and dissemination of the outcome(s).

3.4 The Complaints Manager has the role of overseeing the work of the appointed SUI group, including the Case Manager, and the conduct of the investigation.

3.5 The case manager is responsible for the timely production of interim and final reports which must always include time-limited recommendations. The CEO, Director of

Operations and Medical Director will be kept informed of developments, as will other appropriate managers

4.0 Responsibilities of Case Manager

The responsibilities of the Case manager are;

4.1 To monitor the progress of the investigation and ensure the procedure is followed correctly.

4.2 To immediately appoint a Family Liaison Officer (FLO) to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives and the SUI Group. The role of the FLO is defined in **Appendix 3**. **Any information given to staff, patient(s), relatives and the public must be documented**. Every effort will be made to ensure that patient(s) and/or relative(s), staff and other persons potentially affected by the incident are informed at the earliest opportunity and in advance of any public announcement. This will be facilitated by the FLO.

4.3 To immediately appoint a Staff Liaison Officer (SLO) to provide regular feedback and support, as appropriate for staff. All staff involved should be informed when this procedure has been invoked.

4.4 To ensure the immediate appointment of an appropriate Investigation Officer to coordinate the enquiry. The investigation officer must produce the report of the investigation in accordance with the timescale set by the SUI group appointed. The quality assurance of the report will be undertaken by the case manager. The case manager will be expected to ensure that the cause of the incident has been understood and set out in the report.

4.5 To ensure that full details of the incident are relayed to the Strategic Health Authority for NHS London (or its successor) and other NHS organisations as appropriate. The Communications Directorate will be responsible for informing and updating the Department of Health, which may include the Chief Medical Officer. The Case Manager must ensure that the SUI process and reporting of it complies with strategic health authority requirements. SUI Information must be provided so that it enters at the top of the flow chart set out in **Appendix 2**. If subsequent changes are made to the process by any strategic authority level NHS body, then this procedure will need to be amended and the amendment agreed by the Trust Board.

4.6 To ensure that a comprehensive record of the incident is maintained (see **Appendix 4**) as part of the FLO's role. Included in this record should be a note describing all information that is given by the LAS to the patients, carers, relatives and families of those involved in the SUI during the SUI investigation and afterwards. Any information given to those potentially affected directly by the incident and/or the public must also be documented.

4.7 The Head of Legal Services is responsible for informing the National Health Service Litigation Authority (NHSLA). The HR department will be responsible for advising the Health & Safety Executive in appropriate cases, and keeping them informed and updated during the progress of the SUI management.

4.8 Ensure the appropriate debriefing and support for all staff involved in the Incident is provided.

4.9 Ensure timely and effective dissemination of the final SUI report is made, internally and externally. This report must routinely contain recommendations and an action plan including a time scale for their implementation.

4.10 See **Appendix 4** for SUI Check list.

5.0 Reporting requirements

5.1 The interim, draft and final SUI reports must be produced to the deadline set by the Director of Operations or (through his delegated authority) by the Complaints Manager. The Complaints Manager will check that the scope of the recommendations reflect accurately and appropriately the scope and conclusions from the investigation of the incident. The Complaints Manager will then complete the preparation process within the deadline set by giving the report to the Director of Operations (or through delegation) to an appropriate Executive Director to confirm the report and recommendations will be considered by the Senior Management Group for immediate implementation. The Datix file on the incident must be opened within 24 hours of the incidents.

5.2 The Case Manager will convene a meeting of those contributing to the SUI management process in order to prepare a final report for the Chairman, CEO, Director of Operations, Medical Director and the Trust Board. SUIs will be reported to the Trust Board as part of the CEO's report. Every report must include a root cause analysis or similar methodology that identifies what factors contributed to the incident occurring:

- All SUI reports must be dated (on every page) so that the time elapsed between the incident and the production of the report is clear.
- Making time –limited recommendations for further action to be taken / lessons to be learnt to prevent recurrence.
- SUI reports should be placed in the S Drive and SMG informed accordingly.
- In the event of a delay in completing the investigation (e.g. due to information awaited from an external organisation) an interim report must be produced in accordance with deadlines originally determined. The interim report must be constructed using the same process as the final report (see 5.1 above) and must clearly set out the caveat that further recommendations or actions may be produced on receipt of the information outstanding.

- Implementing agreed action measures.

- Ensuring feedback to the patient(s) and/or relatives and/or staff and/or member(s) of the public of the outcome of the investigation and the action taken/proposed. In respect of clinical incidents, in addition to the formal written response to the patient/relatives outlining the investigation findings, consideration should also be given to offering a meeting with the senior staff involved in the investigation process

  Note: In the event that, following a SUI, concurrent related internal investigations are ongoing (e.g. disciplinary investigation involving staff), such investigations will not delay the resolution of clinical issues including the final response to patient/relatives or agreeing with relevant parties any additional media notification as necessary and appropriate.

- Ensuring that arrangements are in place for the relevant external stakeholders including the SHA and National Patient Safety Agency (NPSA) to be notified of the outcome of the investigation and the actions taken or proposed.

- The CEO and/or relevant Director will be responsible for advising the Chairman and the Trust Board of the outcome of the investigation and the action taken or proposed

- Monitoring of agreed action measures will be undertaken as part of the wider Incident Reporting System arrangements via the Risk Compliance and Assurance Group and/or Clinical Governance Committee and Complaints Panel in order to keep these committees advised of progress against agreed action plans.

The focus of SUI reports will be on delivering outcomes aimed at preventing recurrence and improving patient care. This focus will be monitored by the Complaints Panel to ensure these benefits occur. The SUI Group should also include a review reflecting on how it managed the incident, in order to continuously improve the quality and effectiveness of this procedure

6.0 Responsibilities of CEO and Trust Board

6.1 There may be instances when it is appropriate to establish a serious incident team independent of the Trust. This decision should be made by the CEO and Trust Board.

7.0 Communications with the LAS Trust Board

7.1 The CEO / Director of Operations will ensure that other Executive Trust Board Directors are informed of the incident and updated on developments.

7.2 The CEO / Director of Operations will inform and liaise with the Trust Chairman who will inform Non Executive Trust Directors.

7.3 The resulting Report and Action Plan will be disseminated internally and externally as appropriate

7.4 The Report and Action Plan will be made available to the LAS Complaints Review Panel to ensure outcomes have been achieved, lessons learned and prevention of recurrence noted.

7.5 The Case Manager will be responsible for informing and liaising with relevant Health Authority(s) and provider(s).

7.6 The SUI Group will decide on any other organisations to be informed and how and when that will occur.

8.0 Patient and Public Involvement

"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately. This open approach minimises the trauma they feel." (Seven Steps to Patient Safety NPSA 2003)

8.1 All areas of health care are moving towards greater public involvement.
It is recognised that this can be a complex matter so the Trust supports this approach in supporting the patient and public involvement by :-

- The FLO visiting the patient/relatives to explain the process to them and to ascertain any questions/issues raised.
- Making available the final report and action plan and offering any advice about the options available in respect of pursuing matters. This should involve a further meeting to explain the report.
- Inviting patients /relatives to be a part of any ongoing development and/or audit

8.2 If a patient /relative does attend a meeting it is suggested that they bring along a 'friend' for support. This person does not need to be actively involved in the review and need not be a legal representative.

9.0 Media Relations

9.1 The Director or Head of Communications will be responsible for media relations, and liaising with those responsible for media relations in other organisations. The Medical Director will be responsible for and involved with clinical issues.

9.2 If the LAS takes a proactive stance on the incident – i.e. the LAS plans to inform the media of the incident before the media is aware, the Director of Communications will ensure that patient(s) and relative(s) are aware of any LAS statement to the media. This will be done through the appointed FLO.

9.3 Relatives and patients will be notified before any statement is made by the Trust to the media. Similarly, if the LAS is reacting to media inquiries, the Director of Communications will ensure that patient(s) and relative(s), staff and other persons potentially affected by the incident are aware of media interest and the content of any LAS statement. These functions will usually be facilitated by the appointed FLO.

9.4 No member of staff will provide statements independently of this process.

9.5 For serial incidents and dealing with multiple enquiries the following arrangements will be made:-

A 'hot-line' will be set up by the Communications Directorate in accordance with the *CHI/Healthcare Commission's "Guidance for the NHS in Establishing and Running Rapid Response (Telephone) Help Lines" 2003* to deal with all calls coming in from the media and public about the incident. PSU, PALS and Legal Services teams will also be briefed accordingly. The Director of Communications will delegate these arrangements within his directorate so that there is a process to ensure staff are available and skilled to assist. The designated room will be the Communications Directorate Office and will mirror arrangements in the Trust's Major Incident Plan, when SUIs occur that may potentially affect large numbers of people or where serial incidents may occur e.g. exposure/screening problems, terrorist attacks.

9.6 The Director of Communications in liaison with the Chief Executive or Director of Operations will appoint a senior representative of the Trust to act as spokesperson for the LAS in the event of a Press conference, radio or TV interviews.

References:

The London Ambulance Service NHS Trust Major Incident Plan
Safer Practice Notice 10 National Patients Safety Agency 15 September 2005[1]
Serious Untoward Incident Guidance (South West London SHA).
Incident Reporting Procedure
Complaints Procedure TP/004
The Protocol for the Investigations & Analysis of Clinical Incidents (Prepared by University College Hospital)
C.N.S.T. Standards 2002
NHSLA Standards
Building a Safer NHS for Patients (An Organisation with Memory). April 2001, DoH 23720 1P 2K
Strategic Health Authority SUI policy.
Seven Steps to Patient Safety (NPSA 2003)
Criteria for Assessing Core Standards (Healthcare Commission 2005).
Being Open Policy (2006)
Whistle Blowing Policy

Signature: 

Peter Bradley CBE
Chief Executive Officer

Appendix 1

1.0 Standards and Audit Instructions

This audit should be routinely undertaken at the conclusion of an SUI investigation and reviewed by the LAS Complaints Panel.

Standard 1
There will be an up-to-date SUI policy available on Pulse and the LAS website; general instruction publicised in RIB and LAS News; specific memoranda to AOMs and DSOs.
Audit instruction:
Has the above been completed? Check SUI file.

Standard 2
In the event of a SUI being declared, the policy will be adhered to and the checklist completed.
Audit instruction:
Check SUI checklist

Standard 3
Following a SUI a full incident review will take place within 28 working days and a report completed within 45 working days
Audit instruction:
Did a clinical incident review take place? When was the report finalised?. If the incident is non clinical an incident review should still occur. This standard assumes that a root cause analysis would be undertaken routinely as part of every incident review.

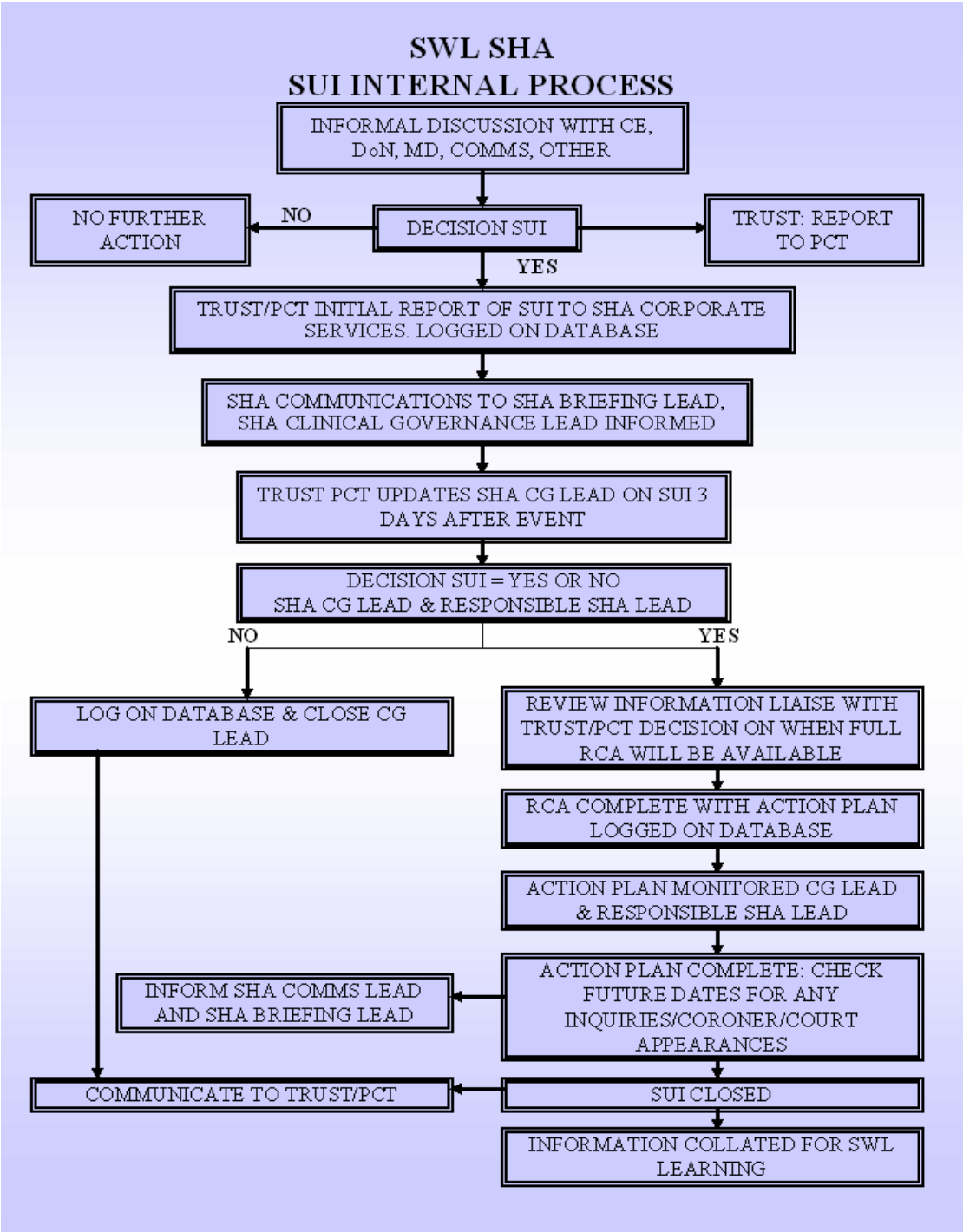
Standard 4
The support needs of those involved (patient, relatives, staff) will be considered immediately and the need for ongoing support reviewed at the point of declaring an SUI
Audit instruction:
Was support offered? Check SUI file; consider employing feedback mechanisms.

Standard 5
Carers/relatives will be offered a named contact for support and information.
Audit instruction:
Were relatives offered a named contact? Check SUI file

Standard 6
The risk management service will notify the Strategic Health Authority of any SUI which meets their criteria within 72 hours*
Audit instruction
Was the SHA informed? Check SUI file

**In extreme cases the Trust will notify the SHA immediately*

Appendix 2


SWL SHA
SUI INTERNAL PROCESS
INFORMAL DISCUSSION WITH CE, DoN, MD, COMMS, OTHER
NO FURTHER ACTION
NO
DECISION SUI
TRUST: REPORT TO PCT
YES
TRUST/PCT INITIAL REPORT OF SUI TO SHA CORPORATE SERVICES. LOGGED ON DATABASE
SHA COMMUNICATIONS TO SHA BRIEFING LEAD, SHA CLINICAL GOVERNANCE LEAD INFORMED
TRUST PCT UPDATES SHA CG LEAD ON SUI 3 DAYS AFTER EVENT
DECISION SUI = YES OR NO
SHA CG LEAD & RESPONSIBLE SHA LEAD
NO
YES
LOG ON DATABASE & CLOSE CG LEAD
REVIEW INFORMATION LIAISE WITH TRUST/PCT DECISION ON WHEN FULL RCA WILL BE AVAILABLE
RCA COMPLETE WITH ACTION PLAN LOGGED ON DATABASE
ACTION PLAN MONITORED CG LEAD & RESPONSIBLE SHA LEAD
INFORM SHA COMMS LEAD AND SHA BRIEFING LEAD
ACTION PLAN COMPLETE: CHECK FUTURE DATES FOR ANY INQUIRIES/CORONER/COURT APPEARANCES
COMMUNICATE TO TRUST/PCT
SUI CLOSED
INFORMATION COLLATED FOR SWL LEARNING

Appendix 3

Family Liaison Officer – role description

Introduction

The primary focus of the Family Liaison Officer (FLO) is to act as a conduit to convey information to and receive queries from relatives and others concerning an event, which has been declared a Serious Untoward Incident (SUI) by the London Ambulance Service NHS Trust. (LAS). The FLO must always keep a record of any information given to staff, patient(s) and/or relative(s) and the public to comply with the requirements set out in sections 9.3 and 4.2 of the SUI Policy.

- The main purpose of the FLO is to keep the service user, relatives ,carers and others with a direct responsibility for their welfare, fully briefed about the progress of the investigation process, how the incident is being managed, and to provide advice relating to the implementation of LAS policy and procedures. The FLO may also offer information about other agencies such as the Healthcare Commission and the Independent Complaints Advocacy Service (ICAS) who can provide advice about the NHS Complaints Procedure.

- The FLO does not have an active role in the investigation of the incident, although the FLO may facilitate communication channels between LAS NHS Trust investigations so that the relationship between them is connected to the chronology of the investigation.

- The FLO must always maintain a contemporaneous summary log of the progress of the incident inquiry including a record of all contacts by LAS NHS Trust staff with the Service User, family, relatives and carers. This record will also be routinely available to LAS NHS Trust staff, complainants, Investigators and representatives of those involved in the incident.

- In the event of a request for information about the SUI from the media, the FLO should immediately refer the enquirer to the Communications Directorate.

- The FLO has no role in advising on or defending the position of the London Ambulance Service NHS Trust (LAS NHS Trust) regarding the Serious Untoward Incident (SUI) in which their staff have been indirectly or directly involved. The FLO is a source of accurate information for the service user, relatives, carers and others with a direct interest in/responsibility for the welfare of those involved in the SUI.

- The FLO should not offer opinion or comment on matters related to the incident or the inquiry into it, to the Service User/complainant/Relative/Carer/ Representative other than to explain the implementation and progress of the application of the LAS NHS Trust SUI Policy process to the incident or the relationship of it to NHS complaints procedures.

- The FLO must always connect and respond in a timely manner with those seeking information, and be able to demonstrate that the parties with a direct interest (as described above) in the welfare of the service user have good access to all appropriate information about the incident. To facilitate this, the FLO will hold a minimum of at least one initial meeting with them.

- The FLO must liaise with all departments of the LAS NHS Trust to ensure the information requirements from the incident are addressed and complied with.

Appendix 4

SUI Checklist

The following points must be part of every SUI process undertaken by the LAS. It is by no means exhaustive:

Being Open – This advice reflects the approach to "Being Open" issued by the NPSA

1.0 Preliminary meeting with the patient and/or their carers

1.1 Who should attend?

A lead member of staff with appropriate experience will attend the preliminary meeting with the patient and/or carers.

It is important to ensure that those staff who attend the meetings can continue to do so to aid continuity.

The person taking the lead should be supported by at least one other appropriate member of staff,

Ask the patient and/or their carers who they would like to be present

Consider the communication skills of each team member; they need to be able to communicate clearly, sympathetically and effectively.

Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting.

1.2 When should it be held?

As soon after the incident as possible.

Consider the patients and/or their carer's home and social circumstances.

Check they are happy with the timing.

Offer them a choice of times and confirm the chosen date in writing.

Do not cancel the meeting unless absolutely necessary.

1.3 Where should it be held?

Use a quiet room where you will not be distracted by work or interrupted.

Do not host the meeting near to the place where the incident occurred if this may be difficult for the patient and/or their carers.

1.4 How should you approach the patient and/or their carers?

Speak to the patient and / or their carers as you would want someone in the same situation to communicate with a member of your family.

Do not use jargon or acronyms: use clear, straightforward language.

Consider the needs of patients with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities.

1.5 What should be discussed?

Introduce and explain the role of everyone present to the patient and/or their carer and ask them if they are happy with those present.

Acknowledge what happened and apologise on behalf of the team and the organisation. Expressing regret is not an admission of liability.

Stick to the facts that are known at the time and assure them that if more information becomes available it will be shared with them.

Do not speculate or attribute blame.

Suggest sources of support and counselling.

Check they have understood what you have told them and offer to answer any questions.

Provide a named contact who they can speak to again.

1.6 Follow – up

Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines.

The patients notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the patient and/or their carers have been told, and a summary of agreed action points.

Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counselling, as appropriate.

2.0 Quick reference guide to *Being Open (NPSA 2005)*

- Obtaining a full set of the contemporaneous records.
- Producing a chronology of events.
- Seeking internal or external clinical advice.
- Using management information data.
- Identifying the key staff involved in the incident.
- Deciding who needs to be interviewed and the order in which the interviews will take place.
- Ascertaining the final outcome.
- Ascertaining the key problems and when they arose.

- Produce a draft report for the SUI Review Manager to sign off following consultation with the SUI Review Group.

Interviews will be undertaken by members of the SUI Review Group following consultation with the Investigation Officer to:

- Establish the chronology and role played by the member(s) of staff and asking each interviewee to identify the main problems without apportioning blame.

- Establish to what extent action was guided by National Clinical Guidelines and, if not, how reasonable it was to depart from those guidelines and protocols.

- Identify the contributory factors e.g. work load, availability of equipment, training and distinguishing the specific and general contributory factors.

An analysis of an SUI using 'root cause' methodology must always be done as stated in the policy to establish at least the minimum facts below:-

- What happened?
- How did it happen?
- Why did it happen?
- What can be done to change things and prevent it happening again?
- Where and when can the LAS monitor that actions and recommendations from the report have been implemented and improved patient care?