Serious Incident Analysis

A Practical Guide for Directors, PGME

A COMPANION PUBLICATION TO THE NACTUK GUIDE FOR MANAGING TRAINEES IN DIFFICULTY

This guidance is written primarily for Directors of PGME who are responsible for the oversight and management of trainees involved in serious incidents. It suggests ways of managing and learning from such events and shares experiences from around the UK provided by NACT UK members. NACT UK considers the DMEs to be the key individuals to ensure that information is captured and appropriate outcomes achieved.

DMEs should also be able to access LETB/Deanery and Trust/Board guidance.

Background

All Trusts have a policy for the Definition and Investigation of Serious Incidents (Sis) and in addition, are required to report such events externally to the commissioners. These investigations may involve working with the Coroner or the Police and may be used by other external bodies like the GMC. DMEs should be familiar with local policies and LETB/Deanery guidelines. Within each Trust it is useful for DMEs to have in place a system which captures all information about the involvement of trainees in incidents, to provide background data on where errors are occurring, and to be formally notified of any SI investigation when a trainee is involved.

In many cases where a SI has occurred the practice of the trainee is not at fault. Nevertheless the trainee is expected to declare the incident in their e-portfolio and show appropriate reflection and learning form the event. In addition, involvement in such cases may prove challenging and distressing and trainees may require additional support and pastoral care. DMEs need to be assured that trainees who need this extra support are receiving it.

Collecting Information

NACTUK recommends that DMEs have in place a system which provides them with on-going information of all incidents involving trainees reported within their organisation, to provide background information about types of incidents, grade of staff and when these incidents occur. With increasing use of IT to report and collate information this should be possible to achieve. This data can then inform Induction and local teaching.

Serious Incidents

Each organisation will have a policy for recognising and investigating these events. DMEs should ensure their local policy includes a requirement for DMEs to be informed immediately should a trainee be involved. DMEs should be involved in the writing and regular review of this policy to ensure it meets the needs of trainee doctors and their circumstances.

DMEs will then need to assure themselves that an assessment is made of the trainee, a clear decision made about what support is needed and who is going to provide it and the level of clinical supervision required. (*Ref NACTUK Managing Trainees in Difficulty*)

Coroner's Investigations

Most trainees will not have been involved with the Coroner and should be provided with support in preparing statements. They should access their own defence organisations for independent advice but can benefit from generic support from PGME, clarifying the role and responsibilities of the coroner and how to write clear statements. Access to clinical notes should be provided. A single comprehensive and clear statement suitable for all possible investigations is essential. Preparing multiple different statements is not appropriate.

If trainees are required to attend the Coroner's court as a witness they should be offered support to do this. In some cases Defence Societies advise that they do not need to attend but trainees should be offered support and this may include sending a member of staff with the trainee. Some Trusts offer all staff attending a briefing by the Trust solicitor, which is basically a run through of how such proceedings are conducted. This is extremely beneficial.

Police Investigations

When a criminal investigation is initiated all other investigations are suspended until these are complete and a decision is reached about prosecution or otherwise. This may take 9-12 months and trainees may be left in "limbo" until such time as a decision is made. Early involvement of the Postgraduate Dean is essential as trainees may be unable to move to another Trust or clinical post until this has been resolved. It is also necessary to ensure appropriate on-going clinical supervision, possible restriction of duties and pastoral care during this time. All decisions will need to be made in collaboration with the Medical Director, TPD and the Postgraduate Dean.

NCAS advice is that trainees should not be excluded from the place of work unless patient safety cannot be guaranteed or the presence of the trainee would prejudice the integrity of an on-going investigation. For trainees it should be possible to meet these requirements without exclusion. This may mean a revised or restricted timetable, possibly no on call or out of hour's duties, supervision by consultants only or transfer to another placement, depending on circumstances.

This does not preclude very distressed trainees being offered some leave of absence and reduced clinical duties on compassionate grounds.

Assume everything will be reviewed by external bodies and ensure all documentation is thorough and contemporaneous. Remember to include all emails in your documentation. In a recent case both the Crown Prosecution service, Coroner and GMC required full copies of a trainee's portfolio in addition to supplementary information about training programmes, GMC survey data and internal policies and written evidence of on-going supervision and management of the trainee. All police investigations include referral to the GMC.

Factors the GMC might consider in deciding what to do would include a range of aggravating or mitigating issues:-

- A genuine expression of regret/ apology
- Previous good history
- Whether the incident was isolated or whether there has been any repetition
- Any indication as to the likelihood of the concerns being repeated
- Any rehabilitative/corrective steps taken
- Relevant and appropriate references and testimonials

Trust SI Report

Most Trusts will produce a formal report about declared SIs with recommendations for changes in practice. Where trainees are involved DMEs should see draft reports before they are finalised and ensure appropriate senior clinical review. These reports should be shared with trainees but may not become available for some months as they are not finalised until any police or coroner requirements are completed. This may mean that trainees have moved on and do not have the opportunity to see the report. DMEs should try to ensure they can send on such reports to trainees and their Educational Supervisors as they become available. A recent survey of trainees in one training programme revealed 55% had been involved in a serious incident but only 17% had received a copy of the formal trust report.

Collated information should be shared at School and LETB/Deanery level to inform training programmes.

Individual roles and responsibilities

Clinical Supervisor: ensures trainee remains supported in their day to day clinical work, and provides extra supervision as necessary.

Educational Supervisor: ensures trainee has extra support during the process and has reflected on the incident and is aware of their own role and responsibility. Supports trainee during on-going investigations and ensures they are aware of other agencies e.g. Occupational Health, Counselling, MPS/MDU etc. The Educational Supervisor will need to comment on the SI in the form of a formal report. The Educational Supervise should ensure they seek advice and keep all appropriate parties fully informed.

Specialty / College Tutor: responsible for ensuring that a trainee involved in a SI has appropriate clinical supervision and an Educational Supervisor with the knowledge and skills to provide good support.

Director of Medical Education: Supports primarily trainers during on-going investigations and ensures they are aware of other agencies e.g. Occupational Health, Counselling, MPS/MDU etc. with Educational Supervisor. Ensures lessons are rolled out more widely in the organisation and liaises with Medical Director, Clinical Director, Head of School, Dean and other external agencies as required. Reports outcomes to Dean/ School. Ensures final report reaches trainee.

Medical Education Manager: key role in facilitating communication between all parties and providing ad hoc pastoral care. Maintain confidential records.

Training Programme Director: supports trainee if issues reflect on their performance which might be relevant to overall progress through training and ensures that placements of trainee are suitable and on-going support is provided as required.

Medical Director: ensures that DME is informed of all incidents involving trainees at a very early stage and that the final SI report is sent to the DME.

Postgraduate Dean: ensures that DMEs report trainees involved in SIs to LETB/Deanery/ School and that mechanisms are in place to support trainees, identify patterns of incidents and that learning is shared across schools and specialties.

Educational Governance Groups

Many Trusts and Deaneries have now set up Educational Governance Groups to monitor issues around Doctors with difficulties using a multi-disciplinary approach. Membership at Trust level might consist of

- Director Medical Education
- Medical Director
- Occupational Health Physician
- HR Representative
- Foundation Programme Director
- Medical Education Manager
- Foundation Programme Administrator

Other parties by invitation.

At LETB/Deanery level this would include Dean or Deputy, Associate Postgraduate Dean and specialized support such as a Psychologist. Trainees involved in SIs should automatically be reviewed by the group.

Specialized Support

Trainees are sometimes extremely traumatized by their involvement in SIs even when they themselves may not have been the key participant. It is very important to be able to support them with high quality pastoral care, sometimes for months or years after the event. DMEs should make sure they have access to the services of counselling, career guidance and Educational Psychologists.

Conclusion

Ensuring that lessons are learnt and disseminated at local, LETB/Deanery and national level is essential. DMEs are encouraged to ensure that the learning outcomes from all such events are shared.

NACT UK

Serious Incident – Reflective Activity to Support Learning
Please describe the experience and how you were involved
What went well and why? What should have been better and why?
How you may wish to change the way you respond to similar events in the future. How will you change the way you respond in future?
Explanation, including references to other literature
How will this be presented in your Personal Development Plan?

NACT UK

Serious Incident – Analysis
Trainee Issues Recommendation
Organisational Issues Recommendation
Educational Issues Recommendation