Responding to, and learning from, incidents at an organisational level

Responding to a suicide

An ability to provide guidance and support for all employees affected by a person's suicide
An ability to maintain services and to provide stability and appropriate information to staff, other service users and their families and carers
An ability to appoint appropriate individuals to investigate the circumstances leading up to the death
An ability to offer support to individuals and teams who worked with the person who has died, aimed at helping them review the death, discussing their reactions and feelings and receive help if necessary
An ability to communicate with other service users involved and affected by the death (e.g. providing clinical follow-up and support)

Family and carer engagement and communication

An ability to ensure that the terms of reference of any investigation explicitly include arrangements for engaging and communicating with the family or carers of the person who has died
An ability to ensure that the people making contact are suitable to take up this role (e.g. have the appropriate communication skills and an appropriate level of authority)
An ability to ensure that information is provided to the family or carers of the person who has died in a timely and compassionate manner (in line with the duty of candour)
An ability to put in place appropriate support for family or carers of the person who has died
Where a person's family includes children and young people, an ability to signpost or to put in place developmentally appropriate support for them, and to support the family or carers to care for them

Establishing an independent review

An ability to identify an independent team with relevant experience, expertise and authority, including external membership where appropriate, which is empowered to:	
	investigate the circumstances of the death
	compile a record of a person's care and service use
	write a clear report
An ability to ensure that reviews are set up, completed and disseminated in as timely a manner as is practicable	

Competences for the investigating team

An ability for the investigating team to:
review relevant documentation
identify the agencies and services with which the person was in contact
interview members of the staff teams with whom a person was in contact
review and evaluate the course and quality of care or service provided
review legal and ethical matters, particularly those concerning sharing of information within and between services
seek the views of the person's family, carers and significant others
An ability to review the degree to which the service is operating in line with national and local guidance designed to reduce the risk of suicide, such as:
maintaining safe staffing levels
maintaining a consistent staff group who are familiar with the people in their care (by minimising staff turnover)
putting in place appropriate training for staff carrying out critical tasks (such as direct observations, search and restraint)

Clinical policies relating to the management of self-harm and suicide

An ability to review policies relevant to the safe management of people who self-harm or are suicidal, such as:
care planning
risk assessment
routine search
use of restraint
use of seclusion
use of observation
An ability to determine the ways in which these policies are implemented in practice (including arrangements for regular staff training)

Use of information and reporting systems

An ability to draw on knowledge of the information systems used in the workplace and the reporting arrangements used locally and nationally to record and flag serious incidents
An ability to examine information and reporting systems to ascertain the degree to which:
staff in the organisation routinely and systematically record information and particularly information potentially relevant to the management of self-harm and suicide (e.g. risk assessments, communication with other parts of the service or with other services)
the organisation follows up and acts on reports of adverse events and potential areas of concern (e.g. use of seclusion and restraint)
reporting of serious incidents to national external bodies is appropriate (e.g. CQC, NHS Improvement)

Effectiveness of leadership

- An ability to identify how information about potential adverse events or areas of concern is considered by senior leaders in the organisation, for example:
  - whether, how and at what level the organisation receives, takes account of and responds appropriately to information about serious incidents, unexpected deaths and previous incident reports
- An ability to assess the quality of reports of previous investigations (such as serious incidents), for example, considering:
  - the standard of investigation
  - the quality of the report
  - the appropriateness of the actions it recommended
- An ability to determine whether and how recommendations from previous investigations have been implemented

Dissemination

- An ability to draw on knowledge of the ways in which reports can be disseminated so as to be helpful to front-line staff and those close to the person (by giving them access to the report, by presenting its findings or otherwise providing a full account of the circumstances leading up to the death)
- An ability to report both in writing and to present information verbally to relevant parties
- An ability to recommend that reports are disseminated in a timely manner to:
  - all staff who can potentially learn from them, for example:
    - managers
    - staff (including front-line clinical staff, particularly those with whom the person was in contact)
    - other partners (such as local services or local agencies)
  - the person's family or carers