Memorandum of Understanding

Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive

Foreword

This protocol coincides with a changing culture in the NHS. Public and patient safety is being put at the forefront of everyday practice. This requires openness on the part of the individuals working in the NHS in reporting errors, ensuring that lessons are learned for the future and that patients concerned receive proper treatment. It also requires fairness when considering whether action is to be taken against the individuals concerned.

Some patient safety incidents involve systems failures while others may also involve the failure of an individual or individuals. We recognise the important role of the NHS in investigating such failures using methods being developed by the Department of Health, the National Patient Safety Agency and the Health and Safety Executive.

The Department of Health is pursuing its commitment to patient safety among other things by encouraging a shift in the NHS from a prevailing culture of blame to one that is fair and just. All experience in other high risk industries shows that a culture in which blame predominates in the handling of errors and adverse incidents creates a climate of fear leading to concealment of safety problems. This can lead potentially to more, rather than fewer, incidents.

As a result, the police and HSE may conduct initial investigations into matters of concern reported to them and the threshold for taking these forward is usually set at a high level. This means that such investigations should take place only where there is clear evidence of a criminal offence having been committed or where a breach of health and safety requirements is the likely cause or a significant contributory factor.

In taking forward such investigations, we recognise that the safety of the public and of patients is our first priority and that this requires a

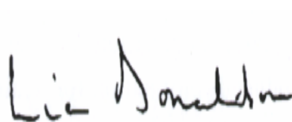
collaborative approach. This protocol sets out our agreement as to how this should be achieved.

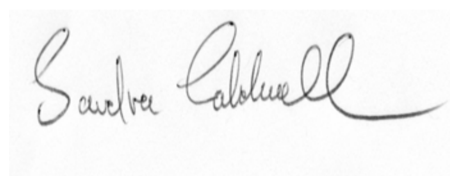
This protocol has been agreed between the Department of Health on behalf of the National Health Service, the Association of Chief Police Officers and the Health & Safety Executive. It will apply to patients receiving care and treatment from the NHS in England. It will also apply, with modifications, to Wales, where a separate memorandum will be issued. While the protocol does not apply in Scotland and Northern Ireland, the relevant bodies have been consulted informally about it.

The national group responsible for the work will monitor the use of the protocol so that it can be developed further in the light of experience. The first annual review will be preceded by a questionnaire to all three organisations.

We commend the protocol to you.

Signed





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February 2006

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Introduction

1. NHS patient safety incidents involving unexpected death or serious untoward harm and requiring investigation by the police and/or the Health & Safety Executive (HSE) are rare. However, there has been an increase in the number reported in the past few years. Such incidents must be handled correctly, both for the sake of public safety as well as confidence in the NHS, police and HSE and in the interests of fairness and justice.

2. It is important that investigations into such incidents - be they conducted by the NHS, police and/or HSE - are carried out effectively and consistently. These investigations and any remedial actions need to ensure that:

   - public and patient safety is assured
   - patients, where appropriate their relatives, and NHS staff are informed, consulted and supported
   - health & safety in the NHS workplace are safeguarded
   - NHS services are maintained as far as possible
   - the NHS can learn effectively from the incident to reduce future risks to patients
   - the actions of NHS staff and services are properly and promptly examined where appropriate
   - criminal investigations that may be necessary are conducted promptly and effectively with appropriate support from the NHS, helping to expedite decisions on any prosecutions
   - links are made to investigations conducted by coroners to ensure coordination and minimise duplication
   - links are made to other types of reviews or investigations as appropriate, for example, serious case reviews on children who die or are seriously injured where abuse or neglect is the cause or a factor in the death or injury

3. To achieve these objectives it is important that the three organisations communicate and work with one another in a consistent and well-coordinated manner. This will include informed decision-making about those incidents that require investigation by the police and/or the HSE, appropriate discussion and continued attention to the matter of safety. Sharing information and timely discussion are essential ingredients for such outcomes. Both need to be conducted in such a way that they do not impede the statutory responsibilities and duties of the three organisations or the coroner; or jeopardise any legal proceedings.

This protocol is intended to help the three agencies:

- meet their responsibilities for the safety of patients and NHS staff
- make clear to one another from the outset their particular statutory responsibilities
- set out their own operational needs
- prompt early decisions about the actions and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these
- provide an efficient and effective approach to the management of the investigation(s)
- develop and strengthen partnership working
- prompt the identification of lead personnel to manage liaison between the three agencies
- save time and other resources of all the agencies concerned.

4. In developing the protocol, the three signatory bodies have consulted widely, including publicly, and with a variety of organisations ranging from professional regulatory bodies to those representing victims. The views and opinions of NHS staff, police officers, HSE inspectors and others who have practical experience of these matters have also

been sought. All have offered strong support for the development of the protocol.

5. Guidelines to the NHS, an additional chapter in the Police murder manual dealing with investigations in healthcare and internal guidance to HSE inspectors support the protocol. A joint training programme is also being commissioned to spur the development of good practice. This will be aimed at NHS staff, police officers and HSE inspectors. A list of documents relevant to the protocol appears in annex 1.

6. Criminal investigations into deaths at work are covered by an existing agreement between the Association of Chief Police Officers (ACPO), HSE, Crown Prosecution Service and local authorities known as the *Work-related deaths protocol* (WRDP, see annex 1 for details). This memorandum of understanding does not affect the operation of the WRDP but should be used in conjunction with it.

1. Purpose

1.1. The purpose of this protocol is to promote effective working relationships between the three organisations. The protocol will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the police, or the police and the HSE jointly. This will normally be the case if an incident has arisen from or involves criminal intent, recklessness and/or gross negligence or, in the context of health & safety, involves a work-related death or serious injury.

1.2. The protocol sets out the general principles for the NHS, police and HSE to observe when liaising with one another. It focuses on investigations in NHS Trusts, although the principles and practices it promotes should apply to other locations where healthcare is provided and the NHS is required to investigate under its performance management and other duties. For example, it should apply when considering an incident in the practice of a family doctor or dentist.

1.3. The protocol provides a framework for embarking on such liaison and is supplemented by detailed guidelines to the NHS. Police officers and HSE inspectors have their own guidelines.

Circumstances in which the protocol will apply

1.4. This protocol applies to those patient safety incidents involving unexpected death or serious untoward harm requiring investigation by the police or by the police and HSE jointly. By definition, these incidents will be serious and may have significant public safety implications.

1.5. All patient safety incidents should be investigated fully using existing NHS procedures, including those developed by the Department of Health and the National Patient Safety Agency. This includes using the

services of such bodies as the Medicines and Healthcare products Regulatory Agency (MHRA) to investigate patient safety incidents involving devices or medicines. The majority of patient safety incidents can and should be dealt with by these means.

2. Roles and responsibilities of the three organisations and other relevant bodies

2.1. NHS bodies, the police and the HSE have various responsibilities in relation to investigating patient safety incidents in the NHS.

2.2. **NHS bodies** have a responsibility, among other things, to ensure the safety and well being of patients and staff and to investigate when things go wrong. This responsibility is placed upon every NHS chief executive and upon the board of their organisation and is a critical component of corporate and clinical governance. NHS organisations must conform to national and local policies and procedures in discharging this responsibility.

2.3. **The police**, who also have a duty to uphold public safety, may investigate all criminal offences and, in doing so, will seek to balance matters of public safety against the need to prosecute.

2.4. **The HSE** is responsible for the enforcement of the Health & Safety at Work etc Act 1974 (HSWA) throughout Great Britain. Its work includes ensuring that 'risks to people's health and safety from work activities are properly controlled'. The HSE does not normally seek to apply the HSWA to matters of clinical judgement or to the level of provision of care, although it is responsible for enforcing work- related health and safety legislation in a variety of settings including hospitals and nursing homes.

2.5. Other organisations may also have a role in investigating patient safety incidents. These include the coroner, Medicines and Healthcare products Regulatory Agency and the Healthcare Commission. (The associated guidelines contain more information about those organisations that may play a role in investigating patient safety incidents including the actions of the professional staff associated with the incident.) On occasions patient safety incidents may also result in

other concerns coming to light e.g. fraud. In such instances, the NHS Counter Fraud and Security Management Service must be informed.

2.6. For the purposes of this protocol, an NHS patient is defined as: 'A person receiving care or treatment under the NHS Act'.

Patient safety incidents that may involve the police or the police and HSE

2.7. The types of patient safety incident that may prompt an NHS Trust to involve the police are those that display one or more of the following characteristics:

- evidence or suspicion that the actions leading to harm were intended
- evidence or suspicion that adverse consequences were intended
- evidence or suspicion of gross negligence and/or recklessness in a serious safety incident, including as a result of failure to follow safe practice or procedure or protocols.

2.8. The police and/or HSE may also investigate an incident following contact by patients, relatives or, in the case of the death of a patient, by a coroner. Further information about the coroner is given in the NHS guidelines.

2.9. NHS guidelines contain general definitions of terms such as gross negligence, manslaughter, recklessness and corporate manslaughter.

2.10. Some accidents to patients must be reported to the HSE by NHS Trusts under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). HSE will normally investigate all fatal accidents reported under RIDDOR, but not accidents to patients that arise from medical treatment or diagnosis.

2.11. The police may decide either initially or later in their investigation that a death or serious injury to a patient may have been caused by the use of unsafe equipment or procedures. In such cases, they may consider referring the incident to HSE whether or not it was reportable under RIDDOR. Given the potentially large number of such events, the HSE will apply normal criteria in deciding whether it should investigate. General liaison between the police, HSE, local authorities and the Crown Prosecution Service over deaths in the workplace is covered by the *Work-related deaths protocol*.

3. Immediate action following the reporting of an incident

3.1. It will sometimes be immediately obvious to NHS Trusts that the police and/or the HSE should be contacted, but in other cases the need may not come to light until the Trust, coroner or other body such as the Medicines and Healthcare products Regulatory Agency has carried out its own investigations. The decision to report an incident to the police should be made at a sufficiently senior level, for example, by either the chief executive or another executive director.

3.2. Once such a decision has been taken, representatives of the Trust, police and, where appropriate HSE, should arrange an initial meeting. The meeting of this 'Incident Coordination Group' should be called as soon as practicable following the referral and, in any case, the group should meet within five working days of the referral. All three organisations are entitled to call an Incident Coordination Group, but responsibility for organising the meeting rests with the NHS.

3.3. The police and/or the HSE may also call an Incident Coordination Group in response to a complaint, referral from a coroner or in response to other concerns.

3.4. Until the first meeting of the Incident Coordination Group, the Trust should continue to deal with concerns about patient safety but not undertake any activity that may compromise any subsequent investigations conducted by the police and/or the HSE. If in doubt about this matter, the Trust should seek legal advice and consult the police, the HSE or where appropriate, other investigating bodies.

3.5. It is also critical that any relevant physical, scientific and documentary evidence is secured and preserved.

3.6. It is important to recognise that some patient safety incidents may result in the police or HSE investigating possible offences by individual NHS employees and / or the NHS employer. Investigation of the NHS employer will normally involve the HSE because health and safety legislation places the primary responsibility on the employer. In such cases, it may not be appropriate for those who may be investigated or could be defendants in a criminal case to be members of the Incident Coordination Group. When this issue arises, it should normally be discussed at the outset by the agencies involved and, if necessary, the strategic health authority should take on the role of liaising with the police and HSE on behalf of the Trust. In the case of Foundation Trusts, this liaison may be taken on by the appropriate Primary Care Trust.

4. The Incident Coordination Group

4.1. The purpose of the Incident Coordination Group is to provide strategic oversight of a patient safety incident involving the NHS and the police and/or HSE. It is a forum for communicating, exchanging information and coordinating multiple investigations. It allows all three organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation e.g. legal proceedings, or the phasing, extent and timing of further NHS investigations.

The Incident Coordination Group has no role in directing the investigations of the police and/or the HSE.

4.2. Those who attend on behalf of the three organisations should be sufficiently senior to take decisions concerning the management of the incident. They must also have sufficient skills, experience and training to deal with any immediate concerns. Police representation should normally be an accredited senior investigating officer at the level of inspector or above. HSE representation will normally be at main grade inspector level. NHS representation will normally be at executive director level. In instances of suspicious death, the Incident Coordination Group may ask the coroner if he or she wishes to send a representative to the meeting, in addition to the police. In instances of the unexpected death of a child where an investigation under child protection procedures might be appropriate, the Incident Coordination Group may want to ask children's social services if they want to send a representative to the meeting. The NHS should chair the first meeting of the group unless the circumstances preclude this.

4.3. The first meeting of the Incident Coordination Group should consider matters under the following headings (model documents for the Incident Coordination Group are provided in the associated NHS guidelines and include terms of reference, a draft agenda for the first meeting and responsibilities for action):

- nature of the incident(s)
- reasons for meeting, including an explanation from the organisation responsible for calling the meeting
- NHS actions to date, including the outcome of any internal or external investigation or root cause analysis
- public safety concerns
- safety of NHS systems and the need for continuity of patient care i.e. the need for remedial action, further investigation by the NHS or reporting to another safety body
- the extent of further, immediate NHS investigations and how these may need to be constrained in subject matter or format by the needs and requirements of the police and/or HSE
- role and responsibilities of the police and/or HSE and next steps to be taken (except where this would jeopardise any police/HSE investigations or subsequent legal proceedings)
- other statutory responsibilities e.g. safeguarding children
- need to inform professional regulatory bodies e.g. General Medical Council, General Dental Council, Nursing and Midwifery Council
- need to inform and involve other investigating bodies e.g. the Medicines and Healthcare products Regulatory Agency, Healthcare Commission
- securing and preserving evidence
- sharing information
- needs of and support to patients, relatives and NHS staff

- information to other interested parties e.g. the coroner
- handling communications/media
- future handling and coordination, including the appointment of a liaison officer from each organisation.

4.4. The precise nature of what is discussed at the first meeting of an Incident Coordination Group will be determined by local circumstances. However, all the above issues should be considered even if some are covered in more detail than others.

Responsibility for investigating

4.5. Where possible, the police and/or the HSE will come to an early view about the nature of the incident and where responsibility for any future investigation lies. For instance, the police and HSE may conclude that they have no further role in the matter. On some occasions, it may be decided that the Trust should investigate further and, if more information or evidence comes to light, convene another meeting of the Incident Coordination Group to discuss its findings. This will provide an opportunity for the police and/or HSE to decide if they need to conduct their own investigation or if some other course is appropriate.

4.6. There will be occasions when the incident may raise important concerns about wider patient safety. In such circumstances, the conduct of any further NHS investigations will need to be discussed by the Incident Coordination Group so that the necessary further investigation by the NHS can be conducted in such a way as to avoid the danger of prejudicing the police and/or HSE investigation, for example, by interviewing members of staff who may subsequently give evidence at court.

Documenting the Incident Coordination Group

4.7. A written record of each meeting of the Incident Coordination Group must be made. This should set out matters discussed, decisions reached and actions agreed by each agency. Where possible, objectives should be agreed and further meetings of the Incident Coordination Group scheduled to correspond with these. The NHS has responsibility for preparing the written record and for circulating it to other agencies. It is important that these meetings take place so as to ensure that all agencies remain up to date with one another's actions and so that communications with other parties remain consistent.

4.8. A meeting of the Incident Coordination Group should take place also at the conclusion of any investigation into a patient safety incident. This should provide an opportunity to consider what went well and what could be improved. Learning from such de-briefings will allow the national and local arrangements to be improved.

5. Securing and preserving evidence

5.1. It is easy in the immediate aftermath of a patient safety incident to overlook the need to secure and preserve evidence. This may be particularly true of busy clinical areas that are in constant use by patients and staff and when people are following routine Trust operational practice *e.g.* sterilising a piece of equipment after a procedure or operation.

5.2. However, safeguarding physical, scientific and documentary evidence may be critical to understanding what has happened, thereby protecting public safety and ensuring the conduct of a satisfactory investigation by any agency. Destruction of evidence may also delay the introduction of safety measures. It may also lead to a more protracted and complex investigation than would otherwise have been necessary. For example, the absence of the packaging and batch number of a piece of equipment may lead to a delay in the Medicines and Healthcare products Regulatory Agency issuing a medical device alert to the NHS or instituting appropriate investigations into a device or medicine.

5.3. It is especially important that evidence is retained where a criminal offence is suspected, since failure to do so may undermine legal proceedings.

5.4. Even in incidents where concerns arise long after the event, it is important to make every effort to secure and preserve all available evidence.

5.5. A record must also be kept and receipts obtained wherever possible of any NHS documents, records or other items passed to other agencies.

6. Sharing information

6.1. The NHS, police and HSE have a duty to uphold the health and safety of patients and the public in addition to their responsibilities for investigation and enforcement. In discharging this duty, the three organisations will share all appropriate information where necessary to ensure patient safety. Such sharing should take account of the health and safety of patients and the public and the legal responsibilities and duties of the three organisations, in particular the limits on what information the organisations may disclose during criminal investigations.

6.2. The three organisations also need to share information to discharge their specific responsibilities.

NHS

- to ensure the safety of patients and wider NHS systems and processes
- to continue to manage health services in a timely and effective manner and ensure the delivery of services to patients

Police/HSE

- to conduct investigations in a way that helps maintain patient safety as a priority
- to conduct investigations in a timely and effective manner

6.3. Subject to legal requirements and safety concerns, there are a number of factors to bear in mind when making judgements about sharing information. These include:

- the nature and degree of risk associated with the incident itself and the circumstances and individuals involved

- the purpose for which any shared information is to be used and by whom
- whether consent to disclosure is necessary and, if so, whether it can be obtained
- current law and guidance e.g. the statutory requirement to provide information to the HSE and the obligations put upon different professionals by their individual codes of conduct
- confidentiality agreements with those with whom information is shared
- the justification for any necessary breach of patient confidentiality

6.4. Sharing information is an important matter for the Incident Coordination Group to consider. Where necessary, legal or other specialist advice *e.g.* from professional, regulatory or indemnifying bodies – including that of the Crown Prosecution Service – should be sought.

6.5. It may sometimes be necessary for the police and/or HSE to interview NHS staff. All efforts should be made following an incident to encourage NHS staff to make early, voluntary statements. Where necessary, NHS staff should be given access to legal representation for this purpose.

7. Supporting those harmed, patients, relatives and NHS staff

7.1. In the event of a patient safety incident it is important that the NHS, police and/or HSE work together to keep patients, relatives, injured parties and NHS staff informed and to provide support as appropriate. The organisations should therefore, as far as possible, agree and follow a liaison strategy for each incident. Such a strategy should be agreed at the first meeting of the Incident Coordination Group and as necessary at subsequent meetings.

8. Handling communications

8.1. A communications strategy needs to be agreed for dealing with patients, relatives, other organisations and the media. Where possible, the three organisations need to take a common approach to communications although in the event of legal proceedings this may not be practicable. Specialist help and advice should be sought as necessary.

9. Monitoring the implementation of the protocol

9.1. Good practice suggests that the protocol should be subject to regular review both locally and nationally and that the practical experience of liaising and working together should be evaluated and lessons learned. The three organisations will ensure that this happens and the national development group will review use of the protocol at the end of the first year.

Acknowledgements

The national development group is grateful to individuals and organisations that helped to develop this protocol and the associated guidelines.

Other related documents and websites

More information can be found in the following free publications or via the following web sites.

Seven steps to patient safety – a guide for NHS staff SSG/2003/01 The National Patient Safety Agency

Decision making tool to reduce unnecessary suspensions and support a safety culture – The National Patient Safety Agency
www.npsa.nhs.uk/idt

Maintaining high professional standards in a modern NHS: A framework for the initial handling of concerns about doctors and dentists in the NHS HSC 2003/012

Confidentiality: Code of Practice Department of Health, November 2003

Working Together to Safeguard Children Department of Health, Home Office, Department for Education & Employment, December 1999. The Stationery Office, London

Work related deaths protocol MISC491 02/03 C140, Health & Safety Executive

Websites:
National Patient Safety Agency
www.npsa.nhs.uk

Department of Health
www.dh.gov.uk

Department for Education and Skills
www.everychildmatters.gov.uk

Health & Safety Executive
www.hse.gov.uk

NHS Counter Fraud & Security Management Service
www.cfs.nhs.uk/pub/sms/documents.html

Healthcare Commission
www.chai.org.uk

Medicines and Healthcare products Regulatory Agency
www.mhra.gov.uk

Independent Healthcare Forum
www.ihf.org.uk

Membership of MOU national development group

Police

John Broughton, Assistant Chief Constable, Association of Chief Police Officers (chair)

Ian McNeill, Chief Superintendent, Association of Chief Police Officers

Steve Watts, Detective Chief Superintendent, Association of Chief Police Officers

Paul Fell, Detective Chief Inspector, Association of Chief Police Officers

Adrian Tyson, Detective Chief Inspector, Association of Chief Police Officers

HSE

Chris Taylor, HM Principal Inspector of Health & Safety, Health & Safety Executive

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Department of Health

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Observer

Dr Heather Neagle, Medical Officer, Department of Health, Social Services & Public Safety, Northern Ireland (observer in 2004)

Janet Attwell-Thomas, Clinical Governance Support, Welsh Assembly Government, Department of Health

Organisations consulted when developing the MOU & those that responded to public consultation

Organisations consulted when developing the MOU

Commission for Health Improvement
Coroners' Officers Association
Coroners' Society
Crown Prosecution Service
General Dental Council
General Medical Council
Medicines & Healthcare products Regulatory Agency
National Clinical Assessment Authority
National Patient Safety Agency
Nursing & Midwifery Council

Organisations that responded to public consultation

Action against Medical Accidents
Addenbrooke's Hospital
Bassetlaw PCT
Bedford Hospital
Birkenhead & Wallasey PCT
Bournemouth Teaching PCT
Bristol North PCT
Capsticks
Cardiff University
Christie Hospital, Manchester
Coroners' Officers Association
County Durham and Darlington NHS Trust
County Durham and Tees Valley NHS Trust
Crown Prosecution Service
Department for Education and Skills
DHSSPS, Belfast (Dept. of Health, Social Security & Public Safety)
Derbyshire Constabulary
Devon & Cornwall Police
Doncaster and Bassetlaw Hospitals
Ealing Hospital PCT
Epping Forest PCT
Field Fisher Waterhouse
Five Boroughs Partnership
General Dental Council
General Infirmary at Leeds
Greater Manchester SHA
Guild of Healthcare Pharmacists

Gwent Community Health Council
Hartlepool PCT
Health and Safety Executive (internal consultation)
Healthcare Commission
Herefordshire PCT
Hertfordshire Constabulary
Home Office
Lancashire Teaching Hospitals
Leeds Teaching Hospitals NHS Trust
London Ambulance Service
Maidstone and Tunbridge Wells NHS Trust
Medical Defence Union
Medical Protection Society
Mentoring Associates Ltd
Mid Cheshire Hospital
Mid Yorkshire Hospitals
NACRO (National Association for Care & Resettlement of Offenders)
Newcastle Under Lyme
Bradwell Hospital, North Staffs NHS
North Middlesex Hospital
North Sheffield PCT
Northampton PCT
Nursing & Midwifery Council
Peterborough & Stamford Hospitals
Queens Mary's Hospital, Sidcup NHS Trust
Rethink Severe Mental Illness
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics & Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians Edinburgh
Royal Pharmaceutical Society
School of Nursing & Midwifery, University of East Anglia
Sunderland Social Services Department
South Essex Partnership NHS Trust
South Warwickshire PCT
South Yorkshire Police
Staffordshire Moorlands PCT
Staffordshire Police
Suffolk Police
The Queen Victoria Hospital, NHS Foundation Trust, East Grinstead
The Royal College of Anaesthetists
The Royal College of Midwives
University Hospitals of Leicester
Victim Support
Wandsworth PCT
West Cumbria PCT
West Dorset General Hospitals

West Sussex Health and Social Care NHS Trust
West Yorkshire SHA

TERMS OF REFERENCE

MEMORANDUM OF UNDERSTANDING

Aim

To create a Memorandum of Understanding concerning the investigation of serious incidents affecting NHS Patients which require Police and/or the Health and Safety Executive (HSE) intervention. The Memorandum will be drawn up by the Department of Health, the Association of Chief Police Officers and the HSE, with the overriding objective of enhancing public safety. The Memorandum will:

- Agree on the role and responsibility of each agency when dealing with incidents involving NHS patients in England;
- Provide guidance to the NHS about identifying incidents which require, or may require, referral to the Police, HSE or other agencies, and then procedure to be followed;
- Determine and agree the process for the initial referral and response (the first 24 hours) by the relevant agency(s);
- Provide guidance for the NHS, the Police and others about working together effectively, including points of contact; and
- Determine the internal/external communication strategy for the work of the National MOU Group.

The memorandum will apply to serious incidents and those patients defined in the document, and will provide guidance for the investigation of other incidents involving the NHS, the Police and/or HSE. All of the above objectives will take account of national best practice from the respective organisations and other bodies.