Aberlour Child Care Trust – Duty of Candour report 2023 - 2024

The health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 was implemented on 1st April 2018 placing an organisational duty (Duty of Candour) on health, care, and social work services. This is a legal requirement which means that when things go wrong and mistakes happen, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about the duty of candour in our services. This short report describes how Aberlour Child Care Trust has operated the duty of candour during the time between 1 April 2023 and 31 March 2024.

1. How many incidents happened to which the duty of candour applies?

In the reporting year, one incident occurred to which the duty of candour applied.

Type of unexpected or unintended incident where duty of candour applies	Number of times this has happened
A person dies	0
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	0
Harm which is not severe but results or could have resulted in	
An increase in the person's treatment	0
Changes to the person's body	0
The shortening of the life expectancy of the person	0
An impairment of the sensory, motor, physiological or intellectual functions which lasted, or is likely to last for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	0
The person required treatment by a registered health professional in order to prevent	
The person dying	0
An injury to the person which if left untreated would lead to one or more of the outcomes mentioned above	1

2. Summary of incident

An incident took place within one of our residential services and involved a young person falling from a swing, resulting in breaks to their ankle and leg.

3. Review

Organisations must carry out a review of the circumstances which they consider led or contributed to the unintended or unexpected incident.

A full investigation, carried out under our Health and Safety Procedures, found that the swing was known to be unsafe and removed from the play area, yet it was put back and resulted in a serious accident that resulted in injuries to a young person. An action plan was drawn up including:

- Immediate removal of the play equipment
- development and dissemination of guidance on responsibilities and how to carry out daily and weekly checks on equipment.
- database of all equipment and commissioning of different external inspector for play equipment.

There was a delay in recognising that the incident triggered the organisational duty of candour in that it 'would have caused pain for a period of at least 28 days *if it had not been treated*.' Thereafter it took time to identify a health professional to confirm this.

Timeline

May 16th, 2023, Accident – reported under RIDDOR and to Care Inspectorate
2nd June 2024 - Investigation completed
28th June – potential for duty of Candour identified internally.
July – August delay in identifying health professional to confirm
28th September 2023 - Written apology and offer of meeting extended under Duty of Candour. The letter outlined the steps the organisation had taken to learn from the accident.

2. Our duty of candour procedures

Training and awareness

Relevant Managers in Aberlour carryout e-learning on duty of candour legislation.
All new managers learn about the duty of candour at their induction.

When an incident happens

All managers reviewing incidents will consider if Duty of Candour applies. Where something has happened that a staff member believes triggers the duty of candour, we will follow the 4 step process outlined in the Scottish Government Health Care Standards on Duty of Candour.

Learning from incidents

Aberlour is committed to learning from mistakes. We have carried out all actions identified in our action plan. We have communicated our learning with regards identifying incidents triggering organisational duty of Candour with regards pain which would have lasted 28 *days without treatment.* We have developed a proforma for recording any future duty of candour incidents. Our

Health and Safety Steering group has a standing agenda item for consideration of organisational duty of candour.

If you would like more information, please contact:

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