



NETWORK GUIDELINE

Guideline:	Duty of Candour – A Network Approach
Version:	1
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Consultation:	CNN & TPN Clinical Governance Groups
Distribution:	Neonatal Units within EMNODN
Risk Managed:	Ensuring appropriate communication between parents, providers and CenTre Neonatal Transport service around clinical incidents

This document is a guideline. Its interpretation and application remains the responsibility of the individual clinician, particularly in view of its applicability across the different Trusts in the East Midlands Neonatal Operational Delivery Network. Please also consult any local policy/guideline document where appropriate and if in doubt contact a senior colleague.

This guideline was previously a joint Central Newborn & Trent Perinatal Networks Guideline.

Caution is advised when using guidelines after a review date.

REVIEW AND AMENDMENT LOG

Version	Type of Change	Date	Description of Change
1	-	May 2016	-
1	No change	May 2020	Joint CNN & TPN Guideline transferred to EMNODN Guideline format

Whilst it is well understood that parents need to be informed of any adverse incidents that occur during neonatal care, the statutory requirements of Duty of Candour mean that a formalised process for sharing information with parents, when babies are moved between units, is required.

The requirements:

Any incident that could result in moderate or severe harm, prolonged psychological harm or death – REGARDLESS OF FAULT.

- Recognise and report
- Inform parent/carer
- Apologise
- Write to parent/carer following discussion
- Document
- Investigate
- Update

This must be in a timely manner, ideally within 7 days.

This can create difficulties when an incident has occurred in one hospital, or during transport, and the baby is then residing in a different hospital. It is also possible that the baby's mother may still be in the original hospital.

It is essential that each trust has an internal process for managing incidents, and that this is reviewed in light of the recent statutory duty of candour requirements.

Neonatal Incidents:

Incidents that do not involve transfer of an infant should be managed as per the trusts risk management policy, and duty of candour requirements met.

If the infant is transferred then it is essential that clear communication between the referring team, receiving team, and transport service where appropriate, occurs so that a plan for communicating with parents according to the duty of candour requirements is met. Due to the timeliness of the duty of candour requirements, it is practical that the consultant who is in the hospital within which the parents are located will usually have these discussions. Whilst an initial discussion may be had, detailed discussions should not occur until all the fact finding about the incident has taken place, by liaising with the consultant responsible for the infants care when the incident occurred. If there is to be a further incident investigation, and the opportunity for the parents to discuss this with the team where the incident occurred, then reference to this opportunity should be made during the DOC discussion and documentation.

The process of managing neonatal incidents is summarised in the flow-chart below ([Fig-1](#)).

Serious Untoward Incidents (SUIs) should continue to be reported through current pathways and copied to the network team.

Obstetric incidents

If an obstetric incident or concern is brought to a neonatologist/paediatricians attention, we have a duty of candour to ensure that this is raised and reviewed. We are not obstetricians and should not be discussing the details of obstetric concerns with parents. Again this may prove difficult when parents have moved from one unit to another. Liaison with referring and receiving unit obstetric staff to ensure that the parents are informed may be required.

Fig-1

