**Incident Reporting and Management Policy and Procedure**

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| Version: | V3 |
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| Responsible management group: | Patient Safety Oversight Group (PSOG)  |
| Directorate/team accountable: | Quality & Nursing |

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| --- | --- |
| Security Access/ Sensitivity | Public Domain |
| Where Held | Corporate Records Register |
| Disposal Method and Date  | In line with national guidelines |

**Supports Standard(s)/KLOE**

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|  | **Care Quality Commission (CQC)** | **IG Toolkit** | **Other** |
| Criteria/KLOE: | Name core service area and CREWS elements |  |  |

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1. **Introduction**
	1. South East Coast Ambulance NHS Foundation Trust (here after known as the Trust) is committed to an open and just culture on the reporting of incidents. This is to empower staff to report all incidents that affect the safety of patients, staff, contractors, and the Trust whether harm has occurred or not, or if a near miss event. Evidence shows that health services with higher reporting of incidents learn more from them compared to those organisations with lower reporting. The aim for the organisation to develop a culture where staff are praised for raising incidents where they have made a mistake. The Trust believes that operating units with a greater number of incidents reported are viewed positively, as they are considered to have a greater level of patient safety awareness.
	2. The Trust’s reporting tool is DatixCloudIQ (DCIQ) to report all adverse incidents and near misses. Historical data is stored on DatixWeb. These systems are the Trust’s databases for all patient safety information including incidents, complaints, compliments, safeguarding, learning from deaths, claims, risks, and safety alerts.
	3. This document is intended to support the proactive reporting and effective management of incidents, and to facilitate learning to minimise and prevent future incidents to patients, staff, and other stakeholders.
2. **Aims and Objectives**
	1. The objectives of this policy are as follows;
* Outline the process and the stages of incident reporting.
* Identify the responsibilities of individual posts and groups in response to the management of incidents.
* Understand what constitutes an incident.
* Ensure the Trust prioritises the management and governance of incidents.
* Maintain consistency in approach across the Trust.
* Ensure the Trust acts in a transparent manner.
* Involve and fully inform service users, stakeholders and staff and act in a manner consistent with the Statutory Duty of Candour.
* Ensure there is an emphasis on learning and action is taken to minimise reoccurrence.
* Share learning across the Trust and when appropriate the Ambulance Service and wider NHS.
1. **Definitions**
	1. **Incident reporting tool** – DCIQ (current data) DatixWeb (historical data prior to January 2024)
	2. **Incident:** Any adverse event or circumstance arising that could have or did lead to unintended or unexpected harm, loss or damage to patients, staff, visitors, carers, members of the public or Trust premises, property, other assets, information, or any other aspect of the organisation. They can involve any number of different factors, e.g. injury, damage, loss, fire, theft, violence, abuse, accidents, ill health, disruption to services etc. (Appendix A provides an overview of incident types with a working definition).
	3. **Risk:** is an uncertain future event.
	4. **Issue:** is an obstacle or challenge which is already present. It may be a risk which has materialised.
	5. **INC1 / DIF1:** Incident Form 1 (reporting form), the form that all staff have access to on DCIQ, to report incidents.
	6. **INC2 / DIF2:** Incident Form 2 (management form), the form used by managers to investigate/review incidents.
	7. **Near Miss or Prevented Incident:** An incident that was prevented from occurring, whether intentionally or by chance, so did not lead to harm, loss or damage but had serious potential to do so. Where lessons can be learnt to implement changes in procedures, processes and systems, for example a prevented clinical/patient safety incident.
	8. **BIF1 Form:** Back-up incident form 1, the form to be used when the system is not working.
	9. **Patient Safety Incident (PSI)**: Any incident that has involved or could have affected the safety of one or more service users. Patient safety incidents are reported directly to NHS England via the Learning From Patient Safety Events (LFPSE) portal.
	10. **Duty of Candour (DoC)**: This is a statutory requirement which describes being open and honest in communication with patients for incidents that have resulted in moderate harm, severe harm and death.
	11. **Hazard:** something with the potential to cause injury, ill health, harm, damage or loss and may include substances, equipment, or a work practice.
	12. **RIDDOR:** Reporting of Injuries, Diseases, Dangerous Occurrences Regulations. This is legislation that requires certain information on workplace and health and safety incidents to be reported to the Health and Safety Executive.
	13. **Accident:** An unplanned and uncontrolled event that has led to harm to people, property or process. Examples include incidents that have caused injury, ill health, loss or damage to equipment.
	14. **Handler**: Handlers are assigned to incidents to enable accountability of the incident review/investigation and assist with the completion of the required review. The Manager/Handler (OM/OUM or head of department) has the responsibility of ensuring a suitable investigator is assigned and the incident review/investigation is completed within the required time.
	15. **Investigator:** person(s) assigned by the handler to undertake a review of the issue being raised and to identify any actions and learning that need to take place.
	16. **Working Days:** A day that is not Saturday, Sunday or a Bank Holiday.
2. **Responsibilities**
	1. **The Trust Board**: will consider the overall safety of the Trust based upon the trends and themes within reports.
	2. **The Quality & Patient Safety Committee**: is directly accountable to the Trust Board and seeks to provide assurance relating to systems and procedures relating to patient safety. The committee will receive reports relating to the incident management process and issues highlighted through investigations in order to provide assurance to the board, or to raise concerns.
	3. **The Chief Executive Officer**: as Accountable Officer, they have overall responsibility on behalf of the Trust Board for risk management and patient safety, including the management of incidents. The Chief Executive delegates specific roles and responsibilities to the appointed executive director/senior managers to ensure incident management is co-ordinated and implemented equitably to meet the Trust’s strategic objectives.
	4. **The Executive Director of Quality and Nursing**: is responsible for the incident management process, including all incidents identified as relating to Patient Safety. They have Trust Board level responsibility for quality, regulatory compliance, health & safety, safeguarding adults and children, patient experience, decontamination, and infection prevention and control. The Director of Quality and Nursing is the executive lead for Duty of Candour and will ensure there is an open, honest, and transparent culture throughout the incident process.
	5. **The Chief Medical Officer**: has delegated Trust Board level responsibility for Medicines Management, clinical outcomes and clinical effectiveness. The Chief Medical Officer is both the designated Controlled Drugs Accountable Officer and Caldicott Guardian.
	6. **Executive Directors**: have unitary responsibility for the safety of services. Each Executive Director is also responsible for the safety of the services within their remit.
	7. **The Head of Patient Safety**: is responsible for ensuring this policy is in line with government legislation, Department of Health and Social care policy, and other regulatory policy and / or frameworks. They are also responsible for ensuring the incident management process is not isolated and has integration with incident reporting processes and evaluation of patient experience and clinical outcomes.
	8. **The Patient Safety System Manager:** will ensure that Patient Safety Systems are kept in line with current patient safety guidelines and that the system operates smoothly. They will raise any issues that cannot be resolved by the Incident Team for external support.
	9. **All** **staff:** have a responsibility for identifying, reporting and managing incidents. This includes improving the delivery/quality of services through the implementation of corrective/mitigating actions and preventative action plans through lessons identified.
3. **Principles and Process**
	1. **Approach**
		1. An open approach to reporting incidents will enhance the Trust’s ability to learn. The Trust aims to move away from apportioning blame when an incident occurs and focus on Trust wide learning. The Trust promotes a culture that fosters learning and improvement whilst encouraging accountability by committing to an open and fair culture and promoting a non-punitive approach to the investigation of incidents.
		2. This policy does not cover performance and disciplinary processes. The Trust recognises that a systems approach using various learning response methodologies to investigate incidents will offer the most effective opportunity to learn lessons and prevent reoccurrence.
		3. The Trust is required to report all patient safety incidents (PSIs) through to the Learning from Patient Safety Events (LFPSE), and this should be completed at the time of reporting, by the reporter completing the relevant fields on the INC1.
		4. Staff will not be subject to disciplinary action or suffer any material loss or disadvantage when an incident is the result of human error. The following are guiding principles when assessing human error:
		* The absence of criminal behaviour.
		* The absence of patient abuse.
		* The absence of gross negligence.
		* The absence of an intention to cause harm to the patient.
		* The absence of a drug or alcohol problem with the member of staff.
		* The intention of the staff member was to do their best for the patient.
		* The member of staff can offer an explanation/personal logic to their behaviour.
		* Another body of individuals possessing the same level of skill and experience in the same set of circumstances would be likely to behave in the same way.
	2. **Types of Incidents to be Reported**
		1. The Trust operates an incident reporting tool for all incidents. On submission of the report form an automatic notification is provided to key individuals, such as the responsible lead to ensure that prompt and appropriate support is provided. All Trust staff must be able to access this system to report incidents and should only use their internal secamb.nhs.uk email addresses to complete this process.
		2. Where an incident relates to concerns raised by non-Trust members (members of the public or clinical staff from external organisations) this must be raised on the DCIQ on their behalf by a member of the Incident team. Staff receiving such notifications should forward them to the Incident team Inbox (Datix@secamb.nhs.uk). The personal / work email addresses of the non-Trust member must not be included in the reporting form for the purposes of receiving the automated notification.
		3. It is the responsibility of all staff to report any adverse incidents, potential incidents (i.e. near misses) and all identified hazards and risks. In all cases, reports must be made as soon as is practicable with best practice being within 24 hours of the incident occurring.
		4. Sub-contractors and consultant staff working on behalf of the Trust are equally required to report all adverse incidents. If any staff member is unable to access DCIQ or require support to report incidents, they can seek assistance from a colleague or the Patient Safety Team. Inability to access DCIQ is not an explanation for failing to report incidents.
		5. It is essential that all cases are reported where there has been or there was the potential for patient safety to be compromised using DCIQ in order to maintain the Trust’s proactive approach to learning from these events.
		6. On receipt of the incident, the Incident team will review all the information submitted to check for quality and completeness. They will ensure that the categorisation of the incident is correct and assign a handler. The Incident Team are also responsible for ensuring that all patient safety events have been reported to the NHS England Learning from Patient Safety Events (LFPSE) portal and raised with the Patient Safety Team for further review.
		7. Where two or more situations occur within one incident (as per the definition of incident above), separate DCIQ records must be submitted for each situation.

1. **Incident Grading**
	1. Incidents must be initially graded to establish the level of harm caused by the Trust (based on guidance from NHS England [NHS England » Policy guidance on recording patient safety events and levels of harm](https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/#definitions-harm-grading)). The grades of severity are reported as:
* None (No harm caused)
* Near Miss
* Low (minimal harm caused)
* Moderate (short term harm caused)
* Severe (permanent or long-term harm caused)
* Death / Fatal (caused by the incident)
	1. The majority of incidents that relate to staff or affect the Trust will be reviewed at a local level. All incidents that are reported as affecting a patient will be reviewed by the Patient Safety Team and where deemed appropriate, the incident will be referred to the weekly Incident Review Group (IRG) Where the most appropriate learning response will be determined.

* 1. Consideration should also be given to risks arising out of incidents, viewed as serious enough to be placed on the Trust Risk Register at directorate, corporate or strategic level. Please email risk@secamb.nhs.uk to report a risk.

1. **Incident Reporting Cycle**
	1. A process map supports this policy by identifying the expectations for the reporting and investigating of incidents and is supplied in Appendix B.
	2. Comply with ‘Being Open and honest’ and the Duty of Candour requirements and ensure all conversations and other forms of communication is documented within the appropriate section of DCIQ. Further guidance can be found in the policy document [here](https://secamb.sharepoint.com/sites/Intranet-Policies-and-Procedures/SitePages/Being-Open-and-Duty-of-Candour-Policy.aspx).
	3. If any equipment or medication are involved, please record all relevant serial or batch numbers so that it can be tracked. If equipment is then marked as out of service to stop further incidents occurring, the reporter must arrange to have the item removed by reporting it to the Medical Equipment Specialist (MES). The full process for this action can be found within the Medical Devices Management Policy.
	4. Staff should ensure that an INC1 is accurately completed as soon as reasonably practicable. The reporter should include as much detail as possible so that investigators and incident staff can investigate the incident without delay.
	5. Once the reporter has submitted a INC1 they will receive a notification that the incident has been received by DCIQ. Dependent upon what is reported, emails could also be sent to other relevant departments to make them aware of the incident.
	6. After initial quality checks by the Incident team, the manager/handler of the incident will then be assigned. They will need to allocate an investigator within 5 working days. On occasions, the manager/handler will undertake the investigation themselves.
	7. The manager/handler, if applicable, can assign one or more investigators to aid in the assistance of the investigation. The investigators have 30 working days to complete the investigation and move it to ‘awaiting closure’.
	8. The Incident team has 10 working days to review the INC2 and approve it for closure if the investigation is satisfactory and addresses the concerns raised. If it is deemed that this is not met, the incident will be returned to the investigator for additional information.
	9. The Incident Team’s final review includes checking investigation notes, ensuring final severity has been completed, RIDDOR has been completed (if applicable), the PSIRF review has been completed, and Duty of Candour has been completed. If the incident has met these criteria, it will be closed.
2. **Reporting to External Agencies**
	1. When a member of Trust staff witnesses or subsequently discovers an incident caused by or occurring in another NHS Trust or healthcare organisation, an incident report should be completed in the usual way giving as much information as possible so that the organisation can be contacted and the incident identified.
	2. The Trust is required to report all patient safety incidents (PSIs) to LFPSE, and this should be completed at the time of reporting by the reporter.
	3. Someaccidents at work constitute an Injury or Dangerous Occurrence reportable under RIDDOR. If so, the Incident team will ensure that RIDDOR is escalated to the Health & Safety Manager for external reporting to the Health & Safety Executive (HSE) via:<http://www.riddor.gov.uk/>
3. **Duty of Candour, Open and Honest Conversations & Confidentiality**
	1. Duty of Candour / Open and Honest conversation must be initiated as determined by the Patient Safety team. It is the responsibility of the investigating manager to ensure Duty of Candour is actioned, recorded on DCIQ, and that the family/relatives are kept informed at relevant stages of the process.

* 1. Staff involved in the incident must also be open and honest with their colleagues, managers, and relevant organisations and take part in reviews and investigations (when requested).
	2. Any enquiries from the media will be answered as openly as possible but without compromising the confidentiality of those involved. All media enquiries must go through the Trust Communications team by email comms@secamb.nhs.uk.
	3. Rarely, there may be an incident that is sufficiently serious but, due to the confidentiality of the individuals involved, it cannot be managed through the patient safety incident response framework (PSIRF) process. This could include incidents involving allegations against Trust Board members, or other sensitive issues. These should be exceptional and rare. The decision to manage the incident outside of the process must take place with the involvement of the Chief Executive Officer.
1. **Competence**
	1. All members of staff should receive training on DCIQ if appointed as an Investigator. The overriding priority is to ensure that investigations and learning are identified.
	2. Where the investigating officer does not feel adequately trained or experienced, then support or assistance should be sought from the Incident or Patient Safety team. This is particularly important for Duty of Candour / Open & Honest responsibilities as well as Patient Safety Investigations.

1. **Monitoring**
	1. The Executive Management Board have devolved responsibility from the Trust Board for ensuring adherence to this policy. They will also oversee a set of metrics to monitor the operational management of all incidents.
	2. The Quality and Patient Safety Committee will receive a quarterly report to include data extracted from DCIQ.
2. **Audit and Review**
	1. The incident process will be audited at least every three years by internal audit to ensure systems and processes are as effective as possible.
	2. This policy will be reviewed every three years or sooner if new legislation, codes of practice, or national standards are introduced.
	3. DCIQ will be reviewed monthly through the full audit and the login audit to ascertain any breaches within the system.
3. **Associated Documentation**
	1. The following documents are related to this Incident Policy:
* Risk Management Policy
* Issue Management Procedure
* Patient Safety Incident Response Framework Policy
* Health and Safety Policy & Procedures
* Infection Prevention and Control Policy & Procedure
* Compliments, Comments, Concerns, Information Request and Complaints Policy
* Being Open and Duty of Candour Policy
* Risk Register
* Board Assurance Framework
* Freedom to Speak Up Policy
* Capability Policy and Procedure
* Disciplinary Policy and Procedure
* Driving Standards Policy, Procedure and Emergency Driving and the Law
* Security Management Policy
* Anti-Fraud and Bribery Policy
* Safeguarding Policy and Procedure for Children, Young People and Adults
* Safeguarding Supervision Policy
* Medical Devices Management Policy
1. **References**

[NHS England » Patient Safety Incident Response Framework](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/)

[NHS England » Record a patient safety event](https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/report-patient-safety-incident/#:~:text=Patient%20safety%20incidents%20are%20any,action%20to%20keep%20patients%20safe.)

[NHS England » Revised Never Events policy and framework](https://www.england.nhs.uk/patient-safety/patient-safety-insight/revised-never-events-policy-and-framework/)

[RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations - HSE](https://www.hse.gov.uk/riddor/)

[NHS England » 2024/25 NHS Standard Contract](https://www.england.nhs.uk/nhs-standard-contract/24-25/)

[Regulation 20: Duty of candour - Care Quality Commission](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour)

[Regulations for service providers and managers - Care Quality Commission](https://www.cqc.org.uk/guidance-regulation/providers/regulations)

**Appendix A: Types of Incidents (with working definition)**

**Patient Safety Incident**:Any unintended or unexpected incident that could have or did lead to harm (e.g. injury, suffering, disability or death – physical, psychological or social) for one or more persons (adult and child) receiving NHS-funded healthcare, e.g. an occurrence, procedure or intervention which has or could have given rise to actual injury, or to an unexpected or unwanted effect.

**Medication Incidents**: Any incident involving a medicine. The Trust’s Medicines Governance Team, including the Trust’s Medicines Safety Officer, provide advice and support for reporting, managing and supporting with the investigation of medication incidents. In the event of the Trust being notified of a controlled drug (CD) incident, this will be escalated to the Chief Pharmacist and Controlled Drugs Accountable Officer.

**Sudden Unexpected Death:** Unexpecteddeaths are where a death has not been considered as the outcome. There are a number of circumstances where a death is reportable to the coroner and cases that meet the coroner threshold must be part of the incident process. These are;

* cause of death is unknown
* death was violent or unnatural
* death was sudden and unexplained
* person who died was not visited by a medical practitioner during their final illness
* medical certificate is not available
* person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died
* death occurred during an operation or before the person came out of anesthetic.
* medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning

**Maternal Deaths:** A maternal death is defined internationally as a death of a woman, during or up a year after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy (World Health Organisation 2010).

**Health & Safety Incident**:An unplanned and uncontrolled event that has led to or could have caused injury, ill health, harm to persons, damage to equipment or loss. Some accidents at work constitute an injury or a dangerous occurrence reportable under RIDDOR.

**Buildings Incident**:Where an incident occurs due to defects and failures in Trust Estates and Facilities.

**COSHH (Control of Substances Hazardous to Health)**: COSHH is the legal framework applied to most substances that are hazardous to health.

**Medical Devices**: An incident involving the use of medical equipment. The Head of Risk Management will advise the Medicines and Healthcare Products Regulatory Agency (MHRA) and ensure that any devices involved are isolated for inspection. The manufacturer/supplier and will notify other Ambulance Trusts as necessary. Following the failure of a medical device the item of equipment must be immediately withdrawn from service and held securely for inspection.

**Violence/Abuse/Discrimination**: On receipt of a report of physical/ verbal assault or bullying, the manager will immediately complete the NHS Security Management Service *Report of a Physical Assault on NHS* Staff form for review and reporting onwards to the NHS Security Management Service. In such instances it may be necessary for the person involved to inform the police of the incident immediately. If so, the crime number should be recorded on the incident form. All incidents of discrimination are reportable, including social, racial, religious, sexual, ethnic or age-related discrimination.

**Fire Incident***:*Any incident involving a fire or any incident where the fire alarm sounds requiring evacuation (unplanned).

**Security Incident (including Information Governance breaches)**: Any incident where a breach or a lapse of security is the dominating factor, e.g. theft or vandalism, premises window left open overnight, or data security incidents, e.g. missing health records, theft of a PC or unauthorised disclosure of patient identifiable information.

**Information Technology (IT) incidents**:In line with Health and Social Care Information Centre (HSCIC) Information Standards Board (ISB) guidelines and standards, IT systems implemented in healthcare settings must be delivered, deployed and operated in an acceptably safe manner for patients. Information technology incidents/failures, which has or has the potential to put patients at risk will be reported as a Serious Incident, this may include:

* Failure or loss of clinical systems
* Loss of clinical data with no access to back up
* Data corruption, such as incorrect merging of clinical records
* Inappropriate access to clinical records
* Misuse of access rights, such as using smartcard to inappropriately view clinical records

**Infection Control Incident**: MRSA Bacteraemia/Clostridium Difficile and outbreaks.

**Appendix B: Incident reporting process map**

5. Investigators have **30 working days** to investigate an incident before it becomes overdue.

2. User completes INC1 form with accurate and concise information, The reporter and other relevant parties will receive an email once the form is submitted.

3. Quality checks are completed by the Incidents Team and a Handler is assigned – The Incident becomes a DIF2.

8. If the incident does not meet the criteria for closure, it will be moved back to being investigated with feedback attached; step 6 & 7 will be repeated until the incident has met the required standard for closure.

1. User logs into SECAmb staff zone and finds popular links reporting an incident (INC1).

7. The investigation is reviewed by the Datix team within **10 working days.** If the incident has met the criteria for closing, it will be closed.

6. When the investigation is completed. The incident handler/Investigator will then move the incident to awaiting closure.

4. Incident handler moves the INC2 to being investigated and assigns investigators to assist. This must be done within **5 working days**.