Universities UK

POSTVENTION GUIDANCE: RESOURCES

Carrying out a serious incident review

This guide is for those setting up and running a serious incident review, it features template forms to help you capture information, and structure your findings.

Any serious incident involving a student will have a far-reaching impact, even beyond those who have been directly involved. This may extend to other students, members of staff, friends and relatives and those working in partner organisations. In addition, serious incidents have the potential to affect reputation and with that, confidence, in the higher education institution or areas therein.

Purpose of the procedure

This procedure is for use whenever a serious incident has occurred and is intended to support learning to minimise the chance of a recurrence or a similar incident involving another student. The procedure is aimed at:

- analysing what happened, to whom, when and where
- identifying any learnings or reflections that can be drawn from what has happened
- developing a clear action plan and owners for improvements, including how any learning will be implemented

Underlying review principles

The review process should not be used to identify fault or blame. Every effort should be made to support those involved and encourage a culture of honest reflection, identification of relevant learning points and of positive and tangible actions that directly reduce the risk of a recurrence.

Each review should therefore:

- be conducted with due candour
- Ideally, involve the family of the student
- be completed as soon after the incident as practical
- be objective and focused on identifying positive actions

- be focused on addressing specific questions raised by those impacted by the incident
- be proportionate in its scale

What is a serious incident?

Serious incidents are when individuals have or have nearly come to serious or lasting harm or where they have or have nearly caused harm to others. It is impossible to provide a definitive list of events that might be reviewed under this process however they may include:

- the death of a student or group of students through any apparent unnatural means
- a serious incident of self-harm, where there appears to have been clear intent to attempt suicide
- other incidents of serious harm being caused to a student or groups of students through unnatural means
- serious harm caused to others by a student at the higher education institution
- a serious safeguarding issue eg, a child or young person aged under 18 reports abuse

Review process

Each review will be led ('Lead Reviewer') by a senior member of staff, who has had no prior involvement with the student(s) involved.

Stage 1: Initial incident

The priority must be responding to the specific incident and supporting those involved either directly or indirectly. However, the Lead Reviewer should be confirmed as soon as possible after the incident has occurred, so that they can be appraised of what appears to have happened and start the process of collecting relevant information.

Stage 2: Information gathering

Once the initial incident has been resolved or the situation is stable, a wider process of information gathering should begin, using the template at Appendix 1. This stage should normally be completed within two weeks of the incident or as soon as possible thereafter. In cases such as the sudden death of a student, external agencies will require some of this information within a matter of days. Information may be gathered from a range of different sources including, but not limited to:

- staff who dealt with the initial incident
- staff who may have been providing support to the student either recently or in the past
- academic and PS colleagues in the relevant school
- fellow students
- immediate family and other relatives
- staff in partner organisations (e.g. NHS services)

In addition, the Lead Reviewer will seek initial reflective feedback from relevant individuals using the template at Appendix 2.

Stage 3: Incident overview

Having collated information, the Lead Reviewer will produce a chronology of events, which summarises relevant context and interactions between the student and others prior to, during and after the incident. In the case of the death of a student by suspected suicide, this should be long form document that sets out in detail all aspects of the student's time at the higher education institution. To produce these summaries, it may be necessary to seek information from additional people by email or interview. In the spirit of the principles underlying this procedure, any interview will be informal in nature. The Lead Reviewer will also collate reflections submitted by those asked to input into the case on any learnings that can be drawn.

Stage 4: Reflection of whole incident and identification of learning and action points

On completion of the chronology the Lead Reviewer will convene a small review group (normally of up to five people) who will review all relevant documentation and will meet to:

1. Consider whether there remain any outstanding questions or gaps in knowledge relating to the incident that should be filled through a further process of clarification or investigation.
2. Having filled any knowledge gaps, to confirm that the chronology adequately addresses, what happened, to whom, when and where.
3. Identify, through review of the reflections gathered from others and through their own experience, learnings that can be drawn from the incident.
4. What actions should be taken to put in place improvements for the future, which are aimed at minimizing the chance of a recurrence or a similar incident involving another student.
5. Ensure that the resulting action has clear owners and time scales for delivery attached to each action.

It is the responsibility of the Lead Reviewer to determine the membership of the review group based on the nature of the incident. It will usually be comprised of higher education institution staff, but consideration should be given where relevant to how to receive input from others (eg other students, friends and relatives and staff in other organisations).

Stage 5

The Lead Reviewer will be responsible for completing a Serious incident review: final report (Appendix 3) and for ensuring that a summary of outcomes is also reported through the higher education institution's safety and wellbeing governance.

Wider opportunities for enhancement

Each review is not a standalone process, and the outcomes should always inform further refinement of prevention and intervention strategies. In addition, data and review outcomes should also be compared and examined to build a wider profile of vulnerability and enhancement opportunities.

Appendix 1
Serious incident background information form

Name(s) of student(s)

Date of birth

Gender

Course

School

Mode of study

Level of study

Year of entry

Year of study

Fee status (eg home/international)

Status (eg active/suspended/withdrawn)

Home address

Term-time address

Disability declaration

Date, time and location(s) of the incident

Type of incident

Summary of the incident

Was the student's emergency contact or another 3rd party contacted prior to or after the incident?

If yes, then summarise these interactions.

Staff directly involved in responding to the incident

Students directly involved in responding to the incident

Name and contact details for any outside agencies involved in responding to the incident

Any other 3rd parties involved in the incidents (including contact details)

Names of any staff or students who may require ongoing welfare support as a result of the incident:

Details of any communications issued:

Details of any media and social media coverage:

For non-academic areas of the higher education institution:

What contact did the individual/s have with your service/team?

Please produce a timeline of interactions in chronological order, noting in particular any concerns that had been raised about the student and the action taken as a consequence:

- The student's application form and any declarations made at registration should be collated.
- Where a death by suicide is suspected, review of emails and any other information relating to the student will be required.

For academic areas of the higher education institution:

What contact did the individual/s have with your professional services colleagues?

What contact did the individual have with their academic advisor?

Please produce a timeline of interactions in chronological order, noting in particular any concerns that had been raised about the student and the action taken as a consequence:

Please provide a summary of this student's attendance:

Please provide a summary of any applications for mitigating circumstances, noting whether these were successful and the mitigation applied:

Please provide a summary of this student's academic performance:

Where a death by suicide is suspected, a full disclosure of emails and any other information relating to the student will be required.

Appendix 2
Serious incident reflective feedback form

The Lead Reviewer shall determine who will be asked to complete a reflective feedback form, but as a guiding principle they should be as inclusive as possible and by default any member of staff who has provided direct support to the student, where that is deemed relevant to the incident itself, will be asked for their reflections. The Lead Reviewer will also offer the opportunity for a confidential 1:1 discussion with each individual, in lieu of or in addition to completing this form.

Please highlight any areas of good practice related to the support provided to this student during their time at the higher education institution:

Please highlight any specific staff or other individuals who have positively and proactively supported student:

When considering your own interactions with this student, do you have any reflections about:

- ways in which you positively contributed to the student's time at the higher education institution:
- anything you may with the benefit of hindsight have chosen to do differently:
- information that was not known to you, which may have influenced your actions/decisions had this not been the case:
- any concerns, no matter how directly related, that you had prior to the incident

Considering what you know about this student, the background to the incident and the incident are there any lessons that you believe can be learned from this case?

In addition to these lessons, are there other specific actions that you believe should be taken as a result of this incident in order to reduce the risk of a recurrence or of a similar incident?

Please include any further information you would wish to highlight related to this incident:

Appendix 3
Serious incident final report: structure

- student name
- student ID number
- date of review
- name of lead incident reviewer
- summary of chronology of events
- outcome of the incident (including details of any injuries)
- remaining knowledge gaps
- identify areas of good practice and positive support provided to the student by specific staff or other individuals
- identify lessons learned from review of this incident
- agreed actions to reduce the risk of a recurrence or of a similar incident (must have clear owner and delivery date)
- any additional communication required (eg with other teams within the higher education institution who may be required to take action as a result of this incident).