



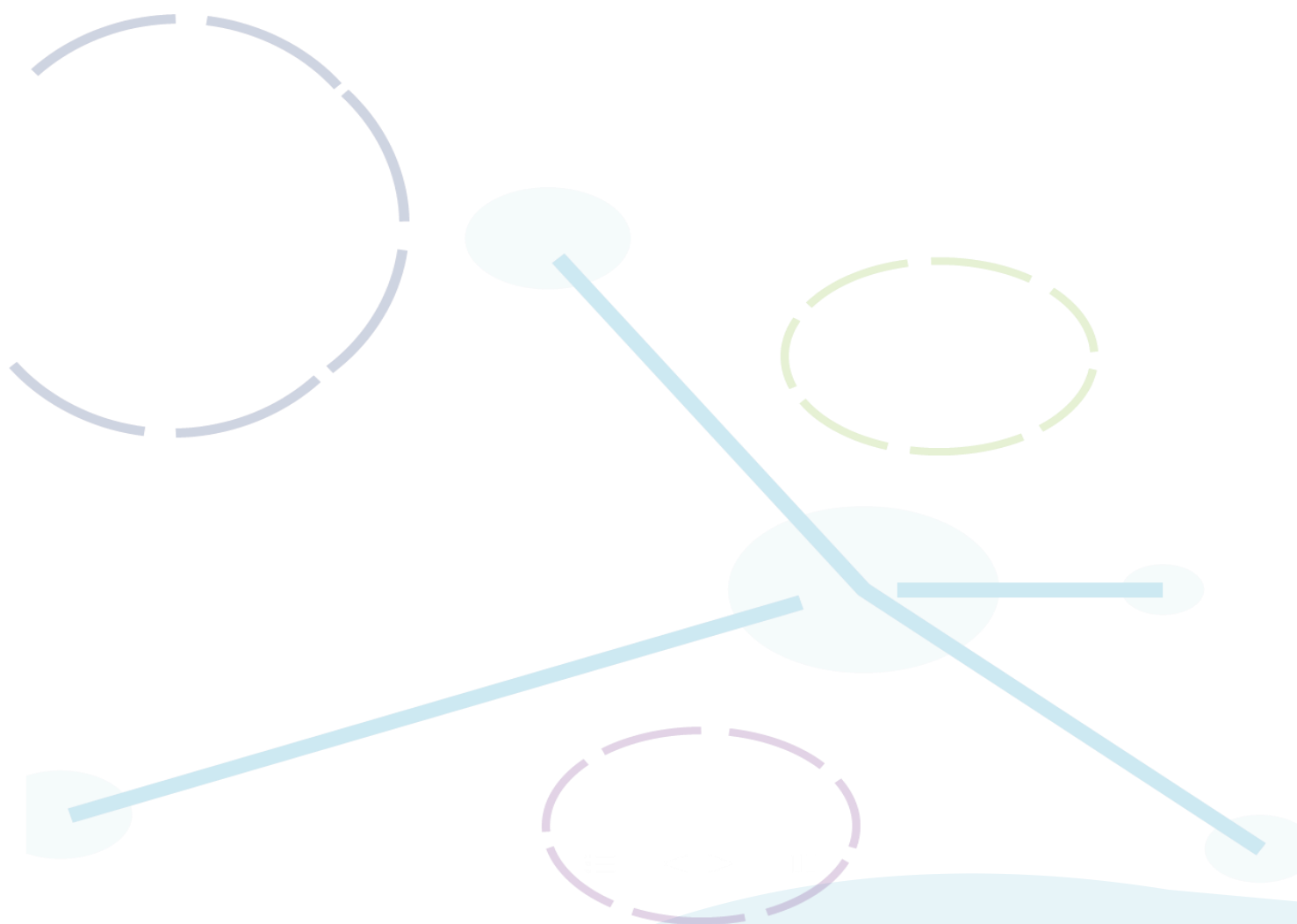
NHSGGC

Organisational Duty of Candour – Addendum Report 2023/2024

April 2026

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1. Introduction

As reported in the Organisational Duty of Candour Annual Report **01 April 2023 and 31 March 2024**, there were some delays in the completion process of some reports, due to delays in commissioning, complex reviews and clinical capacity.

As a result, it was agreed and outlined, in our Organisational Duty of Candour Annual Report **2023/2024**, that this Addendum would be produced and published. It includes details of any additional organisational duty of candour procedures as well as those not yet concluded.

2. How many incidents happened to which Duty of Candour applies

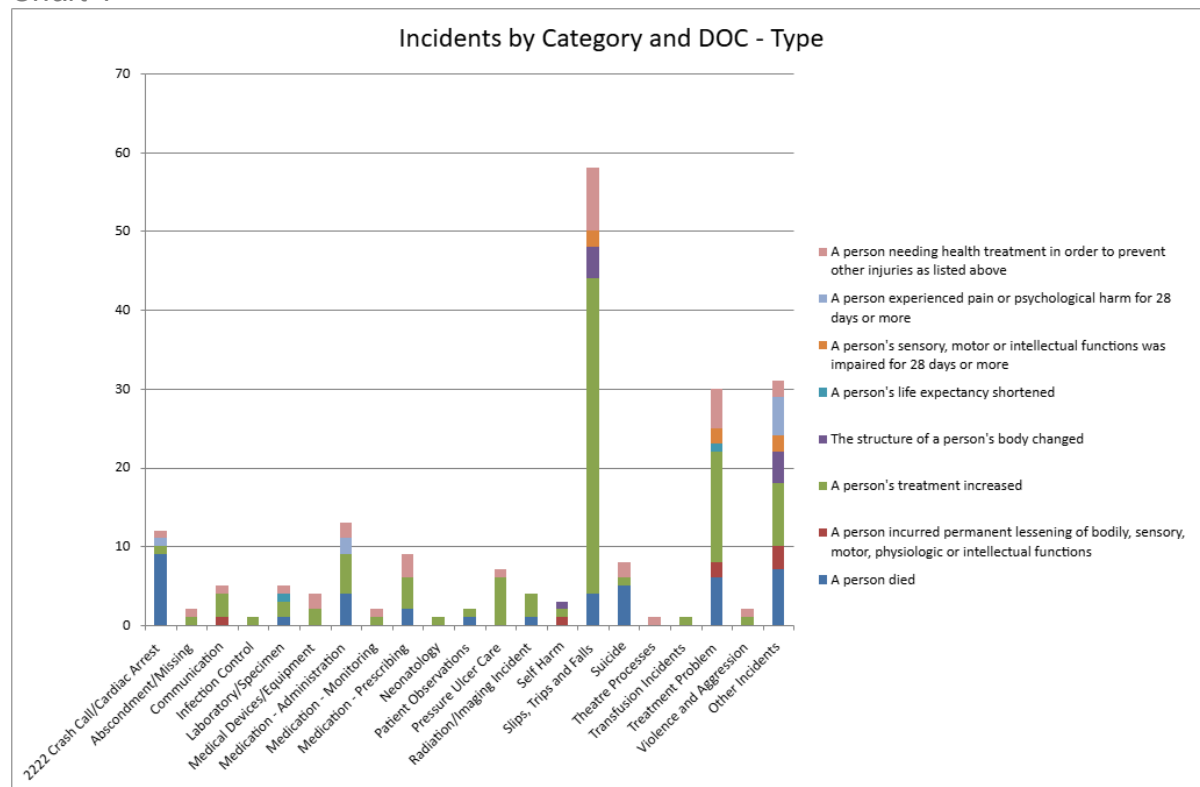
By **November 2025** the figures increased from the **12** reported to a total of **201** incidents between **01 April 2023 and 31 March 2024**. **201** of these procedures are complete and the types of incidents are listed in the table below. Type of unexpected or unintended incident.

Number of instances: 201

Table 1

Incident Type	Number of Incidents
Someone has died	39
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	7
Someone's treatment has increased because of harm	97
The structure of someone's body changes because of harm	9
Someone's life expectancy becomes shorter because of harm	2
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	6
Someone experienced pain or psychological harm for 28 days or more	8
A person needed health treatment to prevent them dying	0
A person needing health treatment to prevent other injuries	32
A healthcare infection incident was acquired during treatment	1

Chart 1



3. To what extent did NHSGGC follow the Duty of Candour procedures?

The 201 completed investigations were assessed to ensure that an apology was provided, patients and/or relatives were informed and invited to participate in the review, and copies of the final report were shared.

In 195 cases, patients or families received an apology. In four cases, the patient or family could not be contacted; one patient had no contact with family, and in one case, disclosure was deemed potentially harmful to the patient.

186 patients or families were involved in the investigation. In two cases, it was considered that involvement would cause further harm; in two cases, a clinical decision was made not to involve the family due to the time elapsed since the event. In one case, there were ongoing legal proceedings, and in eight cases, the team were unable to contact the family. Two patients or relatives requested no contact.

The report was shared with 186 patients or families. In two cases, disclosure was deemed potentially harmful, and three patients had subsequently passed away. Four patients or relatives requested no contact, and in six cases, the team were unable to make contact.

4. Learning from Duty of Candour Events

There were 907 actions generated from the 201 Duty of Candour events. At the time of reporting, 66% (596) of these have been closed.

- A template on Emis has been introduced to assist staff to record decision surrounding observation levels.
- All psychiatric hospitals undertaking environmental risk assessments to reduce ligature risk.
- High strength Alfentanil was removed from routine wards in Acute Service.



This report includes only a small sample of learning from Duty of Candour events. Learning summaries are produced for events where there are system of care issues that contributed to the event (investigation outcome 3 and 4), which are shared through relevant clinical governance structures. The Board Annual Clinical Governance Report also includes consideration of learning.

There is ongoing work to develop a learning system in NHSGGC which will accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

