



Jersey Care
Commission

GUIDANCE

Duty of Candour

Regulation of Care (Jersey) Law 2014

May 2026



Introduction

The Commission has developed this guidance to help organisations understand what the duty of candour is, why it is important, and how it should be applied in day-to-day practice. Being open and honest when something has gone wrong is essential for building trust with the people who use services, as well as with their families and carers. It also helps ensure that individuals are treated with fairness, dignity, and respect at all times.

This guidance explains what organisations are legally required to do when an incident occurs, how they should communicate with those affected, and fulfil regulatory obligations. For the avoidance of doubt, this guidance applies specifically to notifiable safety incidents. It does not relate to incidents that would normally be reported to the Commission as part of routine regulatory notifications.

Notifiable safety incidents have a particular definition and threshold, and the expectations set out in this guidance apply only when those criteria are met. Standard incident reporting such as notifications of deaths, serious injuries, or other events required under routine reporting duties should continue to follow the Commission's usual processes and procedures.

Overall, the purpose of this guidance is to provide clarity, promote consistent practice, and support organisations to strengthen openness and transparency across all aspects of their work.



The Statutory Duty of Candour

The Duty of Candour is a legal requirement placed on health and social care providers to be open, honest and transparent with people who use their services, especially when things go wrong. This principle is now embedded within the Regulation of Care (Jersey) Law 2014¹ (“the Law”), which sets out the regulatory framework for health and social care providers and establishes clear expectations around safe, high quality, and transparent care. The Law has been updated in a way that mirrors the equivalent duty of candour provisions in English legislation.

Under the Law, registered persons² are required to act openly and transparently with anyone receiving care or treatment. This includes applying the duty of candour in relation to how organisations respond

when certain safety incidents occur. These events defined in the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 (“the Regulations”) as **notifiable safety incidents**, trigger duties for providers to inform the person affected, explain what has happened, and outline the steps being taken to address the situation. A crucial part of the duty of candour is providing an apology to the affected individual when something goes wrong.

The Regulations

The purpose of the duty of candour is a general duty to be open and transparent with people receiving care, and this always applies. This is to promote trust, learning, and accountability by ensuring that people affected by incidents are kept informed and receive clear, honest communication, including an explanation and an apology.

Additionally, the Regulations also specifies the actions that must be taken in response to a ‘notifiable safety incident’.

Under the duty of candour, a registered person must, in relation to care and treatment provided to service users:

- act in an open and transparent way
- have due regard to service users’ protected characteristics

- a representative of the registered person must inform a service user (or their representative) of any notifiable safety incident that has occurred, and provide an account of all the facts known about the incident
- advise what further enquiries into the incident are appropriate
- provide reasonable support to the relevant person in relation to the incident
- provide an apology
- provide a written account of the incident, details and results of any enquiries into the incident
- maintain records of all correspondence relating to the incident, and communications with the service user.

¹ Regulation of Care (Jersey) Law 2014

² The registered person is the care provider and registered manager



Definitions of regulated activities

The Law defines a **hospital** service as a premise (except for that at the prison) as a premise that is used for inpatient treatment of: the affected individual when something goes wrong.

- people suffering from disease, injury, or disorder.
- for pregnant people or for people who have recently given birth.
- for in patient treatment of people during convalescence or people requiring medical rehabilitation.
- on site clinics, pharmacies, and outpatient departments.

The Law defines an **ambulance** service as a service that:

- provides treatment or care to patients while being transported to a place of medical treatment.
- provides medical treatment at public events, outside of relevant premises, under an arrangement with the provider of the service.
- operates a call centre for despatching vehicles so they can provide care.

The Law defines **other regulated activities** as:

- Adult day care service
- Care home service
- Home care service
- Adoption service
- Children's home service
- Fostering service
- Social work service for children and young people
- Independent monitoring and review service in respect of looked after children's cases
- Child contact centre service
- Residential family centre service
- Children and young people's mental health service (CAMHS)
- Care service in special schools
- Children and family community nursing service



Notifiable safety incidents

(hospital and ambulance services only)

A notifiable safety incident is defined in the Regulations as an incident that;

- was unintended or unexpected, and
- occurred during the provision of a regulated activity, and
- in the reasonable opinion of a healthcare professional could or appears to have resulted in the death of the service user, or severe, moderate, or prolonged psychological harm to the service user (**Death or harm must be directly related to the noticeable safety incident itself, rather than the service user's illness or underlying condition*)

If any of these three criteria are not met, it is not a notifiable safety incident, however the overarching duty of candour, in as much as being open and transparent should apply.

Notifiable safety incidents

(all other regulated activities except for hospital and ambulance services)

A notifiable safety incident is defined as an incident that;

- was unintended or unexpected, and
- occurred during the provision of a regulated activity
- in the reasonable opinion of a healthcare professional could or appears to have resulted in the death of the service user (**Death must be directly related to the noticeable safety incident itself, rather than the service user's illness or underlying condition*)
- an impairment of the sensory, motor or intellectual functions of the service user lasting 28 days or longer

- changes to the structure of a service user's body
- the service user experiencing prolonged pain or prolonged psychological harm
- the shortening of the life expectancy of the service user
- requires treatment by a health care professional to prevent:
 - the death of a service user; or
 - any injury to the service user that, if left untreated, would lead to any of the above outcomes.



Comparisons between hospital and ambulance services and other regulated activities

The Regulations define what is meant by a notifiable safety incident, and this definition is different depending on whether the incident relates to a hospital and ambulance service or any other regulated service. This table makes clear how the Regulations define notifiable safety incident for each category of service.

Hospital and ambulance services Regulation 6(8)	All other regulated services Regulation 6(9)
<p>A notifiable safety incident is any incident that was:</p> <ul style="list-style-type: none">a) unintended or unexpected, andb) occurred during the provision of a regulated activityc) in the reasonable opinion of a healthcare professional could result in, or appears to have resulted in:<ul style="list-style-type: none">• the death of the service user, if the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition• severe harm that is related directly to the notifiable safety incident, moderate harm or prolonged psychological harm to the service user	<p>A notifiable safety incident is any incident that was:</p> <ul style="list-style-type: none">a) unintended or unexpected, andb) occurred during the provision of a regulated activityc) in the reasonable opinion of a healthcare professional could result in, or appears to have resulted in, or requires treatment by a healthcare professional to prevent:<ul style="list-style-type: none">• the death of the service user, if the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition• an impairment of the sensory, motor or intellectual functions of the service user that has lasted, or is likely to last, for a continuous period of at least 28 days• changes to the structure of the service user’s body• the service user experiencing prolonged pain or prolonged psychological harm• the shortening of the life expectancy of the service user• any injury to the service user, that if left untreated, would lead to one or more of the above outcomes



Definitions

The terms as defined in (Regulation 6(10)) are as follows:

Apology	Means an expression of regret in respect of a notifiable safety incident
Moderate harm	Means harm that a) requires a moderate increase in treatment; and b) is significant but not permanent
Moderate increase in treatment includes	a) an unplanned return to surgery b) an unplanned readmission c) the prolongation of a course of treatment or care d) extra time in hospital or as an outpatient e) cancellation of treatment f) transfer to another treatment area such as intensive care
Prolonged pain	Means pain that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
Prolonged psychological harm	Means psychological harm that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
Prolonged pain	Means pain that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
Severe harm	Means harm that a) causes a permanent lessening of bodily, sensory, motor, physiological or intellectual functions; and b) is not related to the natural course of the service user's illness or underlying condition



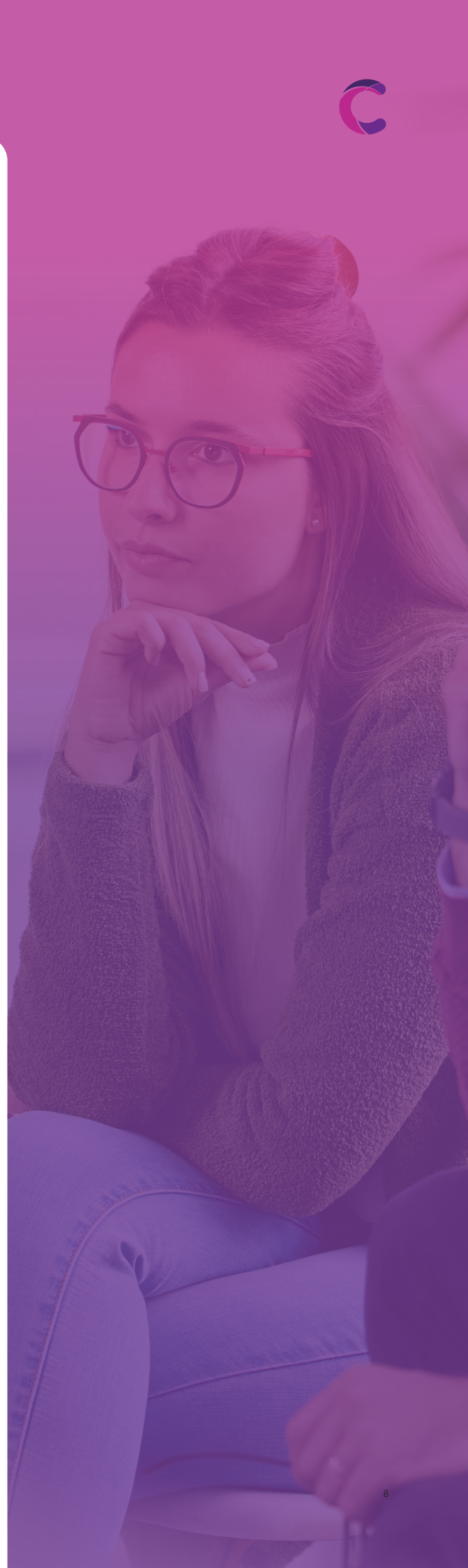
What must happen following a notifiable safety incident

Regulation 6 describes the duty of candour requirements and explains what actions the registered person must take once a notifiable safety incident has been identified.

The purpose of these requirements is to share all known information about the incident in an honest, open, and compassionate way. The person who has been harmed has the right to understand what happened and why.

The provider must:

1. Inform the service user, in person, as soon as possible that a notifiable safety incident has occurred.
2. Provide an accurate explanation of what has happened, based on the information available at that time.
3. Explain what further enquiries or investigations are planned into the incident and why they are needed.
4. Apologise.
5. Provide all the above information and the apology in writing, along with an update on any ongoing enquiries.
6. Keep a secure written record of all meetings and communications with the service user.
7. Throughout the process the registered person must provide reasonable support to the service user.





Providing an apology

Regulation 6, relating to Openness and Transparency, requires registered persons to provide an apology to the service user (or their representative) along with a written notification. This must be done as soon as reasonably practicable. Once a notifiable safety incident is identified, providers should act promptly to ensure the apology and written notification are provided without delay.

Providers are sometimes uncertain about how to apologise when an incident is still being investigated. However, right from the start, simple, straightforward expressions of sorrow and regret can and should be made for the harm the person has suffered.

Apologising when something goes wrong does not mean an admission of liability. Regulation 6(11) makes this clear by stating that an apology given as part of the duty of candour cannot be used as evidence to decide fault or liability for an incident. It should be noted, however, that this would not prevent other information from being gathered and being admitted as evidence of liability in legal proceedings.

It is important that the registered person put duty of candour first, and that services are open and honest, putting service users first, regardless of the possibility of litigation.

Reasonable support

Throughout the process, the registered person should provide reasonable support to the relevant person, both in relation to the incident itself and during any communication about it. Reasonable support will vary with every situation, but could include, for example, environmental adjustments for someone who has a physical disability, an interpreter for someone who does not speak English well, offering information in accessible formats, or arranging support from an independent advocate.

If the relevant person consents, registered persons should involve family members and carers in any discussions. Ultimately, it is about taking reasonable steps to ensure that they communicate in a way that is as accessible, inclusive and supportive as possible.



Applying and evidencing the duty in practice

The duty of candour applies to all registered persons providing a regulated activity. Every provider must ensure they understand their responsibilities and be able to demonstrate that the duty is embedded within their service. This includes understanding when the duty is triggered and how it must be carried out in line with regulatory requirements.

Providers must ensure that staff are provided with appropriate training, and that policies, procedures and reporting systems are in place. These systems should enable staff to confidently recognise notifiable safety incidents and respond appropriately. Effective processes must also support timely, honest communication with service users affected by notifiable safety incidents.

Providers should be able to clearly describe how they support staff to be open, honest, and transparent, and how these expectations align with the organisation's wider culture of safety and learning. Staff should work in an environment where speaking up is encouraged, where transparency is valued, and where openness is recognised as essential to delivering safe, high-quality care.

The registered person holds ultimate accountability for ensuring the duty of candour is met and that the organisation consistently follows the correct processes. They must be able to evidence that the duty is embedded in practice, understood by staff, and applied reliably across the service.

Professional duty of candour

In some organisations, health and social care professionals who are professionally registered are also subject to a professional duty of candour. This professional duty is overseen by regulatory bodies such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Social Work England (SWE).

Even though all health professionals have a professional duty to be open and honest, this alone is not enough when an incident meets the definition of a notifiable safety incident. In these situations, the statutory duty of candour must be followed. This is a legal requirement placed on the organisation, and it is triggered as soon as the criteria for a notifiable safety incident are met.

This means that, even if you have already been open with the person in a professional sense, you still need to make sure the formal duty of candour process is carried out. The professional duty supports good practice, but it does not replace the legal steps that the organisation is required to take.



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