Duty of Candour Annual Report 2025–2026

Corbenic Camphill Community Limited
Scottish Charity No. SC015477 | Company No. SC066657
Reporting period: 1 April 2025 to 31 March 2026

1. Annual statement

During the reporting period, Corbenic recorded **no unintended or unexpected incidents that met the statutory threshold for activating the organisational Duty of Candour procedure**. No accidents or incidents were therefore managed as Duty of Candour events, and no formal Duty of Candour notifications, apologies or procedure-specific reviews were required.

Summary of reported safety activity	
Measure	**2025–2026 outcome**
Recorded accidents	33
RIDDOR-reportable accidents	0
Recorded care incidents	70
Accidents triggering Duty of Candour	0
Incidents triggering Duty of Candour	0
Total Duty of Candour procedures activated	**0**

2. About Corbenic

Corbenic Camphill Community is a registered care home and day service supporting adults with a range of complex support needs. The organisation aims to provide high-quality, person-centred care founded on dignity, respect, compassion, inclusion, wellbeing and responsiveness to individual need. This report covers the regulated care and support delivered by Corbenic during the period stated above.

3. Purpose and statutory context

This annual report is published in accordance with the organisational Duty of Candour requirements introduced by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act

2016 and associated regulations. The duty applies when an unintended or unexpected incident appears to have caused death or harm of the type specified in the legislation and the incident is not related to the natural course of the person's illness or underlying condition.

Corbenic is committed to responding openly, honestly and compassionately when something goes wrong. Where the statutory threshold is met, the organisation will notify the person affected, or their representative; provide a meaningful apology; explain what is known; undertake a review; offer appropriate support; share the review findings; and identify actions to reduce the likelihood of recurrence. An apology is an acknowledgement of the experience and harm caused and does not, of itself, amount to an admission of negligence or legal liability.

4. Accident and incident activity

Board reporting for the period records 33 accidents: 23 between April and December 2025 and 10 between January and March 2026. The principal themes were slips, trips and falls involving residents, staff and volunteers, together with isolated minor injuries arising from everyday activity, a seizure, manual support, equipment failure and contact with an animal. The records include one staff fall followed by a hospital assessment and incidents involving back pain, bruised ribs and a broken finger. Following review, none met the RIDDOR reporting threshold and none met the threshold for the organisational Duty of Candour procedure.

In the same period, 70 care incidents were recorded through Corbenic's incident-reporting arrangements. These comprised 51 incidents between April and December 2025 and 19 between January and March 2026. Incident recording uses a green, amber and red classification to support proportionate oversight. Classification alone does not determine whether Duty of Candour applies; each event must be considered against the statutory harm threshold and the circumstances of the individual. Review of the reported accidents and incidents confirmed that no event activated the duty.

5. How incidents are identified and reviewed

- All accidents and incidents are recorded through Corbenic's reporting arrangements, including the event, immediate response, injury or impact, people informed, follow-up and actions required.
- Immediate care, first aid, medical advice and safeguarding measures are arranged according to the circumstances and the person's needs.
- Managers assess seriousness, foreseeable risk, level of harm and whether statutory or regulatory notification may be required.

- Where appropriate, notifications are made to the Care Inspectorate, Adult Support and Protection, the Health and Safety Executive or another relevant agency.
- Significant events are investigated, with contributory factors, care plans, risk assessments, staffing, environment, equipment and practice considered.
- Incidents involving physical contact or distressed behaviour receive additional review within Positive Behaviour Support and Safety Intervention Training arrangements.
- Actions are allocated, monitored and closed only when completion can be evidenced.

6. Duty of Candour procedure

1. **Identify and escalate:** the senior manager responsible confirms that the statutory criteria appear to be met and appoints a lead person who was not directly involved in the event wherever practicable.
2. **Notify and apologise:** the affected person, or their family or representative where appropriate, is contacted as soon as reasonably practicable, told what is known and offered a sincere apology.
3. **Provide support:** support is offered to the person affected, their family or representative, and staff or volunteers involved. Communication and accessibility needs are considered throughout.
4. **Review:** a proportionate review establishes what happened, why it happened, the impact, contributory factors and the action required to prevent recurrence.
5. **Share findings:** the person or representative is invited to contribute to the review and is offered a written account of the findings and actions.
6. **Record and monitor:** all contacts, meetings, decisions, apologies, review findings and improvement actions are documented, with responsible leads and completion dates.
7. **Report externally:** all required notifications are made promptly to the relevant regulator or statutory body.

7. Learning and improvement

Although no Duty of Candour procedure was activated, Corbenic treated routine reporting as an important source of learning. Recorded accidents were followed up and actions documented. Patterns of slips, trips and falls informed review of individual risk assessments, environments, equipment, moving and assisting practice, staffing arrangements and support plans. Incident analysis also informed de-escalation practice, Positive Behaviour Support, staff guidance and targeted learning where responses to escalating situations required improvement.

During and following the reporting period, Corbenic continued to strengthen assurance by progressing a digital incident-reporting system; developing consistent fields for immediate action, notification, contributory factors, learning, action ownership, deadlines and closure evidence; and moving towards clearer quarterly analysis of frequency, severity, location, timing, recurring themes, physical intervention and outcomes.

8. Staff training and support

Duty of Candour awareness forms part of Corbenic's wider approach to safe practice, incident reporting, safeguarding and professional accountability. Staff and volunteers are expected to report concerns promptly and are supported to understand that reporting is intended to protect people and improve practice rather than apportion blame. Managers provide guidance, debriefing, supervision and access to further support following significant or distressing events. Learning is shared through staff briefings, Care and Support meetings, House Coordinator and Workshop Leader meetings, supervision and targeted refresher training.

9. Governance and assurance

Accident and incident trends are reviewed through operational management, the Senior Leadership Team and reports to the Board of Trustees. The Care and Workforce Sub-Committee supports detailed oversight of care quality and workforce matters. The Board receives assurance on accidents, incidents, complaints, regulatory compliance, risk and improvement activity. Supporting evidence includes accident and incident records, investigation and action plans, statutory notifications where required, meeting minutes, training records, risk assessments, care plans, Positive Behaviour Support records and annual Duty of Candour reports.

10. Priorities for 2026–2027

- Maintain consistent management review of every report, including an explicit record of the Duty of Candour threshold decision.
- Produce quarterly trend information covering severity, recurring causes, location, time, people affected, physical interventions, outcomes and overdue actions.
- Ensure each improvement action has a named owner, timescale and evidence of completion.
- Continue sharing anonymised learning through meetings, supervision, induction and refresher training.

- Review the Duty of Candour policy and staff guidance annually, and sooner if legislation, national guidance or organisational arrangements change.

11. Conclusion

Corbenic recorded no events requiring activation of the organisational Duty of Candour procedure between 1 April 2025 and 31 March 2026. This does not remove the need for careful scrutiny. All reported accidents and incidents continued to be reviewed, followed up and used to inform risk management, staff practice and service improvement. Corbenic remains committed to candour, timely apology, compassionate communication, proportionate investigation and demonstrable learning whenever care does not go as intended.