Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2012 – March 2013

June 2013

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SECTION 1

1.0 INTRODUCTION

An adverse incident is defined as, any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service. Appendix A of this report sets out the criteria of a Serious Adverse Incident (SAI).

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process in place by which learning from these incidents is shared both locally and regionally.

This report identifies key regional learning, action taken and proposed arising from SAIs reported during the period 1 April 2012 to 30 September 2012.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure effective management of the incident.

2.0 BACKGROUND

Responsibility for management of SAI reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1 May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, Special Agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services in conjunction with the adverse incident system in place within the HSCB Integrated Care Directorate.

The procedure details arrangements for internal management of SAIs by HSCB and PHA staff, supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs.
- The nomination of a DRO to review and scrutinise reports.
- Regional SAI Review Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- Escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports
  - assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis.

4.0 SAIS REPORTED DURING PERIOD OCTOBER 2012 – MARCH 2013

During the period 1 October 2012 to 31 March 2013, the HSCB received 204 SAI notifications. This represents an increase on the previous six months (April 2012- Sept 2012) when 141 SAIs were reported to HSCB. A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF A SAI

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate the SAI, however, the decision to approve the de-escalation will be made by the HSCB/PHA Designated Review Officer.

During the reporting period seven (7) SAI notifications received were de-escalated.

6.0 DUPLICATE SAI REPORTING

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, on occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

The purpose of any adverse incident reporting system is to improve patient safety. A key aim of the SAI reporting and learning process is to reduce the risk of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is core to achieving this and to ensure these lessons are embedded in practice and the quality of care provided.

The Regional SAI Review Group analyses reports and comments received from DRO's to identify opportunities for learning across organisations and makes recommendations for change to drive improvements for patients and services across the HSC.

Opportunities for learning can be identified in a number of ways:

- Through individual investigations and Root Cause Analysis (RCA)
- Aggregation of similar incidents over time identifying common themes and trends.
- Systematic reviews of areas of concern.

Both providers and the Regional SAI Review Group have a role in not only identifying actions but ensuring changes are made to practice, for example, training or dissemination of information and in implementing and sustaining these changes to practice.

The Regional SAI Review Group also commission specific thematic reviews to identify trends and patterns across commissioned provider organisations and ensure wider implications and key learning points are disseminated across the HSC.

There are many barriers to learning achieving outcomes as identified in 'An Organisation with a Memory'.[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional SAI Review Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

2.0 DISSEMINATION OF LEARNING INITIATIVES

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of ongoing work.

2.1. PHYSIOLOGICAL EARLY WARNING SCORES

A Regional Learning Event was undertaken to disseminate shared learning in relation to Physiological Early Warning Scores (PEWS) in health care. The Senior Management Team (SMT) recommended a review to identify the number and type of SAIs relating to issues surrounding the identification and response to deteriorating patients in the clinical setting to inform and decide whether any further action is required.

An analysis of incidents between the 1 May 2010 and 19 July 2012 was undertaken and a number of recommendations made, for example, Trusts should continue ongoing work on PEWS as set out in HSS (MD)17/2010 and confirm their commitment to a regional approach to the use of PEWS in the identification and management of the deteriorating patient.

The findings from the PHA/HSCB thematic review in relation to PEWS have been presented to HSC Trust Senior Nurses and shared with Education providers.

The PHA, through the Safety Forum, was tasked by DHSSPS to coordinate a regional approach to the use of PEWS. A National Early Warning Score (NEWS), which is currently being rolled out in England, has been considered by the regional group for use in Northern Ireland and is scheduled to start on August 2013. An online package for training is available for use with this tool.

2.2. GP MENTAL HEALTH REFERRAL FORMS TO SECONDARY CARE

The SAI process has identified an issue regarding patient risk information on the GP mental health referral forms to secondary care. These forms do not have a 'don't know' option in the section regarding forensic history, which would highlight to other professionals that this part of the patient history/information requires further exploration.

A scoping exercise in Mental Health Services in HSC Trusts indicated that there is a variation in referral practices not only across HSC Trusts, but also by teams within HSC Trusts. Therefore identifying a need to standardise these forms regionally and a Safety and Quality Learning Letter has been developed and will be communicated to HSC Trusts.

2.3. INADVERTANT ATTACHEMENT OF OXYGEN TO NASOGASTRIC TUBE

In two recent SAIs, green oxygen tubing was attached to the side vent of a Salem Sump nasogastric tube to prevent leakage of stomach contents. Subsequently, staff attached an oxygen supply to the green oxygen tubing, leading to a flow of oxygen

directly into the patient's stomach. This resulted in major complications for both patients who needed further extensive surgery. A Safety and Quality learning Alert was disseminated to all HSC Trusts and RQIA for distribution to independent providers, identifying the following learning:

- oxygen tubing should never be connected to a Salem Sump nasogastric tube;
- extra care should be taken when attaching an oxygen supply in patients who have a nasogatric tube if they have to receive oxygen;
- no equipment other than that identified as compatible in the manufacturer's instructions should be used to facilitate drainage or prevent leakage from a Salem Sump nasogastric tube.

Responses from HSC Trusts indicate they are compliant with the actions required as identified on the learning alert.

2.4. IMPORTANCE OF TAKING ACTION ON X-RAY REPORTS

A Safety and Quality Alert Letter was distributed to HSC Trusts and RQIA following two recent SAIs, where two patients experienced several months delay in diagnosis of serious conditions because abnormal chest x-ray findings, and suggested CT scans, were not actioned by a number of Consultants and other medical staff during inpatient/outpatient care. There were many factors which contributed to these incidents occurring and the learning alert set out the following actions:

- Radiologists should make it easier for other staff to 'pick-up' abnormal results from the many results they review daily, by reporting the suspected findings and urgency of follow-up action, clearly and precisely, as recommended by the Royal College of Radiologists;
- Radiologists should ensure that referring clinicians know about important abnormal results, by communicating directly to the referring clinician, all critical, urgent and significant unexpected findings as defined by the Royal College of Radiologists. That communication should be documented;
- to avoid patient harm Radiologists should fix all transcription errors on x-ray reports;
- Consultants, Middle Grade and Junior Medical staff should remember that their review of x-ray and lab results is a critical step in patient care. It should not be viewed as a routine task in otherwise busy days. Every result is important and the doctor who has read a result is responsible for arranging follow-up actions;
- Consultants, Middle Grade and Junior Medical staff where practicable, should review x-ray and lab results in a quiet area to minimise the risk of being interrupted or distracted;
- Consultants, Middle Grade and Junior Medical staff should always document in the patient's records, the actions taken to follow-up on an abnormal result;
- Consultants, Middle Grade and Junior Medical should remember that each ward round, the discharge summary, the discharge letter and each outpatient review are important opportunities to review a patients test results.

Action/ recommendations for HSC Trust and Independent Providers:

HSC Trusts have provided confirmation that they have addressed the following risks/actions to minimise the possibility of reoccurrence:

- patients are at higher risk if they are not cared for in the appropriate clinical setting e.g. medical outliers;
- if medical staff review patient x-rays and lab results in a busy ward area, they are more likely to be interrupted or distracted and therefore the risk of not taking appropriate action increases;
- if patient x-ray and lab results are reviewed by a doctor who is not part of the day-time Consultant team looking after a patient e.g. where a surgical junior doctor reviews results for medical outliers on the surgical ward, the risk of not taking appropriate action increases;
- policies should be precise about who is responsible for communicating abnormal x-ray results directly to the referring clinician, and in what circumstances, and should reflect Royal College of Radiologists' guidance.

2.5. WRONG SITE SURGERY

Analysis of a SAI identified that a wrong procedure was undertaken on a patient in a Day Procedure Unit (DPU). No checks were performed before the procedure although the patient did complete a consent form. A number of opportunities were missed to confirm the patient's identity and procedure. A Quality and Safety Learning Alert was circulated to all the HSC Trusts and independent providers, identifying the learning to prevent reoccurrence and requesting the following:

- all relevant staff, including student staff, are made aware of the identified learning;
- all DPU and theatre staff have been provided with formal written procedures to check a patient's identity and procedure, prior to starting the procedure. This can be through a surgical safety checklist, or its equivalent;
- all DPU and theatre staff are trained to use the formal procedures regularly;
- all DPU and theatre staff audit their adherence to those written procedures – adherence should be 100%.

Confirmation has been requested by 31May 2013 and an update on progress will be available in the next SAI Learning Report.

2.6. PATIENT SELECTION AND INTRAPARTUM CARE IN MATERNITY UNITS

A number of similar learning points have been identified from two recent SAIs in Maternity Care Services, in which one baby died and another suffered harm.

Escalation and appropriate action was delayed due to:

- not taking account of the entire clinical picture of the woman and her baby. CTG tracings and risk factors for pregnancy and labour were not considered together;

- failure to recognise pathological CTG tracings and escalate appropriately;
- lack of clarity in communication between members of the multidisciplinary team.

Each HSC Trust is currently addressing issues highlighted in the Safety and Quality Learning letter issued and confirmation of actions will be reviewed again in June 2013.

2.7. MANAGEMENT OF HEAD INJURY

There have been two recent reports of death in patients who presented to Emergency Departments (ED), following head injury. A Safety and Quality Alerts letter was circulated to all HSC Trusts and RQIA. The learning identified that medical and nursing staff in EDs, general surgery and other specialities should take account of the following when assessing and monitoring patients with head injury:

- ensure staff know and apply the contents of the Trust's policy on assessment and treatment of head injury, including frequency of observations, indications for CT scanning and medical reviews;
- take particular care when assessing a head injury in a patient who has also taken alcohol and/or drugs. It is particularly important that scheduled observation times are adhered to and that scores are accurately recorded;
- at times of staff handover, whether a shift change or moving the patient from one ward area to another, ensure the nursing staff who are new to the patient are made aware of their clinical condition and responsiveness;
- if transferring a patient to another location, record the patient's observations immediately prior to transfer, and again on admission to the new clinical area;
- take action on a deteriorating PEWS score in line with Trust policy;
- document in the patient's chart what action, if any, was taken in response to a request to assess a patient with a change in PEWS score;
- if a patient has a deteriorating Glasgow Coma Scale (GCS) and needs urgent CT, seek anaesthetic advice early as the patient may need airway management during imaging and/or immediate surgery afterwards.

Following dissemination of a Safety and Quality Learning Alert, all HSC Trusts have indicated compliance or are developing guidance in response to the alert.

2.8. APPROPRIATE COMMUNICATION

Following the occurrence of a SAI in Mental Health Service, HSC Trusts were issued with a learning letter from the Director of Social Care and Children.

The recommendation related to the failure of staff to check that a patient with whom they were communicating by letter could actually read. In this instance the fact that the patient could not read was clearly recorded in the individual patient notes.

The learning letter requested that this issue was highlighted to the HSC Trusts' Mental Health Services and specifically that HSC Trusts reinforce the need in each case for staff to establish the appropriate communication methods for individuals.

2.9. PSEUDOMONAS OUTBREAK

The emergence of Pseudomonas Aeruginosa in Neonatal intensive care units was a significant development across Health and Social Care in Northern Ireland. Recommendations from the Regulation Quality Improvement Authority (RQIA) review required significant work to be taken forward across HSC organisations to implement new working arrangements and practices. A Regional Workshop was held on Thursday 25th April 2013, at New Mossley Mill Newtownabbey, to identify any learning from a regional perspective. This event had participation from relevant personnel, across HSC in Northern Ireland and had input from an independent facilitator from Public Health England.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIS REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following discussions at the Regional SAI Review Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care and treatment of older people. *(An Older Person is defined as someone 65 years and over).*

A group has been established within the PHA/HSCB to examine SAIs and Complaints reported within the period April 2011 – March 2012, to identify themes, patterns and trends and roll out any learning arising from this in depth analysis.

The methodology for this thematic review will be:

- A review of Older People complaints identifying themes;
- A review of Older People SAIs identifying themes;
- Focus group to elicit first-hand experience of health and social care by older people;
- A cross-reference of the information gathered above with patient experience reports.

In parallel with this thematic review the RQIA have also undertaken a review of the care of older people in acute hospital wards. As both organisations' work is related a Professional Practice Workshop to share the learning from the review of SAIs, complaints and the RQIA review, affecting older people was held on 17 May 2013.

The following themes were discussed at the Learning Event:

- Advocacy (recognising that most complaints are not made by older people themselves)
- Falls
- Privacy and Dignity
- Misdiagnosis and delay in commencement of treatment
- Staff attitude and behaviour and staff communication with patients, service users and families.

The outcome from the workshop and follow up actions for improvement will be included in the next SAI Learning report.

2.0 REVIEW OF THE PROCEDURE FOR REPORTING AND FOLLOW UP OF SAIS

During 2012/13 the HSCB/PHA undertook to carry out a review of the 2010 Procedure for Reporting and Follow up of SAIs and as a result a series of events and meetings were held. These have included meetings with HSC Trusts, in order to identify and resolve issues which have proved problematic in relation to the current procedure.

A group of HSCB/PHA staff involved in the SAI process are currently taking forward the outcome of these events, and a number of sub groups have been established to review particular aspects of the procedure. During the last 6 months subgroups have reviewed and amended specific elements of the procedure, which have subsequently been approved by the SAI Project Team. In addition to this work, further aspects of the procedure were identified as being relevant to the review and as a result additional subgroup meetings have been arranged to consider these issues and where relevant make the necessary amendments.

It is anticipated the draft procedure will be shared with HSC Trusts and DHSSPS in early summer with formal issue in September 2013 for implementation on 1 October 2013.

3.0 REGIONAL ADVERSE INCIDENT AND LEARNING (RAIL) SYSTEM

The PHA working closely with the HSCB and all other HSC Organisations has a responsibility to ensure the Regional Adverse Incident Learning (RAIL) System is successfully designed, implemented and evaluated. The aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The RAIL Outline Business Case (OBC) has been amended and resubmitted for appraisal following review, with departmental colleagues, of the options to deliver the pilot. The OBC recommends a phased approach to the implementation of the RAIL system, with the first phase being a 12-18 month pilot to test and refine the system in practice, and determine the staffing, processes and system infrastructure required for RAIL to operate effectively in the longer term. It is intended that the RAIL system will be fully operational subject to positive evaluation of the pilot phase, and approval of a future separate business case for the recurrent long term staffing and infrastructure.

4.0 PROGRESS WITH IMPLEMENTING MENTAL HEALTH REVIEW RECOMMENDATIONS

On 24 January 2013 the PHA and HSCB held the second Mental Health SAI Learning Event in New Mossley Mill, Newtownabbey.

The workshop brought together key stakeholders from across Northern Ireland to explore and share the learning from serious adverse incidents and suicides in the Mental Health programme of care. Representatives attending the event included

Service Users, Carers, Advocates and HSC Trust staff involved in the delivery of Mental Health Services.

The aim of the event was three fold:

- to provide an understanding of the trends emerging from SAI reports submitted by HSC Trusts;
- to provide an opportunity to update those present on the actions previously identified and to consider the lessons learnt from a regional perspective;
- to facilitate discussions regarding the sharing of information, as well as the process for managing SAIs.

Service user engagement was a key element throughout the day with valuable input from the service users and carers in attendance.

As a result the PHA and HSCB have identified a number of actions to be taken forward by the Mental Health Services within HSC Trusts, the PHA and HSCB.

Feedback from the day was positive with all participants expressing the value of the information presented and the opportunity for discussion.

Review of Mental health IEAP and application of DNA practice standards.

- Lessons from HSCB and PHA DNA Audits are now being embedded into new regional care pathways. This includes revised/new guidance for mental health services in respect of those persons disengagement prematurely and/or do not attend care appointments. A standard has also been developed in relation to embedding Assertive Outreach as a function of core mental health services. The care pathway is still in draft and work with service user/carer on refining the requirements continues, this includes embedding their perspective on how DNA management and assertive outreach can be more effectively managed by the HSC. The plan is that this care pathway should be operational from September 2013.

- Service Improvement Managers will be re-auditing DNA practices in June 2013 with an interim report available early July 13

5.0 FRANCIS REPORT

The HSCB and PHA contributed to a number of seminars which provided some opportunities to hear directly from Robert Francis QC about the Mid Staffordshire experience. The purpose was to share the key recommendations from the Inquiry and to explore with colleagues the key lessons and how we further develop and build progress in our own patient safety and quality journey.

A further half day workshop has been arranged on 5 June 2013, to consider the implications of the Francis Report for governance arrangements in the HSC.

SECTION 4

CONCLUSION

Within this reporting period, a number of learning letters were issued. The six HSC Trusts are positively responding to the interim arrangements for disseminating and implementing change as a result of learning from SAIs. Until agreement is reached on a Regional learning system, the current arrangements enable and support regional learning arising from SAI investigations. Furthermore the arrangements facilitate engagement with HSC Trusts on SAI data analysis, and provide opportunities to collectively agree solutions to improve reporting and dissemination of lessons learned.

Over the next six months further action will be taken forward, to implement and develop reporting systems to further enhance safety and quality processes. Learning outcomes as a result of specific reviews will be disseminated locally, regionally and where appropriate nationally, in order to improve both safety and quality and ultimately the care and treatment of patients and clients.

APPENDIX A

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI CRITERIA

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
  - A service user
  - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
  - A staff member in the course of their work
  - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
  - member of the public

- Unexpected or significant threat to provide service and/or maintain business
  - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2012 – MARCH 2013

The HSCB has **received 204 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[5] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 October to 31 March**.

TOTAL SAI ACTIVITY	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	42	49
BSO	2	0
HSCB	3	1
NHSCT	24	48
NIAS	0	4
NIBTS	0	2
PCARE	16	15
SEHSCT	15	34
SHSCT	25	25
VOL	1	0
WHSCT	17	26
Totals:	**145**	**204**

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **seven (7) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	2	1
HSCB	1	0
NHSCT	2	3
PCARE	7	2
SEHSCT	1	0

[5] Source- HSCB DATIX Information System

TOTAL DE-ESCALATED	Oct 11 - Mar 12	Oct 12 - Mar 13
SHSCT	2	0
WHSCT	1	1
Totals:	**16**	**7**

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident.

TOTAL DUPLICATE	Oct 11 - Mar 12	Oct 12 - Mar 13
WHSCT	0	1
Totals:	**0**	**1**

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	17	16
BSO	0	0
HSCB	0	0
NHSCT	3	9
NIAS	0	3
NIBTS	0	0
PCARE	0	0
SEHSCT	0	8
SHSCT	6	5
VOL	0	0
WHSCT	1	2
Totals:	**27**	**43**

Current period: Forty three (43) incidents were reported. The top five groups related to the following classifications/categories, with less than 5 incidents being reported in any one category.

Classification/category

- Admission
- Unexpected /unexplained deaths
- Cancer- Dx failed or delayed
- Arteries and veins
- Communication between staff, teams or departments

There were no major themes emerging from the SAIs. The largest groups (n=4) associated with this category was relating to 'Admissions' and 'unexpected/unexplained deaths'

MATERNITY & CHILD HEALTH

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	4
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	1
NIBTS	0	1
PCARE	0	0
SEHSCT	0	0
SHSCT	2	2
VOL	0	0
WHSCT	2	0
Totals:	**5**	**8**

Current period: Eight (8) SAIs relating to maternity and child health were reported.

FAMILY & CHILD CARE

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	2	2
BSO	0	0
HSCB	0	0
NHSCT	3	10
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	1	1
SHSCT	1	3
VOL	0	0
WHSCT	0	1
Totals:	**7**	**17**

Current period: Seventeen (17) SAIs were reported relating to the following classifications. The largest groups (n=6) related to 'Abuse' and 'Self harm in primary care'

- **Classification/category:**
  - Abuse by the staff to the patient or patient to patient or other

- Self harm in primary care, or not during 24hour care
- Discharge
- Environmental matters

OLDER PEOPLE SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	0	1
BSO	0	0
HSCB	0	0
NHSCT	3	3
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	4
SHSCT	0	3
VOL	0	0
WHSCT	3	2
Totals:	**6**	**13**

Current period: Thirteen (13) SAIs were reported relating to older people services, with less than three incidents being reported in any one category. The largest group (n=2) related to 'Slips, trips, falls and collisions'

MENTAL HEALTH

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	15	23
BSO	0	0
HSCB	0	0
NHSCT	11	19
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	12	18
SHSCT	11	12
VOL	1	0
WHSCT	8	16
Totals:	**58**	**88**

Current period: Eighty-eight (88) SAIs relating to adult mental health services were reported.

- 71 related to suspected/attempted suicides* or unexpected deaths

The remaining reported incidents related to the following classifications:

- **Classification/category:**
  - Discharge
  - Health and Safety
  - Abuse - other
  - Financial loss
  - Medication error

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	1
BSO	0	0
HSCB	0	0
NHSCT	0	1
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	2
SHSCT	1	0
VOL	0	0
WHSCT	0	0
Totals:	**2**	**4**

Current period: Four (4) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	0	1
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	1
SHSCT	0	0
VOL	0	0
WHSCT	0	0
Totals:	**0**	**2**

Current period: Two (2) SAIs relating to physical disability and sensory impairment services were reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

	Oct 11 - Mar 12	Oct 12 - Mar 13
HSCB	1	1
WHSCT	1	0
NHSCT	0	2
PCARE	9	13
Totals:	**11**	**16**

Current period: Sixteen (16) SAIs relating to Primary Health and Adult Community were reported relating to the following classifications.

- **Classification/category:**
  - Administration or supply of a medicine from a clinical area
  - Preparation of medicines / dispensing in pharmacy
  - Medication error during the prescription process
  - Adverse events that affect staffing levels
  - Cancer - Dx failed or delayed
  - Information Technology
  - Abuse - other
  - Infrastructure or resources - other
  - Test results / reports

The largest group (n=5) related to the administration or supply of a medicine from a clinical area

CORPORATE BUSINESS

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	3	0
BSO	2	0
HSCB	1	0
NHSCT	2	1
NIAS	0	0
NIBTS	0	1
PCARE	0	0
SEHSCT	1	0
SHSCT	1	0
VOL	0	0
WHSCT	1	3
Totals:	**11**	**5**

Current period: Five (5) SAIs were reported relating to the following classifications:

- **Classification/category:**
  - Fires, fire alarms and fire risks
  - Patient's case notes or records
  - Environmental matters
  - Infrastructure or resources - other
  - Security incident related to Premises, Land or Real Estate

HEALTH PROMOTION AND DISEASE PREVENTION

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	0
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	0
SHSCT	1	0
VOL	0	0
WHSCT	0	0
Totals:	**2**	**0**

Current period: No reported incidents