Belfast Health and Social Care Trust
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FOI/32688

04 February 2025

Serious Adverse Incident Reviews

This is a request for information under the Freedom of Information Act for information on Serious Adverse Incident Reviews.

Please provide the following information, for the following years 2020, 2021, 2022, 2023.

1. **The number of mental health related SAIs, broken down by Trust location and investigation level.**

*Corporate Governance can confirm from the data we hold in relation to SAIs commissioned by Mental Health the numbers are as follows:

Table 1A: Mental Health SAIs* by Year and Site for the period 01 Jan 2020 to 31 Dec 2023

Site	2020	2021	2022	2023
Belfast City Hospital Site	<5	<5	0	<5
Community Locations	28	19	14	17
Forster Green Hospital Site	<5	<5	0	<5
Independent Sector Providers	0	0	0	<5
Knockbracken Healthcare Park Site	<5	0	<5	0
Mater Hospital Site	0	0	0	<5
Royal Group of Hospitals Site	<5	<5	0	<5
Totals	**35**	**25**	**14+**	**22**

Table 1B: Mental Health SAIs* by year and review level for the period 01 Jan 2020 to 31 Dec 2023

Review level	2020	2021	2022	2023
Level 1	32	21	15	19
Level 2	<5	<5	0	<5
Level 3	<5	<5	0	0
Totals	**35**	**25**	**15**	**19+**

2. **The number of suicide related SAIs, broken down by Trust location and investigation level.**

Corporate Governance can confirm from the data we hold the numbers are as follows:

Table 2A: Suicide related SAIs by Year and Site for the period 01 Jan 2020 to 31 Dec 2023

Site	2020	2021	2022	2023
Belfast City Hospital Site	<5	0	0	0
Community Locations	28	19	20	19
Forster Green Hospital Site	<5	0	0	0
Independent Sector Providers	0	<5	0	<5
Mater Hospital Site	<5	0	0	<5
Royal Group of Hospitals Site	<5	<5	<5	<5
Totals	**32**	**22**	**20+**	**26**

Table 2B: Suicide related SAIs by year and review level for the period 01 Jan 2020 to 31 Dec 2023

Review level	2020	2021	2022	2023
Level 1	30	20	21	24
Level 2	<5	<5	0	<5
Totals	**32**	**22**	**21**	**26**

Please note: We are unable to provide an exact figure where numbers are very low. To provide this level of information would reduce numbers to discoverable limits where individuals could be identifiable. This is exempt from release under section 40(2) Personal Information relating to a third party, of the FOI Act. This information would be unfair to the individuals to release this information. Disclosure would constitute a breach of the principles of the Data Protection Act 2018.

3. **A copy of the documented process for conducting SAIs.**

SPPG (formally HSCB) SAI Procedure for the Reporting and Follow-Up of Serious Adverse Incidents (SAIs) version 1.1 November 2016 has been attached. Note that this is adhered to regionally.

BHSCT Procedure for Serious Adverse Incidents (SAIs) v5 (Operational from October 2020). This has also been attached.

4. **A copy of the key code for categorising SAI investigation levels.**

SPPG SAI Procedure (attached) provides breakdown of the Level of Review definitions (section 5 pages 14-16). Ref attached document.

5. **All documentation addressing outcomes from mental health and suicide related SAIs.**

A response to this specific question would take considerably longer than 18 hours to answer this FOI, as it would involve reviewing all outcomes from Mental Health and suicide related SAIs and associated follow-up action completed for the period 01 January 2020 to 31 December 2023. This would exceed the costs limit specified in the FOI act.

We estimate that compliance with this element of the request for information would exceed the appropriate costs limit. Under Section 12 of the Freedom of Information 2000, the limit has been specified as £450 and represents the estimated cost of one or more persons spending 18 hours in determining whether we hold the information, locating, retrieving and extracting this information.

6. **All documentation on lessons learnt from mental health and suicide related SAIs.**

Learning from SAIs can be identified at a number of stages throughout the SAI review process. In some instances, immediate learnings identified will be actioned before the review has been completed. Therefore, it will not form part of the recommendations, but will be noted in the lessons learnt section. There is no central repository held within Mental Health Governance or the Speciality teams that contains all correspondence issued in relation to lessons learnt and the follow-up by individual teams. However, recommendations are actively tracked and monitored.
Therefore all documentation based on lessons learnt from Mental Health and suicide related **SAIs** for the period 01 January 2020 to 31 December 2023 would take longer than 18 hours to respond.
Recommendations identified on completion of the SAI reviews applicable to the Directorate/ Trust wide or regionally will be transferred onto the learning template and shared accordingly.
Please see below a summary of shared learnings identified during the timeframe requested, approved by the BHSCT Serious Adverse Incident Group (SAIG).

SAI/22/057
HSC Learning notification Issued 12 March 2024

Shared Learning Letter issued 10 November 2023 re communication with Lifeline re sudden deaths

SAI/20/098
SQR SAI 2022-089 Assessment under the MH Order (NI) 1986 issued by SPPG 06 April 2024
Shared Learning Letter issued December 2021 re Patients must be physically seen when completing assessment for detention

SAI/20/105
Shared Learning Letter issued 21 July 2023 re Transfer Direction Orders from Prison to MH services must be triaged through Shannon Clinic

SAI/20/011
Shared Learning Letter issued 13 August 2024 re Mental State Assessments

SAI/22/001
When an assessment under the **Mental Health (Northern Ireland) Order 1986** (MHO) is required for a service user, there needs to be clearer communication between staff, service users and family around the distinction between the legal role of a 'Nearest Relative' as per the Mental Health Order and that of a nominated 'Next of Kin'.

The attachments can be provided upon request to external viewers of this response