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1.0 <u>INTRODUCTION / SUMMARY OF POLICY</u>

This procedure covers the reporting, review and management of Serious Adverse Incidents for Belfast HSC Trust staff and is based on the SPPG (formerly HSCB) Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013. It should be read in conjunction with the BHSCT Adverse Incident Reporting & Management Policy and other associated procedures.

2.0 SCOPE OF THE POLICY

2.1 Purpose

The purpose of this procedure is to enable a robust and systematic approach to the management of Serious Adverse Incidents that will be consistently applied across the Trust. This will contribute to ensuring that the Trust meets the SAI reporting and management requirements as defined by the SPPG (formerly HSCB) within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (version 1.1, November 2016) through guiding staff on their duties and responsibilities regarding:

- Reporting a Serious Adverse Incident
- Informing the Service User / family / carer
- Coroner Involvement
- Reviewing a Serious Adverse Incident to identify any learning and recommendations
- Completing an action plan on any actions identified

2.2 Scope of this procedure and definitions

This procedure applies to all staff in the Belfast Health and Social Care Trust, including BHSCT employees, students, agency, contractors and volunteers.

Adverse Incident:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation" (*How to Classify Adverse Incidents and Risk, HPSS 2006*).

Harm is defined as 'injury (physical or psychological), disease, suffering, disability or death'. In most instances can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*)

Serious Adverse Incident (SAI) is an adverse incident that must be reported to the Strategic Planning and Performance Group (SPPG) because it meets at least one of the criteria as defined by the SPPG (formerly HSCB) within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents

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(SAI's), version 1.1, November 2016" (see section 4.2). The Trust will be responsible for the onward reporting of SAIs relevant internally, and to their Independent Service Providers (ISPs) and contractors, and will ensure the appropriate review, learning and sharing of lessons regarding same.

3.0 ROLES AND RESPONSIBILITIES

3.1 Chief Executive

The Chief Executive is responsible for ensuring that a system is in place to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by the Trust, which may require urgent attention by the Minister, Chief Professionals or policy leads, and/or require urgent regional action by the Department.

3.2 Corporate Governance

The Corporate Governance team has responsibility for centrally managing the Trust's SAI Inbox (SeriousAdverseIncidents@belfasttrust.hscni.net) and ensuring that SAIs are reported and follow-up in line with Regional SPPG Procedures.

3.3 Directors

Directors are responsible for the reporting and follow-up of SAIs in line with Regional SPPG Procedures, including submission of an SAI Notification within 72 hours of becoming aware an incident meets SAI Criteria.

3.4 Co Directors

Co Directors are responsible for ensuring that incidents which may fall within the criteria for SAIs within their areas of responsibility are reported to the relevant Director as a matter of urgency to allow for a decision by their respective Director as to the merits of reporting to the SPPG.

3.5 Senior Managers

Senior Managers are responsible for making staff aware of this policy and ensuring discussion with the Co Director of any incident which may fall within the criteria for reporting as an SAI.

3.6 Staff

Trust staff (including permanent, temporary, locum, agency, bank, contractors and voluntary) are responsible for making themselves aware of, and adhering to, the content of this policy.

4.0 CONSULTATION

Serious Adverse Incident Group (SAIG)

5.0 POLICY STATEMENT/IMPLEMENTATION

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5.1 REPORTING A SERIOUS ADVERSE INCIDENT (SAI)

5.1.1 What is an SAI?

An SAI is an adverse incident that must be reported to the Strategic Planning and Performance Group (SPPG) because it meets at least one of the following criteria:

- Serious injury to, or the unexpected/unexplained death of:
  - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a 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 self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- serious self-harm or serious assault (including homicide and sexual assaults)
  - on other service users,
  - on staff or
  - on members of the public
  - by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;
- suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;
- Serious incidents of public interest or concern relating to:
  - any of the criteria above
  - theft, fraud, information breaches or data losses
  - a member of HSC staff or independent practitioner

Any adverse incident which meets one or more of the above criteria should be reported as an SAI.

5.1.2 How to Report an SAI

If an adverse incident occurs which meets or seems to meet any of the above criteria it should be reported immediately through the reporters management line and ultimately to Director or Co-Director for consideration for reporting as

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an SAI (the Directorate Governance & Quality Manager or equivalent, should also be included in any communication). This should be done urgently and in the form of verbal as well as email communication.

When Director/Co-Director agrees to report the incident as an SAI, the relevant Manager or Governance & Quality Manager (or equivalent) should then complete the SAI Notification Form (Appendix 1), send it to the Director / Co-Director for approval and forward the approved copy (including details of who approved it) to the Corporate Governance Department SAI mailbox (address below) for onward reporting to the Strategic Planning and Performance Group (SPPG).

The form can also be obtained by emailing your request to Serious Adverse Incident mailbox SeriousAdverseIncident@belfasttrust.hscni.net (also in Outlook address book) or by contacting Corporate Governance Services on Tel: 028 950 48098.

The Serious Adverse Incident mailbox should also be used for all SAI correspondence with Corporate Governance and external bodies.

Corporate Governance will then check and redact the SAI Notification form of personal identifying information and give it a BHSCT SAI reference number. The form will then be forwarded to the SPPG and if applicable to the Regulation and Quality Improvement Authority (RQIA).

A Trust Incident Report Form should also be completed as soon as possible (if not already done so) as per Trust procedures.

All Adverse Incident policies and procedures can be found in the Policies & Guidelines page of Trust Intranet under the Medical Directorate/Risk & Governance sub folders.

5.1.3 Timescale

Any adverse incident that meets the criteria indicated in section 3.1 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (see Appendix 1).

5.1.4 General guidance on completing the SAI Notification form

Guidance on completing the SAI Notification Form can be found at Appendix 2 -Serious Adverse Incidents (SAIs). The following points should be read in conjunction with those procedures:

Sections to complete
Complete all of the following sections (Corporate Governance will complete the remainder)
Sections 3, 4, 5, 6, 8 (excluding CCS coding), 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18.
Section 8: Incident Description:

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- Provide a brief factual description of what has happened and a summary of the events leading up to the incident. Please ensure sufficient information is provided so that the SPPG/PHA is able to come to an opinion on the immediate actions, if any, that they must take.
- Where relevant include D.O.B, Gender and Age.
- All reports should be anonymised – the names of any practitioners or staff involved must not be included. Staff should only be referred to by job title.

5.1.5 Informing the service user / family / carer

The principles of the Being Open Policy must be adhered to when communicating to service users, their families or carers regarding the reporting of a Serious Adverse Incident. Where it is clear or suspected that an SAI has resulted in unexpected serious harm or death to a service user, rapid and open disclosure and emotional support must be given.

The Co-Director responsible for the SAI is also responsible for ensuring the service user / family / carer is communicated with appropriately regarding the SAI and subsequent review. They will nominate the appropriate person to speak with the service user / family / carer initially and also ensure the service user / family / carer has a link person to contact throughout the SAI process as required. An information leaflet covering "What do I need to know about Serious Adverse Incidents" should be given to the service user / family / carer to include contact details for the link person. **NB -This leaflet should only be used when it's confirmed an SAI Notification has been submitted.**

If the Service User/Family/Carer has been notified of the incident before completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form (see appendix 1). If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the "Others" free text field in section 15 of the form, or where relevant in any updated form the SPPG subsequently issues.

5.1.6 Coroner Involvement

Details of involvement with the Coroner must where applicable, be included in the description section 8 of the SAI Notification form. It is also important to include date of notification of the Coroner if applicable in section 17. When it is known that a death is to be investigated as an SAI the Coroner must be notified of this even if previously notified of the death.

Ensure the form is forwarded by email to the Trust SAI email address seriousadverseincident@belfasttrust.hscni.net along with confirmation of approval by the relevant Director or Co-Director (name of whom must be provided).

The Coroner's Reference Number should also be forwarded to Corporate Governance for recording on Datix where applicable.

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5.1.7 Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however, the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the SPPG using the SPPG Interface Incident Notification Form (*see HSCB SAI Procedure Appendix 3*). The SPPG Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

5.1.8 "Query Serious Adverse Incidents" (QSAIs)

The responsibility for identifying and the decision to report an SAI is primarily with the Directorate responsible for that incident. To support Directorate incident review processes and to act as a further control to delayed reporting, the Corporate Governance Department may query any incident report where an SAI criteria seems to have been met but where the date for reporting the incident as an SAI is overdue and with no indication that it is being reported or considered. This is known as a Query SAI (QSAI) and "QSAI" is added to the incident reference until closed.

Once an incident is identified as being a query SAI (QSAI) it is forwarded to the relevant Directorate Governance & Quality Manager or equivalent for consideration for reporting as an SAI.

The incident will remain open as a QSAI until Corporate Governance receives either:

- A completed approved SAI Notification form relating to the incident, OR
- A review report or if not applicable, a clear explanation of why the incident does not meet the criteria for reporting as an SAI. The review report should include any learning and actions taken to prevent re-occurrence where applicable. Please note that the decision not to report as an SAI may be subject to challenge from the Medical Directorate's office.

The response to the QSAI should be sent to the Trust SAI mailbox seriousadverseincident@belfasttrust.hscni.net and any report should also be included within the Datixweb incident record and referenced in the investigation section.

5.2 PROCEDURE FOR REVIEWING SERIOUS ADVERSE INCIDENTS (SAIs)

The following procedures for the review of Serious Adverse Incidents (SAI) are based on, and should be read in conjunction with, the SPPG (formerly HSCB)

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SAI Procedure for Reporting and Follow up of Serious Adverse Incidents (version 1.1., November 2016).

When reporting an SAI, the responsible Director / Co-Director (in conjunction with the Medical Director if considering a level 3) must decide on the level of review required and this must be indicated on section 18 of the SAI Notification form. There are 3 levels of review available for SAIs and these are explained below (see section 4.1).

5.2.1 Level of SAI Review

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning of all SAIs reported, it is important the level of review focuses on the complexity of the incident and not necessarily on the significance of the event.

SAIs will be investigated using one or more of the following:

5.2.1.1 Level 1 Significant Event Audit (SEA)

A level 1 review requires the use of Significant Event Audit (SEA) Review methodology to investigate the incident.

SAI notifications which indicate a level 1 review will enter the review process at this level and a SEA will immediately be undertaken to:

- assess why and what has happened
- agree follow up actions
- identify learning

The possible outcomes may include:

- no action required
- identification of a learning need and actions
- sharing the learning
- Requires Level 2 or 3 review.

An SEA report must be completed, approved by the relevant Director/Co-Director and sent to the Trust SAI mailbox seriousadverseincident@belfasttrust.hscni.net for processes and onward reporting to the SPPG within 8 weeks of the date of the SAI Notification.

To quality assurance SEA reports once submitted to Corporate Governance they will undergo both a clinical peer review and corporate governance review before they are redacted and sent on to SPPG/PHA. This will ensure the robustness of the report and identification of learning prior to submission to SPPG.

On some occasions these reviews may raise queries which will be sent to the Directorate for action. Where subsequent amendments are made to the SEA report it should be sent for further approval by the relevant Director/Co-

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Director before being resubmitted to the Corporate Governance team for processing.

Once all queries have been addressed the SEA report will be redacted and the SEA Learning Summary Report (*see HSCB SAI Procedure Appendix 4 and 5*) will be submitted to SPPG/PHA. The SPPG will not routinely receive full SEA reports unless specifically requested by the DRO.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the SPPG within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

When a level 2 review is required then the process will then need to be initiated as outlined in section 4.1.2. The Director / Co-Director should contact Corporate Governance to identify suitably trained and independent individuals to chair the level 2 process supported by a team of the Directorate choosing and in agreement with the appointed chair.

In most circumstances, completed SEA reviews at this level will be adequate for incidents where the circumstances are of a less complex nature. In these instances it is more proportionate to use a concise SEA to ensure there are no unique factors and then focus resources on implementing improvement rather than conducting a comprehensive review that will not produce new learning. NB Family Involvement (see section 4.4).

5.2.1.2 Learning from Level 1 Reviews

Any learning from these reviews should be shared as appropriate within the Directorate governance structures and in accordance with the BHSCT Policy for Sharing Learning.

If there is significant learning at any stage of the SEA process which requires urgent sharing outside the Directorate, this should be brought to the next SAI Group meeting by the relevant Co-Director on a Shared Learning Template (*see BHSCT Policy for Sharing Learning Appendix 1*).

5.2.1.3 Level 2 Root Cause Analysis (RCA)

Level 2 reviews will usually be conducted for incidents of actual or potential serious harm or death and/or where the circumstances involved are relatively complex and may involve multiple processes/teams/disciplines.

The review should include use of appropriate RCA analytical tools (see section 4.3 below and SPPG SAI Procedure Appendix 7 RCA guidance). They will normally be conducted by a multidisciplinary team (not directly involved in the incident) with a degree of independence determined by the complexity of the incident. The review should be chaired by someone independent to the service area involved as a minimum. The review report

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should be completed using the SPPG RCA report template within 12 weeks from the date of SAI Notification submitted to SPPG as outlined in regional policy (*see appendix 6 & 7 of SPPG SAI Procedure for Reporting and Follow up of Serious Adverse Incidents, November 2016*).

Team membership for level 2 reviews is the responsibility of the Director / Co-Director who commissioned the SAI and should consider team membership to include members independent of the division concerned where appropriate. The Chair will be selected by Corporate Governance from an established Trust wide pool of appropriately trained RCA Chairs held centrally. Where the Commissioning Director / Co-Director requires team member(s) external to the Trust, and is having difficulty obtaining these, they should liaise with Corporate Governance who may contact the SPPG/PHA for further advice if required.

NB: The Trust has provided accredited training in RCA methodology for staff willing to lead/chair level 2 reviews following notification of serious adverse incidents to the SPPG. To further support these staff a twice-yearly forum has been established. This is intended to share best practice and challenges, which may be experienced by chairs of level 2 reviews, encouraging a standardised use of approved methodology and development of learning. In addition, a monthly SAI panel is in place, chaired by the Deputy Medical Director with membership of the Co - Director, Risk and Governance and representation from the pool of trained RCA Chairs on a rotational basis . All reports approaching finalisation are expected to be presented to this panel for peer review and is intended to support consideration of identified learning, consistent approach to use of agreed methodology and format of reports.

Level 2 SAI reviews may involve two or more organisations. In these circumstances, it is important a lead organisation is identified but also that all organisations contribute to the final review report. If required Corporate Governance will liaise with the other organisation(s) to propose a team member(s) and agree who leads the SAI. Refer to Appendix 11 of SPPG Procedures for reporting and managing SAIs, November 2016 for further guidance.

Sections 2 and 3 of the Level 2 review template must be completed and forwarded to the SPPG via the SAI Mailbox by, or on behalf of the Director / Co-Director within 4 weeks of the level 2 SAI being notified, detailing the membership and terms of reference for the level 2 review. Details on service user/ family/ carer engagement can be found in section 4.4.

5.2.1.4 Learning from Level 2 Reviews

Any learning from these reviews should be shared as appropriate within the Directorate governance structures and in accordance with the Trust Policy for Sharing Learning. If there is significant learning at any stage of the review process which requires urgent sharing outside the Directorate, this should be brought to the immediate attention of the appropriate Governance Manager for immediate action and inclusion on the weekly Governance call. This will

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also support formal inclusion at the next SAI Group meeting by the relevant Co-Director for discussion and agreement regarding further urgent actions.

5.2.1.5 Level 3 Independent Review (RCA)

Level 3 reviews will be considered for highly complex SAIs where a high degree of external/independent representation on the review team is required. In some instances all team members may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and membership of the review team will be agreed with the SPPG/PHA Designated Review Officer (DRO) at the outset. The Commissioning Director / Co-Director and Medical Director should liaise with the DRO through Corporate Governance to agree timescales, team membership and terms of reference.

Level 3 review reports will take the same format as level 2 and use the same template structure for the final report.

Any SAI which involves an alleged homicide perpetrated by a service user known to/referred to mental health and/or learning disability services will be investigated as a level three incident. In these instances, the Protocol for Responding to an SAI in the Event of a Homicide. Interim updated guidance issued by HSCB in November 2018 must be followed as below:

The Commissioning Director must ensure there is engagement with the service user and their families in line with existing guidance (refer to Addendum 1 - HSCB Procedure for the reporting and follow up of SAIs - *Engagement/Communication with service user/family/carer following a SAI)*

The Commissioning Director should ensure the following arrangements are in place when the engaging with the family/families of the **victims** of homicide by a mental health patient:

- Communication to be made at the earliest opportunity, whilst being sensitive to the need/wishes of the family.
- a nominated person with the necessary skills and experience is identified, to act as a point of contact to link with the family of the victim(s).
- In line with the family's wishes, a meeting should be arranged to:
    - acknowledge, apologise and explain that the organisation wishes to review the care and treatment of the patient / service user;
    - explain why the incident has been categorised as a SAI and any immediate action that has been taken;
    - explain the purpose of the review in identifying learning opportunities for the HSC Trust and wider HSC family and the role of the HSC Trust in completing the review; outlining timescales;
    - agree information which can be shared; (Terms of Reference for the review and Recommendations from the review; in line with relevant

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data protection legislation and The Access to Health Records (Northern Ireland) Order 1993); and

- Facilitate access to support and advocacy services where requested
- All communication should be in an accessible format that meets the needs of the family.

5.2.2 Timescales

5.2.1 Notification

Any adverse incident that meets the criteria of an SAI must be reported within 72 hours of the incident being discovered using the SPPG SAI Notification Form.

5.2.2 Review Reports

- **Level 1 SEA Review**

  SEA reports must be completed using the SEA template and submitted to the SPPG within 8 weeks of the SAI being notified.

  NB: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to SPPG to allow for redacting and final checks.

- **Level 2 – RCA Review**
  Sections 2 and 3 of the Level 2 & 3 report template must be forwarded to the SAI Mailbox for onward forwarding to SPPG no later than 12 weeks after notification to SPPG of a level 2 review.

  RCA review reports must be completed using the level 2 & 3 report template and submitted to the SPPG no later than 12 weeks from the initial notification of the SAI to SPPG, or if previously a level one review, 12 weeks from submission of the level one SEA report.

  Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to SPPG to allow for redacting and final checks.

- **Level 3 – Independent Review**

  Timescales for completion of level 3 reviews will be set by the SPPG/PHA lead officer and/or DRO in agreement with the Trust.

  NB: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to SPPG to allow for redacting and final checks.

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5.2.3 Timelines for Queries from SPPG Designated Review Officer (DRO)

- **Level 1 SEA Review**
  DRO queries must be responded to within 2 weeks of the query being received.

- **Level 2 RCA Review**
  DRO queries must be responded to within 6 weeks of the query being received.

- **Level 3 Independent Review**
  DRO queries must be responded to within 6 weeks of the query being received

5.2.4 Monitoring

The commissioning Director / Co-Director is responsible for ensuring that review progress is monitored and timetables are met. A performance report will be tabled at each SAI Group identifying any SAIs where progress issues have been identified. The relevant Co-Director will be required to provide explanations for any delays.

When the draft final report is complete, the review team chair is advised to share the report with a Trust colleague independent to the directorate for review. The reviewer may have comments/feedback which should then be considered by the review team before finalisation of the report for approval by relevant Director/Co-Director.

5.2.5 Actions

The level 2 & 3 report template (*appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016*) indicates that an action plan should be included within the Final report for submission to SPPG. This should be done as far as possible. A final draft Action Plan must be forwarded as soon as approved. Actions do not need to be complete when submitting the action plan to the SPPG. Further details on the Action Plan can be found in section 5.0 below.

5.3 COMPLETION OF LEVEL 1 (SEA) & LEVEL 2&3 REPORT (RCA) TEMPLATES

Guidance on completing the level 1 and level 2 & 3 report templates for can be found at Appendix 5 & 7 respectively of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016.

The following points should be read in addition to those procedures:

- Jargon or unexplained abbreviations must not be used within the report. Although clinical shorthand would be understandable to other clinicians, a SEA or RCA report is a formal report and not a clinical record. As such it

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should be understandable to non-clinicians including the service user / family members / carers and the Coroner.

- All reference to services, organisations, facilities etc should be explained fully if not otherwise obvious to the reader e.g. it is not sufficient to include the name of a client accommodation building without explaining the purpose/function of the building.
- The HSCB RCA template is in tabular form. This may cause formatting difficulties. It is acceptable to use a blank word document instead but the HSCB section headings from the RCA template must be included.

5.4 SERVICE USER/FAMILY/CARER INVOLVEMENT

HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 Paragraph 5.4 should be adhered to and states the requirement for service user / family / carer involvement in SAI reviews is as follows:

Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.

In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroner's office and that this is also communicated to the Family/Carer.

The Co-Director responsible for the SAI should ensure the appropriate level of involvement of service user / family / carer throughout the review including discussion / sharing of the final report with the service user / family / carer and this should be agreed with the review team from the outset.

The Director / Co-Director responsible for the SAI should ensure the completion of an SAI Review Report checklist (appendix 2) when submitting Review reports to SPPG via the BHSCT SAI mailbox. This checklist will explicitly describe the involvement (and if not, the circumstances where it has not happened) of Service Users / Relatives / Carers in the Review and whether they received a final report.

Approved SAI final reports should be shared or talked through with the service user/relatives/Carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist and if pending, this should be included as an action in the subsequent Action Plan for that SAI (see below).

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In all cases the principles of consent and patient confidentiality must be upheld.

For guidance on how to involve families in the SAI reviews please refer to the SPPG SAI Procedure Addendum 1 'A Guide for HSC Staff Engagement following an SAI' November 2016.

Involvement specific to level 1 (SEA) reports

Under the SPPG timeframe for completing level 1 reviews it may not be possible to involve the service user / family / carer in the review process before the final report is submitted to the SPPG. Service User/family/carer often provide important information and insight into experiences which will be vital in support learning. Where family involvement is deemed appropriate, the approved report should be discussed / shared with the family at a date as soon as possible after submission of the report and any additional information or issues addressed and those requiring material changes to the level 1 report should be added as an addendum and forwarded to Corporate Governance for sending to SPPG in a revised report.

Where an SAI is also a Complaint

Where a Serious Adverse Incident is also a Complaint, the review under the SAI process will take precedence and the Complaints review will be put on hold until the SAI review is complete. The Complaints Department should notify the Complainant of this as soon as possible. The leaflet '*What I need to know about a Serious Adverse Incident'* should be given to the Complainant along with an explanation of the change in process.

Note that communication through the complaints process with the Complainant should continue regarding timescales and any associated delays. The SAI review process as per above will also have a link person identified to communicate with the service user / family / carer and will communicate through this process as appropriate. When complete the SAI final report will be shared with the Complainant and the complaints process remains open until the complaint is formally closed with all complaints issued addressed.

5.5 CORONER ENGAGEMENT

Reports should also routinely include in their chronology details of all engagements with the Coroner where a death has occurred and if the Coroner has not been involved this should be stated and the decision explained.

The Director / Co-Director responsible for the SAI should also ensure the completion of an engagement checklist when submitting SAI reports to SPPG. This checklist will seek information regarding notification to the Coroner and current status of the case.

5.6 SAFEGUARDING CHILDREN AND ADULTS

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Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be reviewed under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the SPPG as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these reviews informing the SAI review (*see HSC Procedure for Reporting and Follow-up of SAIs, appendix 17*). However, all such reviews should be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults. In these circumstances, the Trust should liaise closely with the DRO on the progress of the review and the likely timescales for completion of the SAI Report.

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the SPPG as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

If a CMR is being considered the SAI process may be suspended and the SPPG notified of this whilst a notification and decision regarding CMR is made. If it is approved as a CMR then the SAI process will close.

5.7 MEMORANDUM OF UNDERSTANDING (MOU), MARCH 2013

Incidents involving unexpected death or serious harm and requiring review by the police and/or Health and Safety Executive (HSENI) need to be handled correctly for public safety reasons as well as maintaining confidence in the HPSS, Police, Coroner and the HSENI.

The Department's MoU between these four organisations seeks to ensure effective arrangements are in place to facilitate these complex interactions. The MoU compliments existing joint procedures in relation to the protection of children and vulnerable adults.

You can access the DoH Memorandum of Understanding (*Investigating Patient Safety Incidents Involving Unexpected Death and Serious Untoward Harm*, HSS(MD) 8/2018 - Published 15 March 2013) via the links below:

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- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mou-patient-client-safety-incidents.pdf

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Table 1: SAI Review process – Teams, tools and timescales
For further details please see HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016

					Responsible officer			
SAI type *(guide only)*	**Review Level**	**Timescale**	**Chair**	**Team**	**Approval**	**Action Plan**	**Learning**	**DRO Queries timescale**
Not complex	Level 1 Significant Event Audit (SEA)	8 weeks	Outside Service Area. SEA trained	Local multi-disciplinary.	Director/Co-Director	Director/Co-Director	To SAI group if sharing beyond Directorate	2 weeks
SEA not sufficient, more complex issues	Level 2 Root Cause Analysis (RCA)	12 weeks from SAI level 2 Notification. ToR & Team membership by 4 weeks	Outside Service Area/Dir. or Trust. RCA trained	Multi-disciplinary / Trust independent input possible.	Director	Director/Co-Director & SAI Group	To SAI group if sharing beyond Directorate	6 weeks
Particularly complex/ multiple orgs involved; requires significant degree of independence; high profile.	Level 3 Independ Review (RCA)	To be agreed with SPPG (formerly HSCB)	Outside Dir or Trust. RCA trained	Highly independent multi organisational	Director/ Chief Executive	Director & SAI Group	To SAI group if sharing beyond Directorate	6 weeks

5.8 ACTION PLANS

5.8.1 Introduction

These procedures outline the responsibilities and requirements to ensure appropriate actions are taken to prevent/minimise re-occurrence and share learning.

The Director / Co-Director responsible for the SAI review has responsibility for ensuring any recommendations and lessons learned are incorporated into a plan of appropriate and realistic actions (SAI Action Plan).

An action plan is an important tool to improve systems and implement recommendations from reviews into adverse incidents.

Action plans for SAIs should be approved by the Director / Co-Director responsible for the review. When all actions are completed they should be signed off by the Director/ Co-Director and in the case of Level 2 & 3 SAIs noted as closed at SAI Group.

A robust Action Plan should be:

- explicit
- time bound
- deliverable
- assign responsibility for the action
- measurable

Avoid actions such as *remind staff* or *promote awareness,* but it they have to be used, explain how this will be done e.g. a poor action would be – *share updated policy with staff*.

Be more specific – *send staff the specific section which has changed highlighting the change and drawing their attention to it*.

SAI Action Plans should include actions for sharing lessons learned from SAI reviews as appropriate.

5.8.2 Generating Actions from the Final Report

Whilst recommendations in a final report are drawn up and are the responsibility of the review team, the corresponding actions are the responsibility of the relevant Director or Co-Director. Action Plans must address all recommendations within the Final Report as deemed appropriate. Where actions are at variance with what has been recommended within the report, then the reason should be given to justify the differing course of action or no action.

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If recommendations include actions external to the Trust, the Action Plan should identify who will take these forward and have sought agreement for this with the named person(s).

Additional actions

- It may be appropriate to include an action in the action plan in relation to sharing the action plan with the service user / family / carer as appropriate and the progress of this should be monitored until complete.
- Actions should be included as appropriate on how the learning from the SAI is being shared.

5.8.3 Developing an Action Plan

- Overall responsibility for the SAI Action Plan (BHSCT Action Plan Monitoring & Tracking Template available on the HUB) must be with the Director / Co-Director responsible for the SAI Review and they must determine who draws up the action plan.
- Where the action identified is within the area of responsibility of the Director / Co-Director responsible for the review, the person identified to take the action forward must be instructed to do so and have the capacity required.
- Where a recommendation is outside the area of responsibility of the Director / Co-Director, discussion and agreement must be reached with the relevant manager for drawing up and taking any action(s) forward as appropriate. The Director / Co-Director must ensure agreement is reached.
- Timescales for each action must be agreed with the person/area responsible for implementing the action.
- A draft action plan should be submitted if possible with the Final Report to the SPPG with a final draft submitted when approved. Actions do not need to be completed when submitting the action plan to the SPPG.

5.8.4 Documentation

- Every Action Plan must be documented using the SAI Monitoring / Tracking Report template (see STAGE 3: SAI Action Plans - Serious Adverse Incidents) which complies with the minimum standard for Action Plans

- The SAI Monitoring / Tracking Report template for recording Action Plans includes the following:
  - The reference number of the SAI
  - Date of the SAI Review report
  - Date of the latest version of the Action Plan
  - Version number and how often the Action Plan is to be reviewed
  - Who will monitor the implementation of the Action Plan.
  - Who will sign off the Action Plan when all actions are complete

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- Each action on the “SAI Monitoring / Tracking Report template” must include:
  - An associated recommendation, Contributory factor or lesson learned from the Review report.
  - A reference or sub-reference number.
  - The current position – this should provide the latest position in relation to progressing the action to date.
  - A description of the action to be taken.
  - Name of the responsible lead for that action (not only their job title).
  - A timescale for completion (if unknown an estimate should be made).
  - Evidence of progress/completion (including any intended Action Plan reviews or audits).
  - Indication of current status which must be one of the following:
    - **RED** – Action agreed but not yet commenced
    - **AMBER** – Action in progress
    - **GREEN** – Action complete

5.8.5 Monitoring

- The Director / Co-Director who commissioned the review is responsible for setting up directorate level monitoring and review processes to ensure actions are progressed as planned.

- Where actions cannot be completed, the Director / Co-Director who commissioned the review is responsible for ensuring that any associated risks are identified and managed in line with the Trust Risk management strategy and brought to the SAI Group for consideration, along with any other unresolved issues.

- The relevant Co-Director responsible for the SAI should notify the SAI Group of the closure of any Action Plans which are complete and have no outstanding issues. Action Plans will not normally be required to be tabled at SAI Group.

- The SAI Group will in respect of its provision:
  - Provide independent review to agree learning points for sharing;
  - Note closure of action plans through exception reporting;
  - Directorate membership will provide assurance of appropriate debriefing and sharing of learning at Directorate level;
  - Agree appropriate escalation of learning to the Learning from Experience Steering Group;
  - Review status reports from external bodies, such as SPPG/RQIA/HSCNI, as and when required;
  - Members will report on identified risks/issues associated with SAIs and agree appropriate escalation to the Learning from Experience Steering Group;
  - Make recommendations to corporate and operational risk registers as appropriate.

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- The Corporate Governance Department of the Medical Director's Office will have responsibility for administering a central monitoring process to facilitate SAI Group monitoring.

- Directorate Senior Managers responsible for governance are responsible for ensuring Corporate Governance has the latest version of action plans held centrally.

- The Corporate Governance Department will have responsibility within the central monitoring process for providing a final check on Action Plan progress and will provide liaison with external organisations as required.

5.9 CLOSURE OF THE SAI

The SAI is closed when signed off by the SAI Group. This will be done when the Action Plan is complete and no outstanding issues remain and will usually include ensuring that the SPPG has also closed the SAI (which they do via email to Corporate Governance and notification of this will be forwarded to the commissioning Director / Co-Director).

When closed, a confirmation email is sent to the Director / Co-Director to include a final version of the Final report and Action Plan. Up until this stage, the version used will be a "final approved draft" and subject to change due to further material changes for example after comments received from family members. Any change will be under strict version control through Corporate Governance, approved by the commissioning Director / Co-Director and presented as an addendum to the report and forwarded to SPPG and any other relevant stakeholders.

5.10 DISSEMINATION

Following approval, the policy will be disseminated widely to all levels of staff across the Trust, including Directors, Co Directors and Senior Managers.

5.11 RESOURCES

Directors are responsible for ensuring that all staff across their Directorates have awareness and understanding of this policy.

5.12 EXCEPTIONS

None.

6.0 MONITORING AND REVIEW

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Accountability/Performance Management Reviews

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- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Controls Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident Group

7.0 EVIDENCE BASE/REFERENCES

BHSCT Adverse Incident Reporting and Management Policy (2018) TP 94/14
BHSCT Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments (2020) TP 45/10
BHSCT Being Open Policy – saying sorry when things go wrong (2020) TP 80/11
BHSCT Policy for Sharing Learning (2020) TP 98/14
BHSCT Memorandum of Understanding policy - Investigating Service User Safety Incidents (2020) TP 111/20
HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents V1.1 (2016)

8.0 APPENDICES

Appendix 1 HSCB SAI Notification Form
Appendix 2 HSCB SAI Notification Form – Guidance Notes
Appendix 3 HSCB Interface Incident Form
Appendix 4 HSCB SAI Report Templates & Engagement Checklist

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Procedure for Serious Adverse Incidents (SAIs)**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not

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directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

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Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

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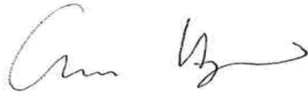
SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Date: 08/10/2020

Name: Dr Chris Hagan
Medical Director

Date: 14/10/2020

Dr Cathy Jack
Chief Executive

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APPENDIX 1: HSCB SAI Notification Form

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM	
1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*
8. DESCRIPTION OF INCIDENT: DOB: DD / MM / YYYY GENDER: M / F AGE: years *(complete where relevant)*	

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRENCE:			
11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*			
12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*	
serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a 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 self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public	

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SERIOUS ADVERSE INCIDENT NOTIFICATION FORM				
by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident				
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident				
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner				
15. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: *(please select)*			YES	NO
if 'YES' (*full details should be submitted*):				
16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY		
	NO	*specify reason:*		
17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*			YES	NO
if 'YES' (*full details should be submitted including the date notified*):				

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*	
DoH EARLY ALERT			
HM CORONER			
INFORMATION COMMISSIONER OFFICE (ICO)			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)			
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)			
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)			
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)			
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)			
19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*
* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6			

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: ___________________________ Designation: __________________________

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: ____________________ Designation: _________________

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

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APPENDIX 2: HSCB SAI Notification Form – Guidance Notes

You can obtain the guidance notes for completion of the SAI Notification Form on the BHSCT HUB via the following link:

Medical - HSCB SAI Procedure_Appendix 2_SAI Notification Form_Guidance Notes for Completion_November 2016.pdf - All Documents

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APPENDIX 3: HSCB Interface Incident Form

<table>
<tr><th colspan="3">HSC INTERFACE INCIDENT NOTIFICATION FORM</th></tr>
<tr><td>1. REPORTING ORGANISATION:</td><td colspan="2">2. DATE OF INCIDENT: DD / MM / YYYY</td></tr>
<tr><td>3. CONTACT PERSON AND TEL NO:</td><td colspan="2">4. UNIQUE REFERENCE NUMBER:</td></tr>
<tr><td colspan="3">5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)</td></tr>
<tr><td rowspan="2">6. ARE OTHER PROVIDERS INVOLVED?
(e.g. HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S)</td><td>YES</td><td>NO</td></tr>
<tr><td colspan="2">if 'YES' (full details should be submitted in section 7 below)</td></tr>
<tr><td colspan="3">7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:</td></tr>
<tr><td colspan="3">8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:</td></tr>
<tr><td colspan="3">9. WHICH ORGANISATION/PROVIDER (FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?</td></tr>
<tr><td colspan="3">10. OTHER COMMENTS:

REPORT SUBMITTED BY: _________________________ DESIGNATION: _________________________

Email: Telephone: Date: DD / MM / YYYY</td></tr>
</table>

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APPENDIX 4: HSCB SAI Report Templates & Engagement Checklist

You can obtain the templates and guidance notes on the BHSCT HUB via the following link:

- Level 1 SEA Report template including learning summery and engagement checklist

  HSCB SAI Procedure_Appendix 4_SEA Report Template, Including Learning Summary and Engagement Checklist_November 2016.docx

- Level 1 SEA Report guidance notes for completion

  Medical - HSCB SAI Procedure_Appendix 5_SEA Report Template_Guidance Notes for Completion_November 2016.pdf - All Documents

- Level 2 & 3 RCA Report template and engagement checklist

  HSCB SAI Procedure_Appendix 6 RCA Report Template and Engagement Checklist_November 2016.docx

- Level 2 & 3 RCA Report guidance notes for completion

  Medical - HSCB SAI Procedure_Appendix 7 Guidance for completion of RCA Report Template_November 2016.pdf - All Documents

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