

25 September 2026

Deaths Attributed To Insulin Pump / Automated Insulin Delivery System Malfunction

Dear Belfast Health and Social Care Trust (Northern Ireland), Under the Freedom of Information Act 2000, I am requesting the following information held by Belfast Health and Social Care Trust (Northern Ireland), 7 questions. For the purposes of this request:

"Insulin pump" means any continuous subcutaneous insulin infusion (CSII) device or automated insulin delivery (AID) / hybrid closed loop system used in the management of diabetes.

The period requested is 1 January 2019 to the date of this request.

1. The number of patient deaths during this period where a Serious Adverse Incident (SAI) report, Datix record, or equivalent internal incident review recorded a device malfunction, software fault, dosing algorithm error, or user-interface fault relating to an insulin pump as a cause or contributory factor, broken down by year.
2. The number of separate non-fatal harm incidents during this period recorded on Datix or equivalent, where a device malfunction, software fault, dosing algorithm error, or user-interface fault relating to an insulin pump was recorded as a cause or contributory factor, and where the incident resulted in diabetic ketoacidosis (DKA), severe hypoglycaemia, severe hyperglycaemia, or another outcome requiring unplanned clinical intervention (including but not limited to contact with a Diabetes Specialist Nurse, unplanned clinic contact, or attendance at emergency care), broken down by year.
3. Of the incidents in question 2, how many were formally escalated to Serious Adverse Incident (SAI) status, and how many were logged on Datix but not escalated further.
4. Of the deaths in question 1, how many were formally reported to the Medicines and Healthcare products Regulatory Agency (MHRA) under mandatory adverse incident reporting requirements for medical devices.
5. Of the deaths in question 1, how many were referred to the Coroner for Northern Ireland.
6. For comparison: the number of patient deaths and, separately, non-fatal harm incidents (as defined in question 2) during the same period where an internal incident review recorded an insulin administration error via multiple daily injection (MDI) therapy as a cause or contributory factor, broken down by year.

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- 7. The total number of deaths, from any cause, among patients under the Trust's care who were insulin pump users during the same period, provided as context for the figures above.**

The regional pump service and the Belfast Health and Social Care Trust diabetes service have not had any incidents of device malfunction, software faults or user-interface faults reported from January 1st 2019 to the date of this request.