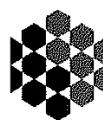


From the Acting Director Safety, Quality  
& Standards Directorate  
Fergal Bradley



Department of  
**Health, Social Services  
and Public Safety**

www.dhsspsni.gov.uk

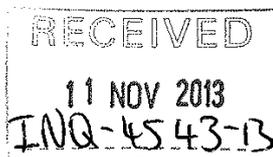
Ms Catherine Rodgers  
Departmental Solicitors Office  
Centre House  
2<sup>nd</sup> Floor  
79 Chichester Street  
**BELFAST**  
**BT1 4JE**

Castle Buildings  
Stormont Estate  
BELFAST BT4 3SQ

Tel: [REDACTED]  
Fax: [REDACTED]  
Email: fergal.bradley@[REDACTED]

Your Ref:  
Our Ref: AD-0688-13

11 November 2013



Dear Ms Rodgers

**ANALYSIS OF ADVERSE INCIDENT AND SERIOUS ADVERSE INCIDENT DATA  
FOR THE 2012-13 FINANCIAL YEAR**

Please find enclosed a statistical analysis of Adverse Incidents (AIs) and Serious Adverse Incidents (SAIs) recorded by health and social care bodies in the financial year 2012/13, as requested by the Inquiry.

**Annex 1** – Provides information on Adverse Incidents by CCS level 1 and CCS level 2 codes and their descriptions. This data is for the Health and Social Care (HSC) Trusts only.

**Annex 2** – Provides information on Serious Adverse Incidents by CCS level 1 and CCS level 2 codes and their descriptions. This data covers Health and Social Care Trusts, Primary Care, the HSCB and the PHA.

I have also enclosed (**Annex 3**) additional background information on reporting by HSC Trusts which I hope will assist the Inquiry in its use of the data.

There may be some differences in how Trusts are applying the coding classifications and the Department, in conjunction with the HSCB and Public Health Agency (PHA), are engaged in a project which will deliver a greater level of consistency around this. However, overall the analysis gives a good indication of the areas in which incidents occur. Each AI is of course individually reviewed and each SAI is the subject of an examination/ investigation by the HSCB/PHA.

Working for a Healthier People



One should not try to deduce solely from the classifications used whether or not there was an absence of care or whether lessons can be learned which would materially have affected what happened. That information primarily arises from the detailed consideration of individual cases.

The data is of course recorded as part of a system which is designed to identify and disseminate learning which will help to improve the safety and quality of services and I understand that the Health and Social Care Board (HSCB) will be providing more detailed information on the process whereby individual Serious Adverse Incidents are investigated. The Departmental panel will also be able to discuss with the Inquiry how this type of information feeds into the discharge of the Department's functions.

Yours sincerely



**FERGAL BRADLEY**

Working for a Healthier People



Annex 3

**TAB 1 – TABLE COMPARING SERIOUS ADVERSE INCIDENTS AND ADVERSE INCIDENTS**

	<b>Adverse Incidents</b>	<b>Serious Adverse Incident Reporting</b>
<b>Purpose</b>	As SAI reporting but Trust specific	Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users.
<b>Definition</b>	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation' arising during the course of the business of a HSC organisation / Special Agency or commissioned service	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation' arising during the course of the business of a HSC organisation / Special Agency or commissioned service and subject to the criteria list below.
<b>Who reports</b>	Trust staff from relevant Programme of Care	The Designated Senior Manager and/or Chief Executive of the HSC Body is advised of the SAI and it is reports to the HSCB/PHA/RQIA by a named lead officer
<b>Where does the report go?</b>	Trust Governance Leads, Medical Director and senior Staff	Email to <a href="mailto:seriousincidents@hscni.net">seriousincidents@hscni.net</a>  An SAI Notification is completed within 72 hours and sent to the HSCB  Level 1 - An investigation report must be completed using a common template and submitted to the HSCB within four weeks.  Level 2 Investigations– For SAIs where a Root Cause Analysis is instigated immediately, Terms of Reference and Membership of the Investigation Tem must be submitted to HSCB within four weeks of notification. The Investigation Report must be

Working for a Healthier People



	Adverse Incidents	Serious Adverse Incident Reporting
		<p>completed within 12 weeks following the date the incident was discovered or from the date of the SEA.</p> <p>Level 3 Independent Investigation – timescales are agreed with the HSCB Designated Review Officer.</p>
<b>Criteria</b>	<p>Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation' arising during the course of the business of a HSC organisation / Special Agency or commissioned service which does not satisfy the criteria to be escalated to an SAI.</p>	<p>Serious injury to, or the unexpected/unexplained death of:</p> <ul style="list-style-type: none"> <li>• A service user (including those events which should be reviewed through a significant event audit)</li> <li>• A staff member in the course of their work</li> <li>• A member of the public whilst visiting a HSC facility;</li> </ul> <p><b>Any</b> death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;</p> <p>Unexpected serious risk to a service user and/or staff member and/or member of the public;</p> <p>Unexpected or significant threat to provide service and/or maintain business continuity;</p> <p>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;</p> <p>Serious self-harm or serious assault (including homicide and sexual assaults)</p> <ul style="list-style-type: none"> <li>• On other service users,</li> <li>• On staff or</li> <li>• On members of the public</li> </ul>

	Adverse Incidents	Serious Adverse Incident Reporting
		<p>by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including Child &amp; Adolescent Mental Health Systems, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;</p> <p>Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and 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;</p> <p>Serious incidents of public interest or concern relating to:</p> <ul style="list-style-type: none"> <li>• Any of the criteria above</li> <li>• Theft, fraud, information breaches or data losses</li> <li>• A member of HSC staff or independent practitioner.</li> </ul>

Working for a Healthier People



ANNEX 1

Incidents by Detail (level 2) grouped by Stage of care (level 1)  
1.4.12 to 31.3.13

	South Eastern	Western	Northern	Belfast	Southern	Total
<b>Access, Appointment, Admission, Transfer, Discharge</b>	<b>1068</b>	<b>621</b>	<b>746</b>	<b>1201</b>	<b>636</b>	<b>4272</b>
Patient absconded	512					512
Access and availability	29					29
Admission	188	127	21	62	140	538
Appointment	125	21	22	100	73	341
Patient AWOL	21					21
Discharge	89	423	669	874	317	2372
Patient's case notes or records	1	1	1	10	11	24
Appointment, Admission, Transfer, Discharge - other	18	9	9	18	7	61
Problem with the referral from primary to secondary care	2	4	4	11	11	32
Transfer	83	36	20	126	77	342
<b>Abusive, violent, disruptive or self-harming behaviour</b>	<b>4650</b>	<b>2458</b>	<b>2368</b>	<b>6667</b>	<b>3475</b>	<b>19618</b>
Abuse of patient by staff	24	7	6	57	45	139
Abuse of staff by patients	2044	1183	1390	2940	2061	9618
Abuse - other	893	238	178	1095	51	2455
Abuse of patient by patient	796	588	425	1556	666	4031
Self-harm during 24-hour care	737	287	315	743	388	2470
Self harm in primary care, or not during 24-hour care	147	148	44	240	241	820
Abuse of staff by staff	9	7	10	36	23	85
<b>Accident that may result in personal injury</b>	<b>4477</b>	<b>3261</b>	<b>4647</b>	<b>6502</b>	<b>2798</b>	<b>21685</b>
Slips, trips, falls and collisions	3530	2644	3761	5147	2191	17273
Exposure to electricity, hazardous substance, infection etc	36	78	123	197	83	517
Lifting accidents	49	32	114	101	66	362
Accidents in the course of moving patients	65					65
Accident caused by some other means	674	286	497	798	246	2501
Needlestick injury or other incident connected with Sharps	117	187	150	231	161	846
Injury caused by physical or mental strain	6	34	2	28	51	121
<b>Administration and management</b>	<b>73</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>73</b>
Dealing with concerns about colleagues	1					1
Communication between staff, teams or departments	14					14
Patient's case notes or records	3					3
Electronic Patient Record	1					1
Scans / X-ray images	2					2
Administration and management - other	8					8
Adverse events that affect staffing levels	42					42
Test results / reports	2					2
<b>Anaesthesia</b>	<b>5</b>	<b>7</b>	<b>0</b>	<b>13</b>	<b>16</b>	<b>41</b>
Cardiovascular					6	6

NIAS	
	<b>1421</b>
Assault	148
Asset loss, damage etc	46
Late Meal Break	247
Building-Land	28
Confidentiality	1
Contact with something	32
Hazardous Substance	13
Drug	105
Equipment	306
Ergonomic	18
Harrassment	13
Manual Handling	78
Organisational	143
Records Management	1
Sharp Object	16
Slip, trip or fall	38
Treatment	19
Vehicle	169
<b>Access, Appointment, Admission, Transfer,</b>	<b>95</b>
Assault	1
Contact with something	1
Drug	4
Equipment	24
Manual Handling	4
Organisational	40
Treatment	11
Vehicle	10
<b>Abusive, violent, disruptive or self-harming</b>	<b>195</b>
Assault	194
Treatment	1
<b>Accident that may result in personal injury</b>	<b>171</b>
Assault	1
Asset loss, damage etc	1
Contact with something	17
Hazardous Substance	6
Equipment	5
Manual Handling	31

Equipment related					2	2
Injury or damage connected with Anaesthesia	1			6	3	10
Neurological factor				1	2	3
Anaesthesia - other	3	6		2		11
Patient factor				3	2	5
Respiratory factor				1	1	2
Preoperative factor	1	1				2
<b>Clinical assessment (Investigations, images and lab tests)</b>	<b>257</b>	<b>165</b>	<b>62</b>	<b>399</b>	<b>181</b>	<b>1064</b>
Administration of assessment	10	14	6	12	38	80
Images for diagnosis (scan / x-ray)	26	15	3	25	11	80
Investigations	7					7
Laboratory investigations	193	120	41	329	108	791
Assessment - other	15	11	7	14	4	51
Patient's case notes or records	6	5	5	19	20	55
<b>Consent, Confidentiality or Communication</b>	<b>182</b>	<b>106</b>	<b>327</b>	<b>598</b>	<b>154</b>	<b>1367</b>
Communication between staff, teams or departments	108	51	208	430	82	879
Communication with the patient (other than consent issues)	11	20	47	57	37	172
Confidentiality of information	12	12	20	89	22	155
Consent	45	3	1	14	10	73
Consent, Confidentiality or Communication - other	6	20	51	8	3	88
<b>Diagnosis, failed or delayed</b>	<b>0</b>	<b>26</b>	<b>3</b>	<b>13</b>	<b>30</b>	<b>72</b>
Leaking abdominal aortic embolism		1			1	2
Cancer - Dx failed or delayed		5	2	2	7	16
Ectopic or other complications of pregnancy		1				1
Fracture - Dx failed or delayed		2		1	2	5
Some other medical condition		2	1	1	20	24
Diagnosis - other		15		9		24
<b>Financial loss</b>	<b>0</b>	<b>8</b>	<b>1</b>	<b>5</b>	<b>50</b>	<b>64</b>
Financial Loss		8	1	5	50	64
<b>Conveyance</b>	<b>127</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>127</b>
Conveyance	20					20
Delays	7					7
Driving incident	51					51
Vehicle non-arrival	8					8
Road Traffic Accident	39					39
Non - conveyance	2					2
<b>Patient Information (records, documents, test results, scans)</b>	<b>301</b>	<b>137</b>	<b>164</b>	<b>620</b>	<b>347</b>	<b>1569</b>
Patient's case notes or records	245	104	70	443	206	1068
Electronic Patient Record	17	12	4	20	15	68
Scans / X-ray images	7	1	25	12	7	52
Information - other	20	5	25	18	8	76
Test results / reports	12	15	40	127	111	305
<b>Infrastructure or resources (staffing, facilities, environment)</b>	<b>271</b>	<b>220</b>	<b>371</b>	<b>1404</b>	<b>417</b>	<b>2683</b>
Environmental matters	35	33	41	162	101	372
Equipment related				1		1
Lack of/delayed availability of facilities/equipment/supplies	29	54	127	346	113	669
Information Technology	9	24	3	145	25	206
Infrastructure or resources - other	23	11	20	28	3	85
Premises	6					6
Adverse events that affect staffing levels	169	98	180	722	175	1344

Sharp Object	13
Slip, trip or fall	20
Vehicle	77
<b>Patient Information (records, documents, test results, scans)</b>	<b>2</b>
Records Management	2
<b>Medication</b>	<b>7</b>
Drug	4
Treatment	3
Late Meal Break	37
Hazardous Substance	440
Drug	2
Organisational	1
Treatment	1
Vehicle	5
<b>Security</b>	<b>2</b>
Asset loss, damage etc	1
Equipment	1
<b>Treatment, procedure</b>	<b>2</b>
Organisational	1
Treatment	1
<b>Other - please specify in description</b>	<b>5</b>
Late Meal Break	439
Totals:	2820

<b>Labour or Delivery</b>	<b>419</b>	<b>267</b>	<b>163</b>	<b>410</b>	<b>268</b>	<b>1527</b>
Placental abruption	2	6	1	2	6	17
Anaesthetic problem connected with labour or delivery	3	5	1		1	10
Born before arrival	14	3	3	4	4	28
Breech presentation	13	1	7	1	5	27
Cord prolapse	5			3	3	11
Elective Caesarean Section	4	6	1	19	4	34
Emergency Caesarean Section	44	18	21	18	50	151
Difficult delivery	6	3	1	5	9	24
Shoulder dystocia	15	50	4	32	25	126
Pathological or suspicious CTG or other fetal distress	7	8		10	7	32
Labour assisted by forceps	9	6	2	16	13	46
Unplanned homebirth		2				2
Delivery using more than one instrument		9		2	3	14
Intrapartum haemorrhage	4			1	2	7
IUGR or placental insufficiency	16	1		3	3	23
Prolonged first or second stage of labour	9	1			1	11
Injury or poor outcome for the mother	115	39	2	92	54	302
Labour or delivery - other	123	48	103	138	30	442
Post-partum haemorrhage > 1,000ml	22	50	10	57	35	174
Twin delivery or multiple birth			1	1		2
Pre-eclampsia	1	1			3	5
Placenta praevia	4	6		1	1	12
Ruptured uterus					1	1
Delivery assisted by ventouse	3	4	6	5	8	26
<b>Medical device/equipment</b>	<b>158</b>	<b>168</b>	<b>200</b>	<b>956</b>	<b>294</b>	<b>1776</b>
Medical device/equipment	158	168	200	956	294	1776
<b>Medication</b>	<b>1627</b>	<b>451</b>	<b>552</b>	<b>2205</b>	<b>1142</b>	<b>5977</b>
Administration or supply of a medicine from a clinical area	558	213	278	987	504	2540
Advice	1	3	0	4	14	22
Monitoring or follow up of medicine use	1	97	1	20	27	146
Supply or use of Over The Counter medicines		16			10	26
Other medication error	187	6	135	28	24	380
Patients reaction to medication		4	3	38	17	62
Preparation of medicines / dispensing in pharmacy	117	55	34	233	119	558
Prescribing			98			98
Supply or use of over-the-counter (OTC) medicine			3			3
Medication error during the prescription process	763	57		895	427	2142
<b>Implementation of care or ongoing monitoring/review</b>	<b>446</b>	<b>535</b>	<b>313</b>	<b>984</b>	<b>316</b>	<b>2594</b>
24-hr monitoring of patients with recognised mental illness	2	3			7	12
Inadequate maintenance of fluids	3	2		2	7	14
Infection control	65	80	1	119	39	304
Possible delay or failure to Monitor	48	34	17	216	161	476
Postoperative nausea and vomiting				1	1	2
Implementation of care or ongoing monitoring - other	109	68	79	145	7	408
Pain management	4					4
Patient complains of inadequate pain management				1	2	3
Problems following radiation therapy	1			4		5
Pressure sore / decubitus ulcer	214	348	216	496	92	1366
<b>Other - please specify in description</b>	<b>78</b>	<b>12</b>	<b>988</b>	<b>337</b>	<b>53</b>	<b>1468</b>

Other	78	12	988	337	53	1468
<b>Patient satisfaction and surveys</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
Handling complaints	6					6
Continuity of care	2					2
<b>Referral</b>	<b>24</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>24</b>
Referrals to secondary care / hospital admission	6					6
Referral - other	2					2
Referral to another specialty	16					16
<b>Security</b>	<b>808</b>	<b>347</b>	<b>167</b>	<b>598</b>	<b>241</b>	<b>2161</b>
Security issue related to Equipment	4	21	2	22	22	71
Fires, fire alarms and fire risks	299	60	49	193	80	681
Staff records or information		1		1	1	3
Public order, Protests, Bomb scares,Riot, Disorder		22		13	8	43
Security - other	362	9	9	49	4	433
Security incident related to Premises, Land or Real Estate	36	145	54	106	64	405
Security incident related to Personal property	87	71	50	197	45	450
Security issue related to Vehicles	20	18	3	17	17	75
<b>Treatment, procedure</b>	<b>656</b>	<b>283</b>	<b>128</b>	<b>836</b>	<b>235</b>	<b>2138</b>
Abdominal organs other than digestive		4		1	6	11
Arteries and veins	8	6	1	5	25	45
Transfusion of Blood related problem	453	64	11	238	25	791
Bones or joints other than skull or spine	1	8		3	18	30
Breast	1					1
Elective Caesarean Section	1	3		2		6
Emergency Caesarean Section			1		2	3
Lower digestive tract	2		1	2	12	17
Upper digestive tract	1			2	2	5
Surgery to the Ear	1	1	1		1	4
Endocrine system		2			2	4
Eye (OPCS4 - CO1-CO86)	3	5		2	2	12
Lower female genital tract		9	1	4	17	31
Upper female genital tract	3	1			1	5
Operations on the Heart		2		3	1	6
Hip prosthesis		1		1	1	3
Hysterectomy		2	2			4
Infection control	18	8	1	9	17	53
Surgery to joint other than hip or knee				3		3
Male genital organs	3	4		1	2	10
Miscellaneous operations	4	9	1		9	23
Mouth		2	1	6	4	13
Treatment, procedure - other	13	35	53	56	2	159
Respiratory Tract	1	2		6	6	15
Skin	4	4		58	18	84
Soft tissue		3			17	20
Bones and joints of skull and spine	1			1		2
Soft tissue				1		1
Connected with the management of operations / treatment	138	106	53	427	40	764
Urinary		2	1	5	5	13
<b>Treatment and intervention</b>	<b>778</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>778</b>
Patient deaths	11					11

Emergencies	6					6
Immunisation	3					3
Infection control	2					2
Infection control	68					68
Medical device/equipment	273					273
Treatment, procedure - other	35					35
Pain management	8					8
Resuscitation	2					2
Treatment and interventions	189					189
Patient unwell or ill	181					181
<b>NOT FULLY CLASSIFIED</b>						<b>269</b>
						269
<b>Totals:</b>	<b>16413</b>	<b>9072</b>	<b>11200</b>	<b>23748</b>	<b>10922</b>	<b>71355</b>

**Incidents by Incident date (Financial Year)**

<b>08/09</b>	11256
<b>09/10</b>	13239
<b>10/11</b>	13525
<b>11/12</b>	15645
<b>12/13</b>	16413
<b>Totals:</b>	70106

## Incidents by Impact grouped by Person Type

1.4.12 to 31.3.13

<b>A&amp;E Patient</b>	<b>90</b>
Insignificant (Impact)	3
Major (Impact)	1
Minor (Impact)	79
Moderate (Impact)	7
<b>Client</b>	<b>660</b>
Insignificant (Impact)	42
Major (Impact)	12
Minor (Impact)	582
Moderate (Impact)	24
<b>Foster Carer</b>	<b>1</b>
Minor (Impact)	1
<b>Home Patient</b>	<b>75</b>
Major (Impact)	3
Minor (Impact)	59
Moderate (Impact)	13
<b>Inpatient</b>	<b>2068</b>
Insignificant (Impact)	80
Major (Impact)	35
Minor (Impact)	1639
Moderate (Impact)	314
<b>Out/Day Patient</b>	<b>94</b>
Insignificant (Impact)	3
Major (Impact)	15
Minor (Impact)	68
Moderate (Impact)	8
<b>Resident</b>	<b>827</b>
Insignificant (Impact)	26
Major (Impact)	6
Minor (Impact)	757
Moderate (Impact)	38
<b>Admin &amp; Clerical</b>	<b>31</b>
Minor (Impact)	29
Moderate (Impact)	2
<b>Admin &amp; Clerical (Agency)</b>	<b>2</b>
Minor (Impact)	2
<b>Works &amp; Maintenance</b>	<b>6</b>
Minor (Impact)	5
Moderate (Impact)	1
<b>Ancillary &amp; General</b>	<b>227</b>
Insignificant (Impact)	9
Minor (Impact)	216
Moderate (Impact)	2
<b>Ancillary &amp; General (Agency)</b>	<b>6</b>
Minor (Impact)	6
<b>Nursing, Midwifery and Health Visiting</b>	<b>355</b>
Insignificant (Impact)	24
Major (Impact)	1

Minor (Impact)	322
Moderate (Impact)	8
<b>Nursing Midwifery &amp; Health Visiting (Agency)</b>	<b>16</b>
Insignificant (Impact)	4
Minor (Impact)	12
<b>Nursing, Midwifery and Health Visiting (Students)</b>	<b>10</b>
Insignificant (Impact)	3
Minor (Impact)	7
<b>Social Work</b>	<b>524</b>
Insignificant (Impact)	17
Minor (Impact)	493
Moderate (Impact)	14
<b>Professional &amp; Technical</b>	<b>29</b>
Insignificant (Impact)	2
Minor (Impact)	26
Moderate (Impact)	1
<b>Medical &amp; Dental</b>	<b>24</b>
Insignificant (Impact)	6
Minor (Impact)	17
Moderate (Impact)	1
<b>Medical &amp; Dental (QUB Students)</b>	<b>4</b>
Minor (Impact)	4
<b>Medical &amp; Dental Students (not QUB)</b>	<b>3</b>
Minor (Impact)	3
<b>General Management</b>	<b>6</b>
Minor (Impact)	6
<b>Contractor</b>	<b>4</b>
Minor (Impact)	4
<b>Visitor</b>	<b>33</b>
Insignificant (Impact)	3
Major (Impact)	1
Minor (Impact)	26
Moderate (Impact)	3
<b>Volunteer</b>	<b>1</b>
Minor (Impact)	1
Totals:	5096

## ANNEX 2

## SAIs by Detail (level 2) grouped by Stage of care (level 1)

1 April 2012 to 31 March 2013	Total
<b>Access, Appointment, Admission, Transfer, Discharge</b>	<b>23</b>
Admission	5
Discharge	13
Problem with the referral from primary to secondary care	1
Transfer	4
<b>Abusive, violent, disruptive or self-harming behaviour</b>	<b>160</b>
Abuse by the staff to the patient	10
Abuse etc of Staff by patients	4
Abuse - other	15
Abuse etc of patient by patient	3
Self-harm during 24-hour care	9
Self harm in primary care, or not during 24-hour care	119
<b>Accident that may result in personal injury</b>	<b>13</b>
Slips, trips, falls and collisions	8
Exposure to electricity, hazardous substance, infection etc	2
Accident caused by some other means	1
Injury caused by physical or mental strain	2
<b>Anaesthesia</b>	<b>4</b>
Cardiovascular	1
Equipment related	1
Respiratory factor	2
<b>Clinical assessment (investigations, images and lab tests)</b>	<b>11</b>
Administration of assessment	6
Images for diagnosis (scan / x-ray)	4
Laboratory investigations	1
<b>Consent, Confidentiality or Communication</b>	<b>7</b>
Communication between staff, teams or departments	2
Confidentiality of information	5

<b>Diagnosis, failed or delayed</b>	<b>13</b>
Leaking abdominal aortic embolism	1
Cancer - Dx failed or delayed	8
Fracture - Dx failed or delayed	1
Diagnosis - other	3
<b>Financial loss</b>	<b>2</b>
Financial Loss	2
<b>Patient Information (records, documents, test results, scans)</b>	<b>14</b>
Patient's case notes or records	8
Electronic Patient Record	1
Scans / X-ray images	1
Test results / reports	4
<b>Infrastructure or resources (staffing, facilities, environment)</b>	<b>11</b>
Environmental matters	3
Lack of/delayed availability of facilities/equipment/supplies	1
Information Technology	2
Infrastructure or resources - other	3
Adverse events that affect staffing levels	2
<b>Labour or Delivery</b>	<b>5</b>
Anaesthetic problem connected with labour or delivery	1
Cord prolapse	1
Emergency Caesarean Section	3
<b>Medical device/equipment</b>	<b>5</b>
Medical device/equipment	5
<b>Medication</b>	<b>13</b>
Administration or supply of a medicine from a clinical area	9
Other medication error	1
Medication error during the prescription process	3
<b>Implementation of care or ongoing monitoring/review</b>	<b>8</b>
Infection control	2
Possible delay or failure to Monitor	6
<b>Other - please specify in description</b>	<b>6</b>
Other	6

<b>Security</b>	<b>9</b>
Fires, fire alarms and fire risks	<b>6</b>
Security - other	<b>1</b>
Security incident related to Premises, Land or Real Estate	<b>1</b>
Security incident related to Personal property	<b>1</b>
<b>Treatment, procedure</b>	<b>16</b>
Arteries and veins	<b>2</b>
Emergency Caesarean Section	<b>1</b>
Lower digestive tract	<b>1</b>
Upper Digestive tract	<b>1</b>
Operations on the Heart	<b>1</b>
Infection control	<b>6</b>
Treatment, procedure - other	<b>1</b>
Connected with the management of operations / treatment	<b>3</b>
<b>Totals:</b>	<b>320</b>