

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:		2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE	
3. HOSPITAL / FACILITY / COMMUNITY LOCATION <i>(where incident occurred)</i>		4. DATE OF INCIDENT: DD / MMM / YYYY	
5. DEPARTMENT / WARD / LOCATION EXACT <i>(where incident occurred)</i>			
6. CONTACT PERSON:		7. PROGRAMME OF CARE: <i>(refer to Guidance Notes)</i>	
8. DESCRIPTION OF INCIDENT: DOB: DD / MMM / YYYY GENDER: M / F AGE: years <i>(complete where relevant)</i>			
DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING			
STAGE OF CARE: <i>(refer to Guidance Notes)</i>		ADVERSE EVENT: <i>(refer to Guidance Notes)</i>	
DETAIL: <i>(refer to Guidance Notes)</i>			
9. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRENCE:			
10. CURRENT CONDITION OF SERVICE USER: <i>(complete where relevant)</i>			
11. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? <i>(please select)</i>			YES NO N/A
12. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? <i>(please specify where relevant)</i>			YES NO N/A
13. WHY INCIDENT CONSIDERED SERIOUS: <i>(please select relevant criteria below)</i>			
serious injury to, or the unexpected/unexplained death of:			
- a service user			
- a staff member in the course of their work			
- a member of the public whilst visiting a HSC facility.			
any 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			
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 <i>(including attempted suicide, homicide and sexual assaults)</i> 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 <i>(including homicide and sexual assaults)</i>			
- 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 <i>(as defined within the Mental Health</i>			

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(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				
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				
serious incidents of public interest or concern relating to:				
<ul style="list-style-type: none"> - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner 				
14. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: (please select)			YES	NO
if 'YES' (full details should be submitted):				
15. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS A SAI	YES	If NO – specify reason		
	Date Informed:			
16. 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):				
17. OTHER ORGANISATION/PERSONS INFORMED: (please select)	DATE INFORMED:	OTHERS: (please specify where relevant, including date notified)		
DHSS&PS EARLY ALERT				
HM CORONER				
INFORMATION COMMISSIONER OFFICE (ICO)				
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)				
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE (NIHSE)				
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)				
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)				
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)				
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)				
18. LEVEL OF INVESTIGATION REQUIRED: (please select)	LEVEL 1	LEVEL 2*	LEVEL 3*	
* FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6				
19. 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 / MMM / YYYY		
20. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: (refer to Guidance Notes)				
Additional information submitted by: _____		Designation: _____		
Email: _____	Telephone: _____	Date: DD / MMM / YYYY		

Completed proforma should be sent to: [seriousincidents](#) [redacted]
and (where relevant) [seriousincidents](#) [redacted]