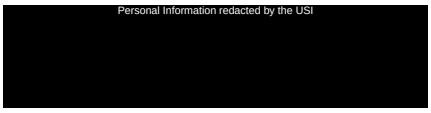
implement given the resources required to do so. However, this aspect of the SAI does raise a wider cause for concern which has not been addressed directly in the RCA or the recommendations.

The report records that it was the practice of the patient's consultant urologist not to review laboratory or radiology reports until patients attended their outpatient appointment. There was no further comment on this practice, nor any recommendation relating to this. I believe that this highlights an area where the Trust would have considered action to be appropriate. It is possible that this was not seen as directly relevant to the actions required to minimise the likelihood for further SAIs relating to retained swabs, hence there were no recommendations for action in this particular RCA report. I am writing to ask whether this issue has been taken forward, for example by considering whether there is a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review.

Yours sincerely



Dr D Corrigan
Consultant in Public Health Medicine

cc Dr J Simpson
Dr G Rankin
Mrs J McCulla

4

Diane Corrigan

From: Magennis, Joscelyn <[redacted]>
Sent: 09 December 2011 15:14
To: Diane Corrigan
Cc: Burns, Deborah
Subject: SAI [redacted] Response
Attachments: Dr D Corrigan response re [redacted] nov 11.doc

Dr Corrigan

Please find attached response from Debbie Burns A/Director of Corporate Clinical & Social Care Governance SHSCT re SAI [redacted]

Kindest Regards

Joscelyn Magennis

Governance Admin Assistant

Corporate Clinical & Social Care Governance Dept

Trust HQ

[redacted]

Southern Health & Social Care Trust IT Department [redacted]

Dr D Corrigan,

Consultant in Public Health Medicine

Public Health Agency

Tower Hill

Armagh

BT61 9DR

24 November 2011

Dear Dr Corrigan,

Thank you for your letter dated 14 November 2011 in relation to Serious Adverse Incident 27891, and your constructive comments on the subsequent review report. The Trust agrees that you raise a very pertinent issue which should have been listed as a recommendation and subsequent action, namely the requirement for assurance that Consultant medical staff review all diagnostic results as they become available and do not wait until the patient is reviewed at an outpatient appointment, specifically in light of the improving but on-going backlog in outpatient review appointments.

Although this issue was not included as a recommendation or action the Trust has recognised the need for the above assurance and a Trust protocol and has taken the following actions:

- The current practice of Consultant surgical staff in relation to review of diagnostic results has been scoped and this baseline of practice is being widened to all four acute divisions where appropriate.
- Initial scoping indicates that in the main Consultant surgeons are reviewing diagnostics in a timely manner, although variances in how this is being done have been highlighted.

As a result of the above findings and with the added impact of on line results being available for diagnostics, for example via PACS and order comms, it is timely that the Trust

undertakes a thorough review of practices which may lead to a Trust protocol being devised. Action on this issue, while not outlined in the review report, is therefore on going, and the Trust would be happy to share the conclusions of this work with you.

Yours sincerely

D Burns

6

Southern Health and Social Care Trust

Quality Care - for you, with you

02 August 2012 Ref: mm / bmc

Dear Dr Corrigan

I refer to your letter of 14 November 2011 regarding the SH&SCT Root Cause Analysis report relating to a retained swab following surgery, (SAI Personal information redacted by USI HSCB re Personal information redacted by USI

Please find below the process which has been implemented in the Trust on the management of patients Discharged but awaiting results.

PAS Function

The communication system used within the Trust to manage patient appointments and patient episodes, including the Discharge of patients awaiting results is PAS. PAS provides a function to alert Secretaries of patients who are discharged but still await results. This function has now been activated within the PAS system and Consultant's Secretaries have been trained in the Management of the function.

A standardised operating procedure (SOP) is now in place. In this SOP there is a checklist of diagnostic tests and the turn-around time/average wait for specific test/results as a guideline – to ensure that patients are not waiting any longer than they should be for a review appointment.

Schedule for Reports

Reports are now run on Business Objects and forwarded to secretarial staff on a fortnightly basis for action.

Escalation Procedure

It has been agreed that there should be a 4 month maximum waiting time set for a patient review appointment, for those patients who are awaiting results. It is the responsibility of the Consultant's Secretary to escalate any patient sitting outside the agreed waiting time to the Service Administrator.

The Service Administrator will escalate to the appropriate Head of Service and Operational Lead.

A time-limited action plan will be put in place and the Service Administrator is then responsible for initiating the action plan. If the actions are not met within the timescale the Service Administrator will inform the Head of Service and Assistant Director responsible, for action.

Please do not hesitate to contact me if you require any further clarification or information regarding this process.

8

Diane Corrigan

From: serious incidents
Sent: 21 January 2014 12:36
To: Diane Corrigan
Subject: FW: Trust Protocol: SHSCT SAI I[redacted] HSCB Ref[redacted]
Attachments: Swab Protocol Nov 2013.pdf; [redacted]osition Report.pdf

Importance: High

Categories: Blue Category

Dr Corrigan,

REF: Retained surgical swab

Following receipt of the Trust Protocol in relation to the above incident, can you advise if you are in a position yet to close. I have attached for your information a Datix Position Report which details all activity in relation to the incident.

Please advise re closure and I will forward a DRO Form for completion.

Thanks
Elaine

From: serious incidents
Sent: 21 November 2013 11:14
To: Diane Corrigan
Subject: Trust Protocol: SHSCT SAI ID[redacted] HSCB Ref:[redacted]

Dr Corrigan,

REF: Retained surgical swab

Please find attached the Southern Trust protocol for counting swabs, needles and instruments in theatre. Please advise if there is anything further you require in order to close this incident.

Thanks
Elaine

From: McCooey, Blaithnid [[redacted]]
Sent: 20 November 2013 16:46

To: serious incidents
Subject: SHSCT SAI ID [redacted]

Elaine

Re SHSCT ID [redacted]
Please find attached the SHSCT Protocol as requested

Please let me know if the DRO requires anything further in order to close this case

Thanks
Blaithnid

HSCB / PHA SAI POSITION REPORT

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:		HSCB REFERENCE NUMBER
FEMALE (DOB Personal Information redacted by the USI /514		Personal Information redacted by the USI
DATE SAI NOTIFIED	DRO	ORGANISATION'S NOTIFIED
3 September 2010	Dr Diane Corrigan	

DATE SAI OCCURRED:	INTERIM REPORT (IR) DUE:	FINAL REPORT (FR) DUE:
7 July 2010		26-Nov-2010

DESCRIPTION OF INCIDENT

Patient operated on 15/07/09. Presented with abdominal symptoms 07/07/10. CT Scan performed showed evidence of a retained surgical swab. Removed 21/07/10. All procedures carried out in Craigavon Area Hospital.

EXTENSION 1	EXTENSION 2	EXTENSION 3	EXTENSION 4	EXTENSION 5
23-Dec-2010				
IR RECEIVED	FR RECEIVED	FR TO RQIA	DATE DRO CLOSED	NFA NOTIFIED
	7-Jan-2011			

HSCB-PHA INVESTIGATION ACTION TAKEN:

29/11/10 - Investigation Report due 26/11/10. To date not received. Reminder email Issued.
29/11/10 - Email from Trust. Report drafted by Ronan Carroll Assistant Director, SHSCT. Trust to seek a short extension with the Board (2 weeks)

8/12/10 - To date no extension has been requested and IR still not received. Email forwarded to Trust requesting further update on IR. DRO informed of latest position.
10/12/10 - Trust have requested extension to submission of IR until 23/12/10. DRO has apaproved extension and Trust advised.

5/1/11 - To date Trust Investigation report has not been received. Reminder email issued to Trust.
7/1/11 - Final investigation report received from Trust and forwarded to DRO via email
9/3/11 - Email to DRO requesting update with regard to closure following receipt of Trust report.
4/5/11 - Update from DRO - to meet the Trust re open SAIs this month to clarify outstanding issues.
15/9/11: Request to DRO for update.
30/01/12: Email to DRO with update request on closure.
30/01/12: Email from DRO-Although I would have been content to sign off the specific issue about theatre staff arrangements for swab counts which should avoid/minimise the risk of recurrence, the RCA of this SAI raised a separate issue on the processes used by consultants to review results of outpatient investigations. I enclose copy correspondence. Until I had confirmation that this is resolved/complete I did not intend to sign off the SAI.
13/03/12: Email request to DRO for update on closure/if anything further is required from the Trust.
16/03/12: Email from DRO to Trust Governance Manager re update/progress - You replied in December indicating that further action was ongoing in relation to scoping current practice in relation to review of test results and assessing if there was a need for a Trust protocol for clinicians. I wondered if there have been any further developments since then or anything further to add? I have kept the SAI open until I can say something definitive one way or the

other.
22/03/12: Email from D Burns - Acute have completed scoping exercise and data being reviewed but initial view is that due to variation in processes we will definitely need to develop a protocol.
26/03/12: Email from DRO to Trust-Thanks for this update. I appreciate that development of a protocol isn't something that could be completed at short notice. However, if the scoping exercise has indicated that there is potentially the risk of a repeat event pending that development, it could result in a patient coming to harm. In the interim might it be useful to consider the internal Trust equivalent of a 'regional learning letter'? With electronic access to lab and radiology results I'm not sure nowadays how paper copies reach the patient's chart, but I suppose I was thinking of a letter to all consultant staff referring to a recent SAI which had revealed that an abnormal test result had been retained on file, awaiting an expected outpatient review which had then been delayed. Then reminding senior staff that if tests have been ordered by a member of a consultant's team the results should not be filed until reviewed by a member of the medical team (and maybe initialled or signed off in some way??) and asking them to ensure their junior staff are made aware of same?
27/04/12: Request to DRO for update on closure.
30/04/12: Email from DRO-Unfortunately not yet. This SAI exposed a process (unrelated to the swab issue) whereby test results were not being reviewed and acted on until the patient next attended an outpatient clinic. In this case reviews were backlogged so the patient was not reviewed in a timely way and the abnormal scan result was never seen/acted on before she was eventually admitted as an emergency.
The Trust had additional work to do to scope all consultants' practice in this regard and decide whether to draw up a Trust-wide protocol. That has not been finished so I feel I cannot sign off.
08/06/12: Email to DRO - does she require seiousincidents to contact Trust for further update.
08/06/12: DRO confirms further update required from Trust.
08/06/12: Trust emailed - Can you provide an update on the above incident. The Trust investigation report was received on 7/1/12 but the DRO is unable to close the incident as the SAI exposed another issue (unrelated to the swab issue) which may require a Trust-wide Protocol being drawn up. (see emails below between Debbie and Dr Corrigan).
03/07/12: No response received fromTrust to email of 8 June 2012. Further request to Trust for update.
20/07/12: Email to Dr Corrigan to advise no further update received from Trust. Next course of action.
03/08/12: Email from Trust with Letter with update on actions. Sent to DRO with request for update on closure.
14/08/12: Email from DRO re Trust letter of 2/8/12. No signature on letter and DRO need to respond. Email to Trust re same. Trust response - This response was put together by myself and Margaret Marshall (Acute Governance Co-ordinator) on Debbie's behalf as she is working remotely from home at the moment. Debbie reviewed and approved, though she is not contactable this week. If the DRO would like any further clarity I can be contacted on behalf of Debbie and will liaise with Margaret. Response forwarded to DRO.
11/10/12: Request to DRO for update.
23/11/12: Email to DRO requesting update.
05/02/13: Further request to DRO for update on incident.
17/05/13: Position Report to DRO with request for update on closure.
10/07/13: Email to DRO for update - The above SAI remains open on the Datix system. The last update I have from yourself is with regard to the attached letter. You advised that you needed to respond to Margaret Marshall. Can you advise if you have been in contact with Margaret either by telephone or letter.
15/08/13: Update from DRO - spoke to Margaret Marshall on the 13th August. She agreed

that the initial protocol did not address all the issues in this case. She said that the Trust had done further work since then to strengthen their internal processes to avoid recurrence. She said she would forward that revised protocol to me for comment. I'm afraid it still needs to stay open.
20/08/13: SAI Status Report forwarded to DRO.
02/09/13: Email from DRO to Trust - Can I just follow up our conversation a few weeks ago about the Urology/swab/CT results SAI [redacted] you said there was an updated protocol that you planned to forward?
16/10/13: Email to Trust for update on Trust Protocol - The Trust were to forward to the DRO a revised Protocol.
I would be grateful if you would follow-up these queries as these are two old outstanding SAIs awaiting closure.
16/10/13: Trust email: Thanks for this Elaine. Apologies this seems to be yet outstanding.
I will liaise with Debbie and Margaret to see how I can move this forward.
08/11/13: Trust Protocol remains outstanding. Trust emailed for same.
20/11/13: Trust Protocol received - Please find attached the SHSCT Protocol as requested
Please let me know if the DRO requires anything further in order to close this case
21/11/13: Protocol forwarded to DRO.
21/01/14: Email to DRO for update on closure of incident. Datix Position Report forwarded.

Diane Corrigan

From: Diane Corrigan
Sent: 23 April 2014 17:47
To: Marshall, Margaret ([redacted]; john.simpson[redacted]
Cc: serious incidents
Subject: SAI[redacted] - Incident ref[redacted] - retained swab
Attachments: Letter from Trust with update on Action Plan (2).docx

Dear John and Margaret

This SAI has been open for a long time. In retrospect perhaps it should have been escalated earlier but on various occasions it seemed very close to closure so I held on for the final information needed. I have summarised below the process to date with a view to getting your comments on how and whether we can bring this to a conclusion. John, I appreciate that you may not routinely be involved in SAI issues, but this one relates to medical practice across almost all specialties so I felt that I should make you aware of the issue.

The patient involved in this SAI was found to have a retained swab following major urological cancer surgery. This came to light when the patient presented as an emergency 1 year later with abdominal pain/sub-acute obstruction and the swab was found at laparotomy.

The RCA identified swab counting issues in theatre and proposed changes to Trust procedures which would have minimised the risk of recurrence. As a DRO, I accept that these would have been sufficient to support sign-off of the primary cause of this SAI. However I did not sign it off for the following reason. It was noted in the RCA that an abnormality/mass had been reported on a planned follow-up CT scan 3 months post-op and reported as either a seroma or a local cancer recurrence. The patient had been due for scheduled out-patient review soon after the scan (i.e. at 4 months post-op) but because of outpatient review backlogs this never took place. It was reported in the RCA that it was the practice of the consultant concerned not to review reports of investigations until a patient was due to attend outpatients.

If this patient had had a recurrence of her cancer, the delay in the scan result being reviewed by her consultant would almost inevitably have resulted in significant consequences.

As DRO I asked the Trust to consider if a system was needed to ensure all reports of diagnostic tests were seen before filing to avoid missing issues needing urgent action (as would be the case in general practice). The Trust agreed to consider this; the first step proposed was to scope the scale of the issue across specialties. After some time had passed the Trust submitted new recommendations (attached). I could not be confident that the action proposed would avoid a similar problem in future so I asked the Trust to reconsider.

I had expected to receive a final report/proposal setting out how the issue would be addressed. Instead a swab counting protocol was forwarded to me via the serious incidents team. Unfortunately it appears that if anything this has gone backwards rather than forward – however I am aware that Governance staff moved jobs in 2013 and it may be that this has inadvertently resulted in some crossed wires in this case.

Could I ask you to re-read the attached description of revised processes in the Trust which was forwarded to me in 2012? My reading of this is that these arrangements only deal with patients discharged from the ward, so would not apply to results following outpatient investigation. Even if that is put to one side, I think that if the sequence of events that happened in this SAI case were to happen again, the patient, who had an abnormal result at 3 months post-op and one month before an expected outpatient review, would not be flagged by the consultant secretary as needing escalation until after the review date – i.e. at least 1 month after the abnormal result had been returned/filed. I don't feel I could sign this off as safe practice. Am I missing something obvious? Can I ask you both what your opinion is on this issue?

Best wishes

Diane

Dr D Corrigan BA MPH FFPH
Consultant in Public Health Medicine
Public Health Agency
Tower Hill
Armagh
BT61 9DR
Personal Information redacted by the USI
Personal Information redacted by the USI
GMC no. 2758116

Southern Health and Social Care Trust

Quality Care - for you, with you

02 August 2012 Ref: mm / bmc

Dear Dr Corrigan

I refer to your letter of 14 November 2011 regarding the SH&SCT Root Cause Analysis report relating to a retained swab following surgery, (SAI Personal Information redacted by the USI HSCB ref Personal Information redacted by the USI.

Please find below the process which has been implemented in the Trust on the management of patients Discharged but awaiting results.

PAS Function

The communication system used within the Trust to manage patient appointments and patient episodes, including the Discharge of patients awaiting results is PAS. PAS provides a function to alert Secretaries of patients who are discharged but still await results. This function has now been activated within the PAS system and Consultant's Secretaries have been trained in the Management of the function.

A standardised operating procedure (SOP) is now in place. In this SOP there is a checklist of diagnostic tests and the turn-around time/average wait for specific test/results as a guideline – to ensure that patients are not waiting any longer than they should be for a review appointment.

Schedule for Reports

Reports are now run on Business Objects and forwarded to secretarial staff on a fortnightly basis for action.

Escalation Procedure

It has been agreed that there should be a 4 month maximum waiting time set for a patient review appointment, for those patients who are awaiting results. It is the responsibility of the Consultant's Secretary to escalate any patient sitting outside the agreed waiting time to the Service Administrator.

The Service Administrator will escalate to the appropriate Head of Service and Operational Lead.

A time-limited action plan will be put in place and the Service Administrator is then responsible for initiating the action plan. If the actions are not met within the timescale the Service Administrator will inform the Head of Service and Assistant Director responsible, for action.

Please do not hesitate to contact me if you require any further clarification or information regarding this process.

Diane Corrigan

From: serious incidents
Sent: 18 December 2014 12:32
To: Diane Corrigan
Subject: Trust Resp: DRO Request for update/Outstanding Trust response: SHSCT SAI [redacted] HSCB REF [redacted]

Dr Corrigan,

See below response from the Southern Trust in relation to your email to Margaret Marshall of 21 July 2014 (also below).

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

From: McCooey, Blaithnid [mailto: [redacted]
Sent: 17 December 2014 09:55
To: serious incidents
Cc: Carroll, Anita; Marshall, Margaret; Corporate.Governance
Subject: Resp: DRO Request for update/Outstanding Trust response: SHSCT SAI [redacted] HSCB REF: [redacted]

Elaine

In relation to Dr Corrigan's outstanding concerns, the process is as follows:

- Secretaries have confirmed that they do not file results without them first being viewed by the consultant.
- Consultants mostly sign these and some then dictate a letter.

I do not think that the Trust can really provide any further assurance on this other than the above feedback from Secretaries?
Can you please outline how Dr Corrigan would wish to move forward on this issue?

Kid regards
Blaithnid

From: serious incidents [mailto: [redacted]
Sent: 27 October 2014 09:57
To: Corporate.Governance
Subject: FW: Request for update/Outstanding Trust response: SHSCT SAI [redacted] HSCB REF: [redacted]
Importance: High

Blaithnid/Eileen,

Reference email trail below, I note a response from the Trust following Dr Corrigan's email of 21 July to Mrs Marshall remains outstanding.

As a matter of urgency I would be grateful if you would follow this up and provide a Trust response for the DRO as soon as possible.

Thank you.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

From: serious incidents
Sent: 05 September 2014 10:15
To: 'Corporate.Governance'
Subject: RE: Request for update: SHSCT SAI Personal Information redacted by the USI HSCB REF: Personal Information redacted by the USI

Blaithnid,

Have you had a chance to speak with Margaret re this one?

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

From: serious incidents [mailto: Personal Information redacted by the USI
Sent: 21 August 2014 11:03
To: Corporate.Governance
Subject: Request for update: SHSCT SAI Personal Information redacted by the USI HSCB REF: Personal Information redacted by the USI
Importance: High

Blaithnid/Eileen,

I refer to Dr Corrigan's email below to Margaret Marshall. To date no response has been received. I would be grateful if you would follow-up with Margaret and provide a response as soon as possible please.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

From: Diane Corrigan
Sent: 21 July 2014 16:12
To: Marshall, Margaret (Personal Information redacted by the USI)
Cc: serious incidents
Subject: FW: SHSCT SAI Personal Information redacted by the USI HSCB REF: Personal Information redacted by the SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Dear Margaret

Thank you for forwarding this clarification. It certainly demonstrates that a robust system is in place to monitor and act on investigations awaited – with the emphasis on ensuring that delays in patients having investigations done are escalated. However this SAI was not about a delay in the patient having her investigation. It was done promptly at the time requested post-surgery. The problem arose because the result was put on file awaiting the outpatient review appointment. In earlier correspondence it was stated that it was the practice of the patient's consultant not to review such results until they attended the clinic. I don't see how the system detailed below prevents that happening again. Am I missing something?

Regards

Diane

From: serious incidents
Sent: 21 July 2014 12:20
To: Diane Corrigan
Subject: SHSCT SAI Personal Information redacted by the USI HSCB REF: Personal Information redacted by the USI - SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Dr Corrigan,

See below response from the Southern Trust in relation to the above incident. I assume this is in response to your email of 23 April to Margaret Marshall and John Simpson.

Regards.
Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

[redacted]

From: McCooey, Blaithnid [mailto [redacted]
Sent: 17 July 2014 11:12
To: serious incidents
Cc: Marshall, Margaret
Subject: SAI Thematic Review: - Relating to Review of SAIs, where a Failure in the Referral or Follow-up Process has occurred.
Importance: High

Elaine
Please see below
Can you please bring this to the attention of Dr Corrigan who is the DRO involved in this query.

Kind regards
Blaithnid

Follow up of patients who are waiting for investigations

Further to previous correspondence on the 2 August 2012 regarding SH&SCT Root Cause Analysis – SAI [redacted] HSCB Ref [redacted]

SHSCT wish to provide some clarification.

In order to ensure that no patient is lost to follow up by a clinician, while waiting for the results of their investigations, the SHSCT has set up a specific code on the Patient Administration System (PAS) to ensure that there is a process in place which will enable the secretary to record that the patient is waiting for investigations, and also that the process will enable a report to be run detailing all patients waiting for their investigation, which can then be used as a monitoring tool.

Process

1. The secretarial staff will discharge the patient on PAS using the code DARO – *Discharge Awaiting Results – Outpatients.*
2. The Line Manage runs a report on a monthly basis which provides a list of all patients by consultant who are recorded as DARO.
3. Each secretary checks this report to ensure that there is no delay in any of the investigations being performed, and they chase any areas of delays with the relevant diagnostic service.
4. When the results are returned these are brought to the attention of the clinician, and PAS is updated to reflect that the results have been received.
5. This report is also checked each month by the Line Managers and any areas of concern are raised with the secretary to determine what action has been taken to date.
6. If there remains a delay in the investigations being performed the Line Manager will escalate this to the appropriate Head of Service for their action.

Diane Corrigan

From: Lynne Charlton
Sent: 13 November 2015 11:28
To: Elaine Hamilton
Cc: Mary McElroy; Diane Corrigan
Subject: FW: SAI CLOSURE FEMALE (DOB [Personal Information redacted by the USI] HSCB Ref [Personal Information redacted by the USI]

Elaine

Apologies for the delay in response – please run query on Datix re SAI's related to filed away results without action.

Lynne

From: Elaine Hamilton
Sent: 09 November 2015 16:27
To: Lynne Charlton
Cc: serious incidents
Subject: RE: SAI CLOSURE FEMALE (DOB [Personal Information redacted by the USI] HSCB Ref: [Personal Information redacted by

Lynne,

I just want to confirm if you want us to run a query on Datix re SAIs relating to filed away results or do you want to reply to Diane via Datix?

Maybe you could give me a call when your free.

Thanks

Elaine

From: Lynne Charlton
Sent: 06 November 2015 16:12
To: Elaine Hamilton
Cc: Jacqui Burns; Anne Kane; Mary McElroy
Subject: FW: SAI CLOSURE FEMALE (DOB [Personal Information redacted by the USI] HSCB Ref: [Personal Information redacted by the USI]

Would it be possible to write a response in datix to Diane's query?

Thanks

Lynne

From: Diane Corrigan
Sent: 29 October 2015 14:33
To: serious incidents
Cc: Heather Martin; Elaine Hamilton; Lynne Charlton
Subject: RE: SAI CLOSURE FEMALE (DOB [Personal Information redacted by the USI] HSCB Ref: [Personal Information redacted by the USI]

I have reviewed the position reports. I apologise for the delay. I have been under a lot of pressure working on other things.

As you know I struggled for several years to get the Trust to propose a simple solution which would have avoided such an incident happening again, i.e. that investigation results could not be filed unless seen by a senior

doctor. Over that time several solutions were put forward which did not address the core issue and the internal processes needed to achieve the optimal solution seemed impossible. I am surprised that without much additional detail on how that logjam was broken the Trust was able to confirm that 'Secretaries have confirmed that they do not file results without them first being viewed by the consultant'. However taking that statement at face value I am prepared to sign off this SAI.

I am copying this email to Lynne Charlton as I do not know if there have been other SAIs relating to filed away results.

Regards

Diane

From: serious incidents
Sent: 08 October 2015 13:53
To: Diane Corrigan
Cc: Heather Martin; Elaine Hamilton
Subject: RE: SAI CLOSURE FEMALE (DOB Personal Information redacted by the USI HSCB Ref: Personal Information redacted by the USI
Importance: High

Dr Corrigan,

Further to Elaine Hamilton's email below, just wondering if you have had a chance to review the above incident and consider it for closure.

I have attached the Datix Position Report and would be grateful if you could advise at the earliest opportunity.

Thanks.
Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

From: Elaine Hamilton
Sent: 28 September 2015 16:54
To: Diane Corrigan
Cc: Heather Martin; serious incidents
Subject: SAI CLOSURE FEMALE (DOB Personal Information redacted by the USI HSCB Ref: Personal Information redacted by the USI

Diane,

I have attached a position report on a Southern Trust SAI (FEMALE (DOB Personal Information redacted by the USI HSCB Ref: Personal Information redacted by the USI.

This SAI was reported in July 2010 but still remains open.

I would be grateful if you could advise if you would be in a position to close this SAI.

If you require any further information please do not hesitate to contact Personal Information redacted by the USI

Regards,

Elaine Hamilton

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HSCB / PHA SAI POSITION REPORT

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:		HSCB REFERENCE NUMBER
FEMALE (DOB Personal Information redacted by the USI **/514**		Personal Information redacted by the USI
DATE SAI NOTIFIED	CURRENT LEVEL OF INVESTIGATION:	ORGANISATIONS NOTIFIED (EXTERNAL)
3 September 2010	**SAIREP**	
DATE SAI OCCURRED:	DRO:	LSR/RCA REPORT DUE:
7 July 2010	**Dr Diane Corrigan**	
CORONER'S REPORT:	DRO SUPPORT OFFICER/S	PROGRAMME OF CARE
		Acute Services

KEY WORDS

DATIX – COMMON CLASSIFICATION SYSTEM - CCS CODING

STAGE OF CARE	DETAILS	ADVERSE EVENT
Treatment, procedure	Connected with the management of operations / treatment	**Retained needle/swab/instrument**

DESCRIPTION OF INCIDENT

Patient operated on 15/07/09. Presented with abdominal symptoms 07/07/10. CT Scan performed showed evidence of a retained surgical swab. Removed 21/07/10. All procedures carried out in Craigavon Area Hospital.

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

Surgery performed to remove medium size swab.

IMMEDIATE ACTION TAKEN BY HSCB/PHA:

29-Nov-2010

TOR DUE:	TOR RECEIVED:	SEA RECEIVED:	LSR RECEIVED:	RCA RECEIVED

RR SENT TO RQIA	TRUST ACTION:	DATE DRO CLOSED	SAIRSG DATE	LEARNING REF
PGOPEN				

SERVICE USER / FAMILY ENGAGEMENT:

DATE SU/FAM INFORMED	DATE CLIST RECEIVED	DATE LSR/SEA/RCA SHARED SU/FAM
REASON NO ENGAGMENT		
REASON SEA/RCA NOT SHARED		

RATIONALE NOT INFORMING the S/User / Family / Carer that the incident was being reviewed as a SAI

RATIONALE FOR NOT SHARING LSR/SEA/RCA

HSCB-PHA ACTION TAKEN:

05/02/13: Further request to DRO for update on incident.
17/05/13: Position Report to DRO with request for update on closure.
10/07/13: Email to DRO for update - The above SAI remains open on the Datix system. The last update I have from yourself is with regard to the attached letter. You advised that you needed to respond to Margaret Marshall. Can you advise if you have been in contact with Margaret either by telephone or letter.

HSCB-PHA ACTION TAKEN:

15/08/13: Update from DRO - spoke to Margaret Marshall on the 13th August. She agreed that the initial protocol did not address all the issues in this case. She said that the Trust had done further work since then to strengthen their internal processes to avoid recurrence. She said she would forward that revised protocol to me for comment. I'm afraid it still needs to stay open.
20/08/13: SAI Status Report forwarded to DRO.
02/09/13: Email from DRO to Trust - Can I just follow up our conversation a few weeks ago about the Urology/swab/CT results SA[redacted] you said there was an updated protocol that you planned to forward?
16/10/13: Email to Trust for update on Trust Protocol - The Trust were to forward to the DRO a revised Protocol.
I would be grateful if you would follow-up these queries as these are two old outstanding SAIs awaiting closure.
16/10/13: Trust email: Thanks for this Elaine. Apologies this seems to be yet outstanding.
I will liaise with Debbie and Margaret to see how I can move this forward.
08/11/13: Trust Protocol remains outstanding. Trust emailed for same.
20/11/13: Trust Protocol received - Please find attached the SHSCT Protocol as requested
Please let me know if the DRO requires anything further in order to close this case
21/11/13: Protocol forwarded to DRO.
21/01/14: Email to DRO for update on closure of incident. Datix Position Report forwarded.
24/03/14: Email to DRO -
At the last meeting of the HSCB / PHA Quality, Safety And Experience (QSE) group a position report which showed the current status on active SAIs where the Investigation Report has been received and the SAI remains open was considered. The report detailed action pending from both Trusts and DROs. The Group agreed, in the first instance, an exercise should be undertaken by all DROs to close where possible any SAIs that had been reported prior to 2013 that remain open.
Please see below a list of Southern Trust SAIs for which you are DRO and where Governance Department await your direction as to whether you are in a position to close the SAI or require any further information from the Trust. I have attached a Datix Position Report for ease of reference. I would be grateful if you would give this your urgent attention.

Organisation	Trust Reference	HSCB Ref
SHSCT	FEMALE (DOB [redacted]	[redacted]
SHSCT	[redacted]	[redacted]
SHSCT	SHSCT-SAI-[redacted]	[redacted]

Once this exercise is complete, work will commence in relation to closure of 2013 SAIs.
If you require any further information in relation to the position of any of the above SAIs, please contact the Governance Department.
24/03/14: DRO email - I am writing to the Trust Governance and Medical Director to try to bring [redacted] to a conclusion. I will now sign off the other two.
23/04/14: DRO email to MMarshall/JSimpson, SHSCT - This SAI has been open for a long time. In retrospect perhaps it should have been escalated earlier but on various occasions it seemed very close to closure so I held on for the final information needed. I have summarised below the process to date with a view to getting your comments on how and whether we can bring this to a conclusion. John, I appreciate that you may not routinely be involved in SAI issues, but this one relates to medical practice across almost all specialties so I felt that I should make you aware of the issue.
The patient involved in this SAI was found to have a retained swab following major urological cancer surgery. This came to light when the patient presented as an emergency 1 year later with abdominal pain/sub-acute obstruction and the swab was found at laparotomy.
The RCA identified swab counting issues in theatre and proposed changes to Trust procedures which would have minimised the risk of recurrence. As a DRO, I accept that these would have been sufficient to support sign-off of the primary cause of this SAI. However I did not sign it off for the following reason. It was noted in the RCA that an abnormality/mass had been reported on a planned follow-up CT scan 3 months post-op and reported as either a seroma or a local cancer recurrence. The patient had been due for scheduled out-patient review soon after the scan (i.e. at 4 months post-op) but because of outpatient review backlogs this never took place. It was reported in the RCA that it was the practice of the

HSCB-PHA ACTION TAKEN:

consultant concerned not to review reports of investigations until a patient was due to attend outpatients. If this patient had had a recurrence of her cancer, the delay in the scan result being reviewed by her consultant would almost inevitably have resulted in significant consequences.
As DRO I asked the Trust to consider if a system was needed to ensure all reports of diagnostic tests were seen before filing to avoid missing issues needing urgent action (as would be the case in general practice). The Trust agreed to consider this; the first step proposed was to scope the scale of the issue across specialties. After some time had passed the Trust submitted new recommendations (attached). I could not be confident that the action proposed would avoid a similar problem in future so I asked the Trust to reconsider.
I had expected to receive a final report/proposal setting out how the issue would be addressed. Instead a swab counting protocol was forwarded to me via the serious incidents team. Unfortunately it appears that if anything this has gone backwards rather than forward - however I am aware that Governance staff moved jobs in 2013 and it may be that this has inadvertently resulted in some crossed wires in this case. Could I ask you to re-read the attached description of revised processes in the Trust which was forwarded to me in 2012? My reading of this is that these arrangements only deal with patients discharged from the ward, so would not apply to results following outpatient investigation. Even if that is put to one side, I think that if the sequence of events that happened in this SAI case were to happen again, the patient, who had an abnormal result at 3 months post-op and one month before an expected outpatient review, would not be flagged by the consultant secretary as needing escalation until after the review date - i.e. at least 1 month after the abnormal result had been returned/filed. I don't feel I could sign this off as safe practice. Am I missing something obvious? Can I ask you both what your opinion is on this issue?
25/04/14: Trust holding response received from MMarshall - I will come back to you regarding the below information hopefully by Tuesday 6th May.
12/06/14: DRO email to MMarshall, STrust - I don't think you forwarded any further information after this email? Can you give me an update on this?
26/06/14: DRO email - I spoke to Anne about this case earlier today. I sent a reminder to Margaret Marshall on 12th June but got a response to say she was on annual leave. Could I ask you to keep an eye on this one and once Margaret is back from leave see if you can get an update/response?
EHyde to bring forward and follow-up with Trust beginning of July.
09/07/14: Reimnder issued to Trust for outstanding response.
17/07/14: Trust respone received to DRO email of 23/4/14 - Can you please bring this to the attention of Dr Corrigan who is the DRO involved in this query.
Follow up of patients who are waiting for investigations
Further to previous correspondence on the 2 August 2012 regarding SH&SCT Root Cause Analysis - SAI Personal Information redacted by the HSCB Ref Personal Information redacted by
SHSCT wish to provide some clarification.
In order to ensure that no patient is lost to follow up by a clinician, while waiting for the results of their investigations, the SHSCT has set up a specific code on the Patient Administration System (PAS) to ensure that there is a process in place which will enable the secretary to record that the patient is waiting for investigations, and also that the process will enable a report to be run detailing all patients waiting for their investigation, which can then be used as a monitoring tool.

Process
1. The secretarial staff will discharge the patient on PAS using the code DARO - Discharge Awaiting Results - Outpatients.
2. The Line Manage runs a report on a monthly basis which provides a list of all patients by consultant who are recorded as DARO.
3. Each secretary checks this report to ensure that there is no delay in any of the investigations being performed, and they chase any areas of delays with the relevant diagnostic service.
4. When the results are returned these are brought to the attention of the clinician, and PAS is updated to reflect that the results have been received.
5. This report is also checked each month by the Line Managers and any areas of concern are raised with the secretary to determine what action has been taken to date.

HSCB-PHA ACTION TAKEN:

6. If there remains a delay in the investigations being performed the Line Manager will escalate this to the appropriate Head of Service for their action.
21/07/14: Trust response forwarded to DRO.
21/07/14: DRO response to Trust - Dear Margaret,
Thank you for forwarding this clarification. It certainly demonstrates that a robust system is in place to monitor and act on investigations awaited - with the emphasis on ensuring that delays in patients having investigations done are escalated. However this SAI was not about a delay in the patient having her investigation. It was done promptly at the time requested post-surgery. The problem arose because the result was put on file awaiting the outpatient review appointment. In earlier correspondence it was stated that it was the practice of the patient's consultant not to review such results until they attended the clinic. I don't see how the system detailed below prevents that happening again. Am I missing something?
20/08/14: Email to DRO to clarify if she has had a response from the Trust re her email (above) before follow-up with the Trust.
DRO response - No I haven't had a reply. Please do follow up. Thanks.
21/08/14: Reminder email issued to Trust for response to DRO email of 21/7/14.
21/08/14:Trust update received - Mrs Marshall is on annual leave returning the 26th August I will raise this with her then.
05/09/14: Further reminder to Trust.
27/10/14: Urgent reminder to Trust - Reference email trail, I note a response from the Trust following Dr Corrigan's email of 21 July to Mrs Marshall remains outstanding.
As a matter of urgency I would be grateful if you would follow this up and provide a Trust response for the DRO as soon as possible.
28/10/14: Trust holding response - Blaithnid and Eileen are both currently on leave and I am only covering the office, I will ask Blaithnid to respond as soon as she returns on Wednesday.
16/12/14: Trust response to Dr Corrigan's email fo 21 July remains outstanding. Urgent reminder issued to Trust for response.
17/12/14: Trust response - In relation to Dr Corrigan's outstanding concerns, the process is as follows:
· Secretaries have confirmed that they do not file results without them first being viewed by the consultant.
· Consultants mostly sign these and some then dictate a letter.
I do not think that the Trust can really provide any further assurance on this other than the above feedback from Secretaries?
Can you please outline how Dr Corrigan would wish to move forward on this issue?
18/12/14: Trust response forwarded to DRO.
11/02/15: Email to DRO - Further to the Trust response received 17 Dec 2014 (see below) in relation to the above incident, can you advise does the response address your concerns, is there anything further you require from the Trust or is this incident ready for closure.
11/03/15: Reminder email to DRO for update on closure.
11/06/15: Reminder email to DRO for update on closure.
28/09/15: Email from EHamilton to DRO - I have attached a position report on a Southern Trust SAI (FEMALE (DOB Personal Information redacted by the USI HSCB Ref: Personal Information redacted by the
This SAI was reported in July 2010 but still remains open.
I would be grateful if you could advise if you would be in a position to close this SAI.
If you require any further information please do not hesitate to contact Personal Information redacted by the USI
08/10/15: Reminder issued to DRO.
15/10/15: Following conversation between EHamilton/HMartin. Position Report forwarded to Heather for follow-up with Dr Corrigan.
20/10/15: Update to EHamilton enclosing Position Report, Trust letter of 2/8/12 and Trust Swab Protocol.
29/10/15: Email from DRO-I have reviewed the position reports. I apologise for the delay. I have been under a lot of pressure working on other things.
As you know I struggled for several years to get the Trust to propose a simple solution which would have avoided such an incident happening again, i.e. that investigation results could not be filed unless seen by a senior doctor. Over that time several solutions were put forward which did not address the core issue and the internal processes needed to achieve the optimal solution seemed impossible. I am surprised

HSCB-PHA ACTION TAKEN:

that without much additional detail on how that logjam was broken the Trust was able to confirm that 'Secretaries have confirmed that they do not file results without them first being viewed by the consultant'. However taking that statement at face value I am prepared to sign off this SAI.
I am copying this email to Lynne Charlton as I do not know if there have been other SAIs relating to filed away results.
06/11/15: Email from EHamilton to LCharlton - Would it be possible to write a response in datix to Diane's query? Thanks.
09/11/15: Email from EHamilton to LCharlton - I just want to confirm if you want us to run a query on Datix re SAIs relating to filed away results or do you want to reply to Diane via Datix?
Maybe you could give me a call when your free.
13/11/15: Email from LCharlton to EHamilton - Apologies for the delay in response - please run query on Datix re SAI's related to filed away results without action.
13/11/15: Email from EHamilton to MCampbell - Please see request (above) from Lynne - could you organise for this to be run for her?
20/11/15: Email from EHamilton to seriousincidents - Has Diane or Lynne came back again about this? The last update I saw was Lynne asking for a report to be run on Datix.
23/11/15: Email from EHyde to EHamilton - I have heard nothing more. See attached last email I have on this one.
03/12/15: Email from MCampbell to JBurns - Elaine Hyde and I looked at this yesterday. We tried to do a search on Datix but struggled with what criteria to use to identify SAIs that Lynne has asked for the search to be run on - 'filed away results without action'.
Can you advise what CCS codes/adverse event I should be searching under?
Will pick this up on Monday when I'm back in the office.
03/12/15: Email from MCampbell to EHamilton - Elaine and I looked at this yesterday. We struggled with how to run the search to identify what Lynne is looking. I have emailed Jacqui to ask advice on what search to run that might identify records that Lynne is interested in. I will pick this up again on Monday.
11/01/16: Email to MCampbell for update on closure.
26/05/16: Email to MCampbell for update on closure
08/06/16: Reminder email to MCampbell for update
22/06/16; Spoke to MC , Advised she will provide a response shortly.
19/07/16: Spoke to MC, advised she will email JB regarding L Charltons request.
19/07/16: Email from MC to JB - Can you please advise if it is possible to answer Lynne's query and if so, how would the search be undertaken
26/07/16: Spoke to MC - No reply from JB - will send reminder email - JB OOO Until 3/08/16 therefore b/f for 8.8.16
22/08/16: Email to JB - I refer to Mareth's email and would be grateful if you would advise how to undertake search or how to move forward with this SAI. JB on leave until 26.8.16 therfore BF for 2.9.16
07/09/16: Reminder email to JB requesting response
14/09/16: Email from JB - Donna

As discussed - see below - often the incident will not indicate that results have been filed away without action therefore this will not be coded on Datix so it is difficult to search for this information. This type of information will be included in the review report. It may be possible to identify a cohort of SAIs but profession input will be required to review the SEA/RCA.
I would suggest perhaps listing this for a discussion at SAI Review Group.
14/09/16: Listed for SAI Review Group 19 October 2016.
03/11/16: Email to J Burns - Further to your email (above), this SAI was listed for the agenda for the SAI Review sub group meeting on 19 October. On reviewing the Action Log of 19 October, this one doesn't seem to have been discussed. Can you advise if it is going to the next meeting. We are trying to move this one forward to closure.
18/11/16: Reminder email to J Burns - Any further update on the above Southern Trust SAI. Is it up for discussion at November's SAI Review sub group?
18/11/16: Email from JB to EHyde - Elaine - ref to Diane email below I read this that the SAI can be closed?

HSCB-PHA ACTION TAKEN:

I will list the issue detailed below for discussion at SAI Review Group next week.
07/12/16: Email to J Burns - Ref email trail (above), was this discussed at the SAI Review Group meeting on 24 November. I don't see it on the Action Log. Trying to seek closure for this one.
09/12/16: Email from Jacqui to Elaine - 'Here is the extract from the action log:
Date Action No ACTION AGREED
23 Nov 2016 2 Data searches - results have been filed away without action - Jacqui outlined some issues in providing information from Datix where information may not be searchable on the system as it may be contained within the SEA/RCA report. Following discussion it was agreed that sometime could be afforded to this topic and identifying key words at the planned DRO session in early 2017.
Person Responsible J Burns
Status Review 18 Jan 2017'
12/12/16: Email to J Burns - Do we keep this one open or can it be closed on the back of Diane Corrigan's email of 29 October 2015?
12/12/16: Email from J Burns - This can be closed on the back of Diane Corrigan's email of 29 October 2015 - Lynne Charlton has scheduled a meeting with me on 4 January 2017 to have a look at searching for this type of information.
13/12/16: Email to J Burns - One final query - Will I go ahead and close it on the back of this email trail or does it need to go to an Acute Review Team meeting?
16/01/17: Email from MC to J Burns - Jacqui - please see attached position report for Irrelevant redacted by which is listed under AOB at today's SAI Review Team Meeting for closure as per your email of 12 December 2016 and discussion with Elaine who asked that I take to the Acute Review Team. I did table it at the December meeting but unfortunately the position report only printed odd pages so the Group didn't get the full position report and asked that it be listed for today. Can you explain what Diane wanted and what you are now doing with Lynne so I can update the meeting and hopefully get this one closed.
16/01/17: Email from JB - Ring me
16/01/17: Telephone conversation between JB and MC - Jacqui advised it is not possible to do a search on Datix to identify records not filed away properely as there is no code for this. Work is underway with Jacqui Burns and Lynn Charleton - a search of all SAIs across Acute Services has been undertaken. Lynn and Jacqui have identified a cohort of SAIs and will look at the review reports and will do a further scoping exercise to identify if there is a wider issue.
ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 16 JANUARY 2017
Members considered the position report in respect of Personal Information redacted by
Further information required - Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately.
Action: Governance Team
Review February 2017
Person Responsible - Review February 2017
30/01/17: Email from Mareth - 'The above SAI was discussed at the recent meeting of the Acute Team. Prior to closure, the Team have asked for a copy of the Trust Protocol with regards filing of results. I have drafted the wording as advised by Dr Farrell (see below). Can you forward to Trust please.'
30/01/17: Fwdd to Trust - The HSCB/PHA Acute Review Team considered the above incident at a recent meeting. Prior to closure, the Team have asked the Trust to forward a copy of their Protocol, detailing how lab results are filed following a procedure. The Trust response should also explain how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately.
Can you please send your response to Personal Information redacted by the USI mailbox by 6 February 2017?
14/02/17: Email to Trust requesting copy of Protocol.
28/02/17: Email to Trust requesting copy of Protocol.
09/03/17: Email from Trust with Swab Protocol attached.
Swab Protocol attached - Personal Information redacted by the USI
10/03/17: Fwdd to Brid and Mareth.

HSCB-PHA ACTION TAKEN:

10/03/17: Email from Mareth to Brid - 'As requested, the Governance Team followed up with the Southern Trust seeking a copy of their Protocol detailing how lab results are filed following a procedure. The attached protocol was received from the Trust today.
This SAI is listed for review at the next meeting on 20 March 2017. Can you review the Protocol and advise if you require any further information from the Trust.'
10/03/17: Email from Mareth - 'Roisin,
Can you follow up with the Trust, as per Dr Farrell's email below?
[From: Brid Farrell , Sent: 10 March 2017 To: Mareth Campbell
They sent the swab protocol not the lab result protocol!]
13/03/17: Email to Trust requesting lab result Protocol.
20/03/17: ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 20 MARCH 2017
DRO not present. Defer to next meeting.
30/03/17: 1st Reminder Email to Trust re Lab result protocol.
ACUTE SERVICES SAI REVIEW TEAM MEETING
ACTION LOG
UPDATED 19 APRIL 2017
Update 19 April 2017 - It was noted SHSCT submitted Swab Protocol - this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust.
21/04/17: Email to E Hyde - I've changed the date to 24/04/17.
Could you check and let me know if you need me to do anything with this one?
27/04/17: Telephone conversation between Nicole Evans, SHSCT and E Hyde. Nicole agreed to follow-up request for Lab result protocol as a matter of urgency.
10/05/17: Telephone conversation between Nicole Evans and G McArdle, Nicole is going to follow up and phone back today.
23/05/17: Email to Elaine - 'Can you please advise re follow up?'
24/05/17: Escalation email to Elaine Hamilton - See attached Position Report in relation to the above incident. We are awaiting the Trust to submit Lab Result Protocol. 1st request was issued on 28/2/17. On 10/3/17 the Trust submitted Swab Result Protocol. On 13/3/17 a request was issued to the Trust to submit the correct Protocol. Two phone calls have been made to the Trust and to date the Lab Result Protocol remains outstanding.
01/06/17: Email from E Hamilton to SHSCT - 'This SAI has been escalated to me as a request for the Lab result protocol has been requested on a number of occasions but remains outstanding. To avoid further escalation of this matter I would be grateful if you could urgently forward a copy of the Lab Result protocol to [redacted]
12/06/17: E Hamiliton will follow up with Trust.
14/06/17: Email to Trust - URGENT REMINDER
A number of requests have been made requesting the Lab Result Protocol in relation to this SAI.
Can the Trust please forward this as a matter of urgency to [redacted]
If the Trust is unable to provide the requested information please provide a rationale . Regards, Elaine
26/06/17: Email from E Hamilton to A Kane - 'We have received no response from Southern Trust in relation to the request below. It was originally requested in April.
Could we have a chat about it tomorrow as I think it needs escalated to yourself.'
04/07/17: Escalation email from Anne Kane to Margaret Marshall (SHSCT) - In line with our internal escalation process within the HSCB we review all active SAIs on a weekly basis. I am following up on information which is currently outstanding from your Trust in respect of the following SAI and would be grateful if you could urgently provide an update. Can you please provide an update on this case and respond to [redacted]
14/07/17: GMcA phoned Trust - unable to contact anyone in Governance office (3 extensions on voicemail - left a messgae for someone to return my call).
17/07/17: Telephone call fro GMcA to Lynsey at SHSCT - she is going to follow up with the Acute Governance Team and provide a response.
****if no response by Monday 24th July ask Anne / Elaine how to proceed***

HSCB-PHA ACTION TAKEN:

17/07/17: Telephone conversation between Truid Reid, SHSCT and EHyde - Trudi rang to ascertain what exactly Dr Farrell required as the Trust Swab Protocol was a large document relating to different aspects of retains SWABs. I advised Trudi it would be best to speak directly with Dr Farrell as she would be able to advise her exactly what was required from the Trust. I gave Truid Dr Farrell's contact details and advised her if she was unable to contact Dr Farrell within the next few days to contact me again and I would make contact with Dr Farrell.
17/07/17: Email from Dr Farrell to Trudi Reid, SHSCT - The SAI you sent me was closed on 23rd October 2013 and relates to Trust SAI [Personal Information redacted by the] and DHH.
The outstanding SAI relates to Trust reference Female(DOB [Personal Information redacted by the USI]) HSCB reference [Personal Information redacted by the] The speciality involved was urology in CAH. The issue was about the consultant not looking at results until the patient was seen in outpatients after surgery. The Trust was asked for a protocol to ensure this reduce the risk of this happening again. (The SAI was reported because the patient also had a retained swab at surgery).
19/07/17: Email from Trudy Reid - Dr Farrell thank you and apologies, the case was well before my time and with annual leave and [Personal Information redacted by the USI] I am unable to find the final report of the case you refer to, I wonder if I could trouble you for a copy of the report we sent and I will endeavour to get a response to you ASAP.
19/07/17: SAI Report forwarded to Trudy Reid.
24/07/17: Trust's response to escalation email of 4 July 2017- This matter has been discussed with Dr Farrell and we are waiting for her to come back with the specific information required.
31/07/17: Email to Trust - Ref your email below. Trudy Reid contacted Dr Farrell for a copy of the SAI Report concerned. I sent her this on 19 July (see email trail attached). Apologies I should have copied you into this email.
Can you please follow-up with Trudy and see if she is in a position yet to forward seriousincidents the information requested. Thanks.
Lindsey
I refer to Elaine's email below and attached correspondence.
To date we still have not received a response in relation to Dr Farrell's request. Given the length of time this issue has been outstanding, I would be grateful if you can liaise with Trudy at your earliest convenience, in order to furnish the DRO with a response and hopefully bring this issue to a satisfactory conclusion.
09/08/17: Email from Trust - Trudy is currently on leave and will not be back until the end of the month. I have forwarded on the previous emails and marked them for her attention when she is back. I have also sent them to the Acute Governance department.
29/08/17: Email from DRO - 'The first of these SAIs I recommend to be signed off in October 2015. I do not know what further action is awaited from the Trust.'
At Acute Review Meeting
01/09/17: MC tried to contact Trudy but no response. Given the fact that Trudy has been on leave until 31 August, follow-up 11 September 2017.
11/09/17: MC rang T Reid - no response
12/09/17: MC spoke to T Reid. Trudy apologiesed for the delay in forwarding information. She undertook to review all this afternoon and respond today/Wednesday morning.
12/09/17: Email to T Reid - Further to our telephone conversation this morning, please see email trail below in relation to the information requested. During the conversation, you undertook to review the report today and respond this afternoon/tomorrow morning. Given the length of time this issue has been outstanding, I would be grateful if you could respond, in order to furnish the DRO with a response and hopefully bring this issue to a satisfactory conclusion.
14/09/17: Email from Trudy Reid (SHSCT) response from Trust - Apologies for the delay in responding, please see attached laboratory protocols for results. With the current advances in electronic systems the acute directorate are meeting to review our systems and process in relation to result management, the 1st multidisciplinary meeting is on 20th September 2017.
14/09/17: Email to Dr Farrell - Please find attached laboratory protocols for results that has been received from Trudy Reid, SHSCT in respect of the above SAI. Can you advise Serious Incidents if you wish this SAI to be listed for review prior to closure at the next SAI Acute Review Team meeting scheduled for Monday 25 September 2017.

HSCB-PHA ACTION TAKEN:

25/09/17: Email from E Hamilton to G McArdle - 'I didn't even send the papers etc to her as she is happy to close off her item I just need confirmation from Brid on it as well.'
ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 25 SEPTEMBER 2017
Update 25 September 2017: CLOSE FROM ACUTE GROUP (PENDING CLOSURE WITH TRUST) The laboratory protocols for results have been received from the SHSCT. The DRO (Dr Corrigan) is content SAI is closed. Dr Farrell will review the protocol and advise the Governance Team if she is content with protocols and confirm closure. Governance Team to follow up with Dr Farrell.
Members were in agreement SAI did not require to be reviewed again at the meeting
STATUS - CLOSE FROM AGENDA (PENDING CLOSURE WITH TRUST)

Follow-up date as 3 October to check if SAI was reviewed at Acute meeting on 25 September

** Correspondence from 29.11.10 to 23.11.12 saved in documents - ID Personal Information redacted by USI
19/10/17: Elaine Hamilton spoke with Diane Corrigan. Diane will review the case and all additional information requested and respond back to serious incidents. Elaine Hyde to forward all relevant information to Diane.

Diane Corrigan

From: Diane Corrigan
Sent: 07 November 2017 10:51
To: serious incidents
Subject: RE: Request for update on closure: SHSCT SAI - FEMALE (DOB [redacted] HSCB REF [redacted]

Elaine
In Brid's absence I have read the documentation provided. As you know the additional request for sight of lab protocols for results was made by members of the SAI group and I was not involved. The unread report in this SAI was a radiology report, so I am not sure if some wires got crossed in seeking lab report arrangements. In either event, what has been provided is a laboratory protocol (which to be fair is what was asked for) but this understandably does not address the wider issue of Trust protocols to ensure results are then seen by a member of medical staff in a reasonable timescale and before being filed away, or left on a file awaiting an outpatient review which may be delayed (as happened in this case). This has therefore not progressed the issue on which the SAI group wanted additional information/reassurance.

I was not part of the SAI group discussion, which stimulated this request for additional information. The Trust appears to have interpreted the request literally and without reference to the underlying SAI. In retrospect perhaps the request was not clear from this end if it was to be actioned by someone in the Trust who had no knowledge of the background issue. The SAI group may wish to decide whether they still need additional information.

Diane

From: serious incidents
Sent: 07 November 2017 09:58
To: Diane Corrigan
Subject: Request for update on closure: SHSCT SAI - FEMALE (DOB [redacted] HSCB REF: [redacted]

Dr Corrigan,

Further to the email below, just wondering if you have you had an opportunity to consider the above incident for closure.

Regards

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

From: serious incidents
Sent: 24 October 2017 12:25
To: Diane Corrigan
Subject: FEMALE (DOB [redacted] HSCB REF: [redacted]

Dr Corrigan,

See attached Datix Position Report in relation to the above SAI. I have highlighted key areas following your email of 29/10/15 confirming you were happy to close.

The delay in closing this SAI arose in November 2015 when Lynne Charlton requested a query be run on Datix for SAIs relating to 'filed away results without action'. Lynne Charlton and Jacqui Burns have subsequently carried out of piece of work on Acute SAIs, a cohert of SAIs have been identified. Jacqui and Lynne to look at the review reports and undertake a further scoping exercise to identify if there is a wider issue. This has now been completed and Lynne is taking forward.

At the Acute Review Team meeting on 16 January 2017 members considered this incident and asked that the Southern Trust forward their Protocol detailing how lab results are filed following a procedure, see below extract from the meeting. The Southern Trust submitted their Swab Protocol in error which again caused further delay.

Following lengthy correspondence between the Trust and seriousincidents, on 14 September 2017 the Trust's laboratory protocols for results was received, see attached.

	Agenda Item	Action Agreed	Person Re
017	9	**Any Other Business** • Personal Information redacted by the USI – **SHSCT SAI** Members considered the position report in respect of Personal Information redacted by the USI **Further information required** – Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately. **Action: Governance Team** **Review February 2017** **Update 20 March 2017** – DRO not present. Defer to next meeting. **Review April 2017** **Update 19 April 2017** – It was noted SHSCT submitted Swab Protocol – this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust. **Update 25 September 2017: CLOSE FROM ACUTE GROUP (PENDING CLOSURE WITH TRUST)** The laboratory protocols for results have been received from the SHSCT. The DRO (Dr Corrigan) is content SAI is closed. Dr Farrell will review the protocol and advise the Governance Team if she is content with protocols and confirm closure. Governance Team to follow up with Dr Farrell. Members were in agreement SAI did not require to be reviewed again at the meeting.	**CLOSE FRO (PENDING WITH TRU**

Following review of the Trust Laboratory Protocol, in Dr Farrell's absence, I would be grateful if you would confirm to seriousincidents if this incident can now be closed from Datix and with the Southern Trust.

If you require any further information please do not hesitate to contact seriousincidents.

Regards

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
www.hscboard.hscni.net

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Diane Corrigan

From: serious incidents
Sent: 30 November 2017 11:31
To: Corporate.Governance ([redacted])
Cc: Diane Corrigan; Louise Herron
Subject: Closure of SAI Trust Ref: FEMALE (DOB [redacted] HSCB Ref: [redacted]

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the HSCB / PHA DRO via the serious incidents mailbox.

Learning issues raised within this SAI have been taken forward within the Delayed Diagnosis Exercise and the Newsletter article 'Accurate Communication of actions and results' which was published in edition 6 of the Learning Matters Newsletter.

In line with the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), please note that it is the responsibility of the Trust to take forward any local recommendations or further actions identified (*including, where appropriate, on-going or further liaison with service users or families*) and monitor these through the Trust's own internal governance arrangements. This is an essential element in reassuring the public that lessons learned, where appropriate have been embedded in practice.

Regards

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [redacted]
Email: [redacted]
www.hscboard.hscni.net

HSCB / PHA SAI POSITION REPORT

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:		HSCB REFERENCE NUMBER
SHSCT SAI Personal Information redacted by the USI		Personal Information redacted by the USI
DATE SAI NOTIFIED	CURRENT LEVEL OF REVIEW	ORGANISATIONS NOTIFIED (EXTERNAL)
22 March 2016	SAILV2	
DATE SAI OCCURRED:	DRO:	LSR/RCA REPORT DUE:
6 January 2016	Dr Joanne McClean	14 June 2016
CORONER'S REPORT:	DRO SUPPORT OFFICER/S	PROGRAMME OF CARE
		Acute Services

KEY WORDS

DATIX – COMMON CLASSIFICATION SYSTEM – CCS CODING

STAGE OF CARE	DETAILS	ADVERSE EVENT
Diagnosis, failed or delayed	Cancer - Dx failed or delayed	Failure in referral process

DATIX – COMMON CLASSIFICATION SYSTEM – CCS2 CODING

TIER 1	TIER 2	TIER 3

DESCRIPTION OF INCIDENT

**DRO advises this is similar incident to Personal Information redacted by the USI and Personal Information redacted by the USI

Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney.

US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate.

MRI performed 2/9/2014

Referral to Urology was not triaged on receipt. Patient 10 sent OP appointment for 6/1/2016. Patient 10 was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer.

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning.

DOB: Personal Information redacted by the USI GENDER: F AGE: Personal Information redacted by the USI

WHY INCIDENT CONSIDERED SERIOUS:
serious injury to, or the unexpected/unexplained death of:
- a service user

CURRENT CONDITION OF SERVICE USER:
The patient is undergoing treatment

HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS A SAI - NO - The Trust intend to inform the family by letter in the first instance of this serious incident review and will advise HSCB when this has been done.

DOB: Personal Information redacted by the USI **GENDER:** Female **AGE:** Personal Information redacted

CURRENT CONDITION OF SERVICE USER:

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

IMMEDIATE ACTION TAKEN BY HSCB/PHA:

TOR DUE:	TOR RECEIVED:	SEA RECEIVED:	LSR RECEIVED:	RCA RECEIVED
19 April 2016	**5 April 2016**			**16 March 2017**

RR SENT TO RQIA	TRUST ACTION:	DATE DRO CLOSED	SAIRSG DATE	LEARNING REF
		10 January 2018		

SERVICE USER / FAMILY ENGAGEMENT:		
DATE SU/FAM INFORMED	**DATE CLIST RECEIVED**	**DATE LSR/SEA/RCA SHARED SU/FAM**
6 January 2016	**16 March 2017**	**31 March 2017**
REASON NO ENGAGMENT		
REASON SEA/RCA NOT SHARED		

RATIONALE NOT INFORMING the S/User / Family / Carer that the incident was being reviewed as a SAI

RATIONALE FOR NOT SHARING LSR/SEA/RCA
meeting took place on 10/4/17

HSCB-PHA ACTION TAKEN:

22/03/16: Incident Acknowledged and DRO Assigned.
22/03/16: Query to Trust - In relation to the above incident, can you please clarify the Date of Birth of the Service User as on the SAI Notification Form it states the Date of Birth as Personal Information redacted by the USI and age as Personal these don't match. Either the Date of Birth should be Personal Information redacted by the USI or age needs changed to Personal Information redacted Can you please clarify correct Date of Birth/Age.
23/03/16: Email from DRO - 'Noted.'
23/03/16: Email from Trust with amended SAI Notification Form attached. Record updated and saved to Datix.
05/04/16: Email from Trust enc TOR and membership - forwarded to DRO
05/04/16: Email from DRO req Position report - forwarded as requested
05/04/16: Email from DRO - 'I would encourage the Trust to consider adding someone from outside the Trust to the Team Membership.'
06/04/16: Email to Trust with DRO Q re Team Membership.
20/04/16: 1st reminder to Trust re DRO query as above.
10/05/16: 2nd reminder to Trust.
02/06/16:Tel call to Trust re repsonse to DRO Comment - advised to send request via email. Final reminder to Trust.
09/06/16: Email from Trust - Further to your email below regarding the team membership of SAI ID 52720, I can advise that Mrs Trudy Reid contacted the DRO and had a lengthy discussion regarding adding an external to the review team. It was agreed during the conversation that the membership would stay the same at present but he did state that during the review the panel may take the opportunity to ask for an independent opinion.
I have enclosed the ToR and Team Membership for your reference.
09/06/16: Email above from Trust forwarded to DRO for their information.
10/06/16: Email from DRO - Noted.
12/08/16: Letter from HSCB CX to Trust CX attaching status report highlighting all review reports that remain outstanding as at 31st July 2016.
23/11/16: Email from Trust with amended ToR attached.
24/11/16: Amended ToR fwdd to DRO for approval.
01/12/16: Email to DRO re approval of ToR.
12/12/16: Email to DRO requesting approval of ToR.

HSCB-PHA ACTION TAKEN:
20.01.17 - Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 31 December 2016 27/01/17: Email to DRO requesting approval of ToR. 08/02/17: Email to DRO requesting approval of ToR. 27/02/17: EMail to DRO requesting approval of ToR. 07/03/17: Email to DRO requesting approval of ToR. If no response escalate. 14/03/17: Email from DRO approving ToR - Thanks. These are fine. 15/03/17: ToR approval to Trust. 16/03/17: Final RCA Report (including chklist) recevied from Trust. 20/03/17: Email to DRO - Final Report / Position Report. 26/04/17: Email to DRO re listing for new Acute Meeting. 28/04/17: Email from DRO - Please list for next meeting. 02/05/17: Listed for meeting on 22 May 2017. ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 10 MAY 2017 First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 STATUS - Review at meeting 9 June 2017 ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 6 JUNE 2017 Governance Team to email the SHSCT with the following points: "Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. "The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? "Ensure Trust Urologists are compliant in accordance with IEAP Review when Trust have responded. 12/06/17: DRO queries forwarded to Trust. 03/07/17: Email to Trust - I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed. Many thanks. 03/07/17: Email from Trust - 'I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.' 17/07/.17: 2nd reminder to Trust for outstanding response to DRO queries. 25/07/17: Telephone call from GMcA to SHSCT (Spoke to Lindsey) - she has followed up the outstanding response with the Directorate twice, she is going to follow up again today and provide an update. ***If no response by 01.08.17 escalate from GMcA / EH*** 02/08/17: Escalated to Elaine Hamilton 09/08/17: Escalated to Elaine Hamilton - I will escalate it now 09/08/17: Email to Margaret Marshall from Elaine Hamilton requesting urgent reponse to DRO queries to avoid it being escalated further 14/08/17: Email from Trust - The staff member currently dealing with this case is on leave until 21st August. 23/08/17: Email from Trust - 'I wish to advise that a response to DRO queries is currently with the Assistant Director for approval .' 30/08/17: Telephone call from MC to L Liggett + follow-up email. Our telephone conversation today refers. You advised on 23 August 2017 that the response to DRO queries was with the Assistant Director for approval. To date the response hasn't been received. During our conversation, you undertook to follow-up with the Directorate and if the response is approved, submit it or provide an update on when it will be submitted. 01/09/17: Forwarded to A Kane for Escalation re outstanding response to DRO queries as of 12.06.17. 08/09/17: AK on annual leave 08/09/17: Telephone call from MC to Lindsay Liggett. Lindsay advised she didn't have an update but undertook to email the co-ordinator and provide an update on status of response on Monday 11 September 2017. 14/09/17: Telephone Call from E Hyde to Lindsey Liggett. Lindsey to do an urgent follow-up with Trust

HSCB-PHA ACTION TAKEN:

Director and contact me to-day by telephone to advise when Trust response to DRO queries will be submitted to HSCB.
15/09/17: Email from Trust - 'Please see below response to DRO queries,
Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
"The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a Breast Surgeon.
"The Trust currently has a short life working group reviewing systems and processes for the management of results
"I am checking if the case was presented at M&M for wider learning
The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
"This SAI was in relation to triage by one urologist, the Trust has addressed this issue with the Consultant involved
"Electronic triage has been rolled out for Urology, this should mitigate against late or uncompleted triage within the specialty.
Ensure Trust Urologists are compliant in accordance with IEAP
"The Trust Urology team have been made aware of the requirements within the IEAP in relation to triage of clinical referrals
Kind regards'
15/09/17: Trust response fwdd to DRO.
ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 25 SEPTEMBER 2017
Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [redacted] and to seek assurance processes have been put in place to prevent reoccurrence.
SAI to be reviewed following meeting with SHSCT
Action: Dr Farrell / Dr McClean
STATUS - Review following meeting with SHSCT
01/11/17: Email from E Hamilton to DRO - 'At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [redacted] and to seek assurance processes have been put in place to prevent reoccurrence. Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?'
Extract from Action Log:
Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [redacted] and to seek assurance processes have been put in place to prevent reoccurrence.
SAI to be reviewed following meeting with SHSCT
Action: Dr Farrell / Dr McClean.
20/11/17: Update from Acute Services SAI Review Team meeting - FURTHER INFORMATION REQUIRED. SAI to be referred to the Elective Care Group (Michael Bloomfield and Lisa McWilliams) in respect of timely triage and categorisation. Request the Elective Care Group to seek assurance from other Trusts if E-Triage would manage the risk of a similar situation.
Action: Elaine Hamilton
ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 10 JANUARY 2018
Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. Governance Team to confirm with Dr McClean/Elaine Hamilton this was sent to Elective Care Group but no further action / follow up is required.
Action: HSCB Governance Team
STATUS - Close
Theme/Key Words - Failure to give ordered treatment/support in a timely way.
10/01/18: SAI Closed.
25/01/18: Composite noting paper received from QSE, see documents.
26/01/18: Trust advised of closure.
12/02/18: Follow up email to Trust if they have sought advise from other Trusts if E-Triage would manage the risk of a similar situation.

HSCB-PHA ACTION TAKEN:

27/02/18: Reminder Email to Trust with above Q re learning.
15/03/18: Reminder Email to Trust Q re learning.
28/03/18: Phonecall to Trust by ARedpath. Governance Team to ring back.
30/03/18: RH Tel Conversation with Lindsey SHSCT. Nothing has been received. She will follow up with Acute Directorate again. If no response, escalate to Elaine.
10/04/18: Email from Trust with attached response - [170175]
10/04/18: Fwdd to DRO cc E Hamilton.
12/04/18: Email to L McWilliams 'Can you please advise if the Elective Care Group have sought advice from other Trusts re E-Triage as per attached outcomes paper.'
18/04/18: Email from DRO - 'That is fine. There is no further action required. The SAI is closed. '
19/04/18: Email from Lisa McWilliams - 'Regional Scheduled Care Group have discussed the learning outcomes and specialty leads have discussed with clinicians.
E-Triage is only available for use in secondary care by clinicians to triage referrals from GPs which are transmitted by CCG to ECR. E-Triage is specifically linked to CCG and there is no mechanism for secondary care clinicians to use CCG, and nor would it be appropriate to do so, therefore E-Triage as currently facilitated is not available for consultant to consultant referrals. Future developments of EHCR may facilitated this in time.
Fail safes in the absence of an electronic consultant to consultant triage is via the relevant cancer MDT meeting where by an onward referral is agreed, recorded and actioned by the MDT clinical lead and MDT tracker. Patients will be notified for required discussion with MDT B by the relevant personnel in MDT A.
The specific incident associated with this learning outcomes report was part of wider look back exercise of clinical practice from a number of years ago - and in this case referrals did not flow via MDT meetings - embedded practice would prevent this for happening now.
Trust this is helpful.
19/04/18: Saved to Datix Record. Fwdd to G McArdle for info.
20/04/18: Email from Geraldine - Can you please forward Lisa's email to Joanne for information.
20/04/18: Lisa's email forwarded to Joanne for information.
20/04/18: Email to E Hamilton - See below response from Lisa McWilliams - re the e-traige follow up that we discussed.
I have asked Roisin to send it the Joanne (DRO) for information, can you please advise if any further action is required by the Governance Team.
I think it is it complete given that Lisa has confirmed that 'embedded practice would prevent this for happening now', just want to check with you.
25/04/18: Email from E Hamilton to G McArdle - 'No I don't think any further action is required. Joanne will be aware of the response so I think that was all that is required.'

To: Anne Kane
Cc: Margaret McNally; Mareth Campbell; Miriam McCarthy; Joanne McClean; Christine McMaster; Muhammad Sartaj; Jackie McCall
Subject: Allocation of SAIs to PHA staff

Anne

Thank you for sending me a breakdown of the work previously being undertaken by Dr Darragh

I can confirm the following for acute services:

- Belfast trust: Dr Miriam McCarthy
- Northern Trust; Dr Christine McMaster
- South Eastern trust: Dr Jackie McCall
- Southern trust: Dr Joanne McClean
- Western trust: Dr Muhammad Sartaj

For elderly services / PD and SI / prison Health I note Dr Darragh was included on your list for each Trust/Prison health but that in the first instance Nursing and Social Services are automatically allocated as DROs and medical advice is only sought if the DRO considers it necessary. I propose not to make any nomination at this stage and ask that I am the contact for the DRO in these service areas if additional advice is required so I can get an understanding of the likely workload impact.

Can you forward to Dr MCCarthy and Dr McClean, the legacy SAIs (numbers and levels) still open from BHSCT and SHSCT. Can you advise Dr McMaster of the status of the open SAIs in the NHSCT.

In 2015 you provided an information session in Tower Hill and a DRO SAI information pack which I have. Can you advise if there have been any changes made since that information session (SEA and RCA guidance is dated June 2015 in the information pack) and send me the most up to date SAI guidance if there have been changes since then.

Dr Brid Farrell
Public Health Agency
Personal Information redacted by the USI

DRO J Mc Clean Status Report 16-06-16

DRO / Manager	Total Active	SEA/RCA received	IR Outstanding /Overdue	In Process
Dr J Mc Clean	33	8	23	2

KEY	Action pending by DRO
	HSC Trust action Pending or Overdue
	In process
	Investigation deferred

HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review	Investigation Report due	Level 2 TOR Received	SEA Report received	RCA Report received	Date SAI Checklist received	SAI Checklist Received	Trust action pending?
SHSCT	Personal Information redacted by the USI	23-Jan-2015	SAI Report Level 1	20-Feb-2015		**23-May-2016**		23-May-2016	Y	
SHSCT		21-Oct-2015	SAI Report Level 1	18-Nov-2015		**23-May-2016**		23-May-2016	Y	
SHSCT		15-Dec-2015	SAI Report Level 1	12-Jan-2016		**24-May-2016**		24-May-2016	Y	
SHSCT		23-Jul-2015	SAI Report Level 2	15-Oct-2015	14-Sep-2015		**25-Apr-2016**	25-Apr-2016	Y	
SHSCT		29-Jul-2015	SAI Report Level 2	21-Oct-2015	14-Sep-2015		**26-Apr-2016**	26-Apr-2016	Y	Y
SHSCT		13-Apr-2015	SAI Report Level 2	6-Jul-2015	24-Jun-2015		**27-Apr-2016**	19-May-2016	Y	Y
SHSCT		29-May-2015	SAI Report Level 2	21-Aug-2015	18-Sep-2015		**23-May-2016**	23-May-2016	Y	
SHSCT		18-Nov-2015	SAI Report Level 2	3-Feb-2016	18-Jan-2016		**24-May-2016**	24-May-2016	Y	
SHSCT		1-Aug-2014	SAI Report Level 2	**24-Oct-2014**	24-Nov-2015					
SHSCT		19-Nov-2014	SAI Report Level 1	**17-Dec-2014**						
SHSCT		28-Jan-2015	SAI Report Level 1	**25-Feb-2015**						
SHSCT		11-Mar-2015	SAI Report Level 1	**8-Apr-2015**						
SHSCT		20-Mar-2015	SAI Report Level 1	**17-Apr-2015**						Y
SHSCT		29-Jan-2015	SAI Report Level 2	**23-Apr-2015**	22-Jun-2015					
SHSCT		28-Jan-2015	**SAI Report Level 2**	**29-Apr-2015**	9-Jul-2015					

HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review	Investigation Report due	Level 2 TOR Received	SEA Report received	RCA Report received	Date SAI Checklist received	SAI Checklist Received	Trust action pending?
SHSCT [redacted]		8-Jun-2015	SAI Report Level 1	6-Jul-2015						
SHSCT [redacted]		13-Apr-2015	SAI Report Level 2	6-Jul-2015	26-Aug-2015					
SHSCT [redacted]		29-May-2015	SAI Report Level 2	21-Aug-2015	18-Sep-2015					
SHSCT [redacted]		13-Aug-2015	SAI Report Level 1	10-Sep-2015						
SHSCT [redacted]		13-Aug-2015	SAI Report Level 1	10-Sep-2015						
SHSCT [redacted]		30-Dec-2014	SAI Report Level 3	9-Oct-2015	5-Nov-2015					
SHSCT [redacted]		20-Oct-2015	SAI Report Level 1	17-Nov-2015						
SHSCT [redacted]		11-Sep-2015	SAI Report Level 2	4-Dec-2015	14-Sep-2015					
SHSCT [redacted]		20-Oct-2015	SAI Report Level 2	12-Jan-2016	10-Nov-2015					
SHSCT [redacted]		28-Jan-2016	SAI Report Level 1	26-Feb-2016						
SHSCT [redacted]		4-Feb-2016	SAI Report Level 2	28-Apr-2016	16-Mar-2016					
SHSCT [redacted]		5-Apr-2016	SAI Report Level 1	3-May-2016						
SHSCT [redacted]		13-May-2016	SAI Report Level 1	10-Jun-2016						
SHSCT [redacted]		17-May-2016	SAI Report Level 1	14-Jun-2016						
SHSCT [redacted]		17-May-2016	SAI Report Level 1	14-Jun-2016						
SHSCT [redacted]		22-Mar-2016	SAI Report Level 2	14-Jun-2016	5-Apr-2016					Y
SHSCT [redacted]		13-May-2016	SAI Report Level 2	5-Aug-2016						
SAI ID [redacted]		26-May-2016	SAI Report Level 2	18-Aug-2016						

LEARNING ACTIONS FOR NOTING AT HSCB/PHA QUALITY SAFETY AND EXPERIENCE GROUP – 10 JANUARY 2018

THIS IS A COMPOSITE REPORT OF LEARNING ACTIONS AGREED BY PROFESSIONAL GROUPS NOTED BY HSCB/PHA SAI REVIEW SUB GROUP

ACUTE SAI REVIEW TEAM

Date of Meeting: 20 November 2017

SHSCT SAI [redacted]	DESCRIPTION OF INCIDENT
	Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 Referral to Urology was not triaged on receipt [redacted] sent OP appointment for 6/1/2016. [redacted] was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer. The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning. **Adverse Event:** Failure in referral process

SAI REFERENCE	LEARNING ISSUES HIGHLIGHTED	LEARNING ACTION AGREED	REASON FOR REFERRAL	DRO	RESPONSIBILITY	ASSURANCE YES / NO
[redacted]	Timely triage and categorisation. Acute SAI Review Team	**Referred to a group for Action:** SAI to be referred to the Elective Care Group (Lisa McWilliams) in respect of	For action	Dr J McClean	Ms Lisa McWilliams	Yes **Elective Care Group to**

SAI REFERENCE	LEARNING ISSUES HIGHLIGHTED	LEARNING ACTION AGREED	REASON FOR REFERRAL	DRO	RESPONSIBILITY	ASSURANCE YES / NO
	proposes that Trusts use an E-Triage system to manage the risk of a similar situation.	timely triage and categorisation. Request the Elective Care Group to seek advice from other Trusts if E-Triage would manage the risk of a similar situation.				**Respond back to the Governance Team following consideration**

Joanne,

You have been identified as the DRO for the above SAI.

Please can you advise by email to [redacted] on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly.

If you require advice in relation to medication related issues please contact Angela Carrington, email: [redacted] Please ensure all correspondence to Angela is copied to [redacted]

I attach the Serious Adverse Incident Notification from the **Southern Trust** received on 21 September 2017. This notification confirms that a **Level 1** Significant Event Audit (SEA) review will be undertaken.

This incident has been reported to the HSCB in line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference:	**SHSCT SAI** [redacted]
HSCB Reference:	[redacted]
Programme of Care:	**Acute Services**

An acknowledgement of receipt of this notification has been forwarded to the **Southern Trust**, requesting the redacted **Learning Summary Report** by no later than **16 November 2017.**

If you require any further information, please do not hesitate to contact me.

Regards
Roisin

Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [redacted]
T: [redacted]

From: Corporate.Governance [mailto: [redacted]]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [redacted]

Please find attached SAI Notification ID [redacted]

Kind regards

Lindsey

Patricia Keenan

From: Joanne McClean
Sent: 13 October 2022 22:43
To: Patricia Keenan
Subject: FW: Response from L McWilliams: Trust Ref: SHSCT SA[redacted] / HSCB Ref[redacted]

Follow Up Flag: Follow up
Flag Status: Completed

Trish can you please print? Thanks

From: Elaine Hamilton (HSCB) <[redacted]>
Sent: 25 April 2018 13:49
To: Geraldine McArdle <[redacted]>
Cc: serious incidents <[redacted]>
Subject: RE: Response from L McWilliams: Trust Ref: SHSCT SA[redacted] / HSCB Ref:[redacted]

Thanks Geraldine,

No I don't think any further action is required. Joanne will be aware of the response so I think that was all that is required.

Elaine

From: Geraldine McArdle
Sent: 20 April 2018 11:18
To: Elaine Hamilton (HSCB)
Cc: serious incidents
Subject: Response from L McWilliams: Trust Ref: SHSCT SAI[redacted] / HSCB Ref:[redacted]

Elaine,

See below response from Lisa McWilliams – re the e-traige follow up that we discussed.

I have asked Roisin to send it the Joanne (DRO) for information, can you please advise if any further action is required by the Governance Team.

I think it is it complete given that Lisa has confirmed that 'embedded practice would prevent this for happening now', just want to check with you.

Thanks
Geraldine

From: Geraldine McArdle
Sent: 20 April 2018 11:11
To: serious incidents
Subject: RE: Trust Ref: SHSCT SAI[redacted] HSCB Ref:[redacted]

Roisin,

Can you please forward Lisa's email to Joanne for information.

Thanks
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: Personal Information redacted by the USI
E: Personal Information redacted by the USI

From: serious incidents
Sent: 19 April 2018 16:48
To: Geraldine McArdle
Subject: Trust Ref: SHSCT SAI Personal Information redacted by the / HSCB Ref: Personal Information redacted by the USI

Geraldine,

I have saved the email from Lisa McWilliams below to Datix Record. I have attached email from DRO stating no further action. Should Lisa's email be forwarded to Joanne? Please advise if any further action is required.

Thanks
Roisin

Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Personal Information redacted by the USI
T:

From: Lisa McWilliams
Sent: 19 April 2018 09:11
To: serious incidents
Cc: Beth Minnis
Subject: RE: For Action: Trust Ref: SHSCT SAI Personal Information redacted by the USI / HSCB Ref: Personal Information redacted by the USI

Regional Scheduled Care Group have discussed the learning outcomes and specialty leads have discussed with clinicians.

E-Triage is only available for use in secondary care by clinicians to triage referrals from GPs which are transmitted by CCG to ECR. E-Triage is specifically linked to CCG and there is no mechanism for secondary care clinicians to use CCG, and nor would it be appropriate to do so, therefore E-Triage as currently facilitated is not available for consultant to consultant referrals. Future developments of EHCR may facilitated this in time.

Fail safes in the absence of an electronic consultant to consultant triage is via the relevant cancer MDT meeting where by an onward referral is agreed, recorded and actioned by the MDT clinical lead and MDT tracker. Patients will be notified for required discussion with MDT B by the relevant personnel in MDT A.

The specific incident associated with this learning outcomes report was part of wider look back exercise of clinical practice from a number of years ago – and in this case referrals did not flow via MDT meetings – embedded practice would prevent this for happening now.

Trust this is helpful
Lisa

From: serious incidents
Sent: 12 April 2018 09:26
To: Lisa McWilliams
Subject: For Action: Trust Ref: SHSCT SAI [redacted] / HSCB Ref: [redacted]

Lisa,

Can you please advise if the Elective Care Group have sought advice from other Trusts re E-Triage as per attached outcomes paper.

Please give me a call if you have any queries.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [redacted]
E: [redacted]

From: Geraldine McArdle **On Behalf Of** QSE Team
Sent: 30 January 2018 11:41
To: Lisa McWilliams
Cc: Joanne McClean; serious incidents; 'Corporate.Governance [redacted]'
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the [redacted] mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: Personal Information redacted by the USI
E: Personal Information redacted by the USI

Attachment 47

Organisation's Unique Case Identifier: ID [redacted]

Recommendation	Action	Achieved
This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP	This is monitored through ETriage on a weekly basis and through recording paper copy referrals received on a database that is also monitored on a weekly basis for Urgent and Routine and daily for red flags	Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required
In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.	As above. Monitored by HOS, Red Flag Team and Booking Centre Team	Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required

Joanne McClean

From: Joanne McClean
Sent: 27 September 2017 09:35
To: Wright, Richard
Subject: RE: Paeds fracture transfer update confidential

Thanks Richard,

I also need to speak to you about a couple of urology SAIs that have come in over past week or so. There are three cases of non-triaged cases in one SAI. There was a similar SAI a while ago where one member of the team did not triage letters. I am guessing that the three new cases have been turned up when checking back following the original SAI and assume it is an issue with an individual's practice rather than a systemic problem with triage in either urology or more generally? The other case was a delay in organising ureteric stents which resulted in the patient no longer being suitable for cancer treatment.

Thanks
Joanne

-----Original Message-----
From: Wright, Richard [mailto: Personal Information redacted by the USI
Sent: 27 September 2017 09:06
To: Joanne McClean
Cc: Gishkori Esther; Hazel Gillis
Subject: Re: Paeds fracture transfer update confidential

Hi Mark Haynes is our new surgical AMD , Gareth Hampton CD for ED, and Ronan Carroll surgical AD. in addition we would need representation from Fracture team which I will confirm shortly. regards Richard

Sent from my iPad

> On 26 Sep 2017, at 17:42, Joanne McClean < Personal Information redacted by the USI > wrote:
>
> "This email is covered by the disclaimer found at the end of the message."
>
>
> _____
>
>
> Hi Richard and Esther,
>
> Further to our meeting with Belfast Trust and the email below, I am going to ask Hazel to set up a meeting to discuss fracture services in SHSCT.
>
> I would be very grateful if you could let me know who from SHSCT should be invited to the meeting so Hazel can start to look for dates.
>
> For information I have attached fracture clinic waiting times for children aged up to 16th birthday from 1st April 2017 - 31st July 2017. You can see waiting times across different hospitals and how SHSCT compares. I have asked David to get figures including adults. I hope this is helpful.
>
> Please let me know who from the Trust should be involved in the meeting and we will get it arranged.
>

ATTACHMENT 49

Joanne McClean

From: Joanne McClean
Sent: 27 September 2017 21:05
To: Carolyn Harper
Cc: Brid Farrell
Subject: Re: DRO Assigned - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]

Carolyn and Brid,

I spoke to Richard Wright about these three cases, the earlier case and the stent case that came in last week. They all relate to an MHPS process with an individual who is on restricted practice. You may remember an early alert a few months ago about a look back into a doctor's administrative processes. It relates to that.

Julian Johnston is chairing the SAI for the Trust. This will look at what Trust could/should have done to prevent this.

Joanne

Sent from my BlackBerry 10 smartphone.

From: Joanne McClean
Sent: Thursday, 21 September 2017 15:57
To: Carolyn Harper
Cc: Brid Farrell
Subject: RE: DRO Assigned - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]

Yes. I think these have been detected as part of a review of an individual's practice following another SAI (position report attached) which is not listed here. Again the issue was not triaging. Apparently it was an issue with one member of the urology team. I will follow up as you suggest.
Joanne

From: Carolyn Harper
Sent: 21 September 2017 15:34
To: Joanne McClean
Cc: Brid Farrell
Subject: FW: DRO Assigned - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]

Joanne through the SAI office could you check that ST have taken immediate action to prevent any other referrals slipping through their processes, secondly, that they have assured themselves that no other referrals to urology have slipped through, and thirdly that they have checked/assured themselves that there is not a similar problem in other specialties.

Carolyn

From: serious incidents
Sent: 21 September 2017 15:05
To: Joanne McClean
Cc: Carolyn Harper; Brid Farrell; Mary Hinds; Lynne Charlton; Mary McElroy; Oriel Brown; Michael Bloomfield; Anne Kane; Jacqui Burns; Margaret McNally; Mareth Campbell; Elaine Hamilton (HSCB); Geraldine McArdle; Elaine Hyde
Subject: DRO Assigned - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]