Serious incident reports (SIR)

This self-help guide contains useful information about serious incident reports (SIRs). These reports used to be referred to as serious untoward incident reports (SUI) or root cause analysis reports. However, in recent years most hospitals refer to them as SIRs.

Please note that SIRs are being phased out and hospital trusts are adopting the Patient Safety Incident Response Framework (PSIRF) instead. For more information please see our PSIRF leaflet:

avma.org.uk/wp-content/uploads/PSIRF-investigations.pdf

If you have any further questions, please visit our website where you will find more advice and a range of specialised self-help guides, or call our helpline.

Contents

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AvMA is the charity for patient safety and justice. We provide specialist advice and support to people when things go wrong in healthcare and campaign to improve patient safety and justice.

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10am-3.30pm Monday-Friday
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Serious incidents

There is no definitive list of events/incidents that constitute a serious incident.

Serious incidents are defined by NHS England as *"Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response".*

NHS England also makes it clear that *"Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare."*

In what circumstances must a serious incident be declared?

Where NHS treatment is concerned a serious incident **MUST** be declared where acts and/or omissions have occurred as part of NHS-funded healthcare (including in the community) that has resulted in:

i. **Unexpected or avoidable death of one or more people**
This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care in the recent past

ii. **Unexpected or avoidable injury to one or more people that has resulted in serious harm**

iii. **Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm**

iv. **Actual or alleged abuse**
There are a number of situations where this applies but in the context of clinical negligence the most relevant ones might be considered to be: sexual abuse, physical or psychological ill-treatment; acts or omissions which constitute neglect, self-neglect. It will also apply where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or where the abuse occurred during the provision of NHS-funded care.

v. **A never event**
All never events are defined as serious incidents although not all never events necessarily result in serious harm or death. For further information a list of never events can be found at:
www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf

vi. **An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services**
This includes incidents in population-wide healthcare activities like screening or inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)

vii. **Systematic failure to provide an acceptable standard of safe care**
This may include incidents, or a series of incidents, which necessitate ward/unit closure or suspension of services.

How can I tell whether an incident is a serious incident?

This can be difficult to identify; outcome alone will not determine whether an incident is serious or not. Sometimes upsetting things happen such as death but the fact someone has died does not, on its own trigger a serious incident report.

If the situation is unclear then healthcare providers must discuss the circumstances with the commissioners to agree the appropriate response. It is important that those discussions are open and honest. If there is doubt then an investigation should take place so the investigation can determine whether the incident was serious.

Serious incidents may be identified in a number of ways including any allegations made by a patient or third party or through the complaints process.

Find out more about **SIR investigations** on page 3

Find out more about the **benefits and disadvantages of a SIR** on page 4

SIR investigations

How thorough is the SIR investigation?

There are three levels of investigation which may be carried out:

Concise investigations

These investigations are suited to complex incidents engaged at local level by a small group of individuals

Comprehensive investigations

These are suited to complex issues which should be managed by a multidisciplinary team (MDT) involving experts or specialist investigators

Independent investigations

These are normally reserved for situations where the integrity of the internal investigation is likely to be challenged or it will be difficult for the organisation to be objective

Should the healthcare provider tell me they are carrying out a SIR?

The short answer to this is yes. One of the key principles under pinning a SIR is that the needs of those affected should be of primary concern.

The duty of candour and the NHS principles of being open and honest envisage families or patients being involved in the process.

Further information

Please see our leaflet on the duty of candour at www.avma.org.uk/guides

When should a serious incident be reported?

Serious incidents must be reported without delay and in any event no longer than 2 working days after the incident is identified.

NHS trusts should have effective systems and processes in place to report, investigate and respond to serious incidents in line with national policy and best practice

What must the report take into account?

What is important is that an investigation is undertaken. The investigation should ask three key questions:

i. **What were the problems?**

ii. **How did the incident happen?**
This will involve looking at the factors that contributed to the problem/s

iii. **Why did the incident occur?**
This is the fundamental question

I don't know if a SIR has been called

It is not unusual for patients and or their families not to know whether a SIR has been called and prepared. If you are not sure, the best advice is to write to the care provider and ask them to clarify whether a SIR has been called and if so to provide you with a copy of the SIR report.

If you know that a SIR has not been called but believe the triggers for such an investigation have been satisfied, you should write to the care provider and ask them to call a SIR setting out the reasons why you believe they should do.

Find out more about **serious incidents** on page 2

Find out more about the **benefits and disadvantages of a SIR** on page 4

Benefits and disadvantages of a SIR

What are the problems with SIRs?

In AvMA's experience the principles behind serious incident reporting are very good. However we often find that in practice problems occur. Some of the most usual problems are:

i. SIRs are not called when they ought to be

ii. The correct level of investigation is not employed

iii. The family is not made aware of the investigation, or involved in the investigation or given a copy of the final report

iv. The reports are not robust, failing to be either sufficiently objective or comprehensive enough in scope.

Why is a SIR useful?

A SIR can be useful in order to identify whether something has gone wrong with care provided. It may also help to identify whether the care provided contributed to a patient's death. If an inquest has been called you may wish to ask the care provider to confirm to you whether a SIR has been prepared.

Alternatively if you want to consider taking legal action, or just want answers to any questions you may have, the SIR may be a useful source of information.

Find out more about **serious incidents** on page 2

Find out more about **SIR investigations** on page 3

Further information

If you would like more information on SIRs you may find the NHS England national framework link useful: www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

You may also find the NHS England frequently asked questions on SIR link helpful: www.england.nhs.uk/wp-content/uploads/2015/03/serious-incident-framwrk-15-16-faqs-fin.pdf

If you need advice on being represented at an inquest or on bringing a legal claim then please look at the relevant Help and Advice section on AvMA's website at www.avma.org.uk/inquests

If you wish to have your case considered by our casework department you will need to complete new client form and send your concerns together with documents in support to AvMA: www.avma.org.uk/new-client-form

Alternatively, if you are unable to find what you are looking for on our website you may wish to contact AvMA's helpline, please look at the helpline page for more information: www.avma.org.uk/helpline.

www.avma.org.uk/donate

Be part of the movement for better patient safety and justice

Support AvMA's work today

You can help make healthcare safer and fairer for all

Our vision is a simple: **People who suffer avoidable medical harm get the support and the outcomes they need.** This vision is underpinned by four objectives, we believe, will transform trust in the NHS and healthcare generally and significantly cut the cost – financial and human – which is incurred annually in settling legal claims as well as dealing with the human costs associated with traumatic medical injuries and death. Our four key objectives are:

- To expand the range of communities we serve and so enabling more people experiencing avoidable harm to access services from us that meet their needs
- To empower more people to secure the outcomes they need following an incident of medical harm, whilst providing caring and compassionate support
- To eliminate compounded harm following avoidable medical harm
- To have the necessary diversity of sustainable resources and capacities to deliver

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£5/month could provide vital advice to patients and families via our helpline

£10/month could help train a volunteer helpline advisor

£50/month could help support a family through an inquest hearing

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