Portsmouth Hospitals NHS
NHS Trust

COMPLAINTS, LITIGATION INCIDENT AND PALS (CLIP) QUARTERLY REPORT

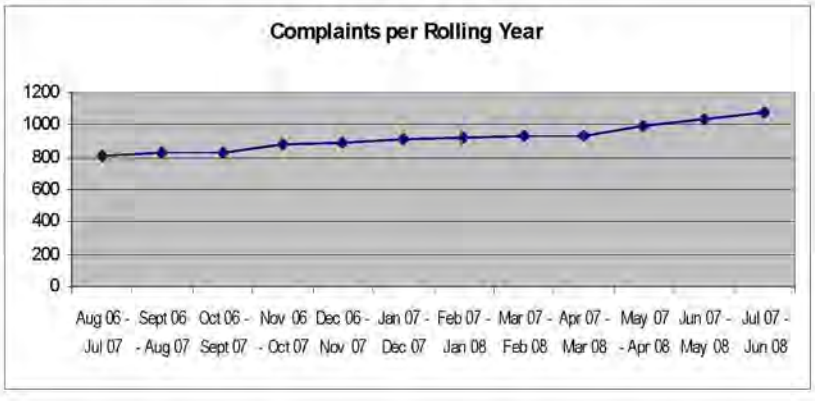
Code A

Head of Risk Management, Complaints & Legal Services

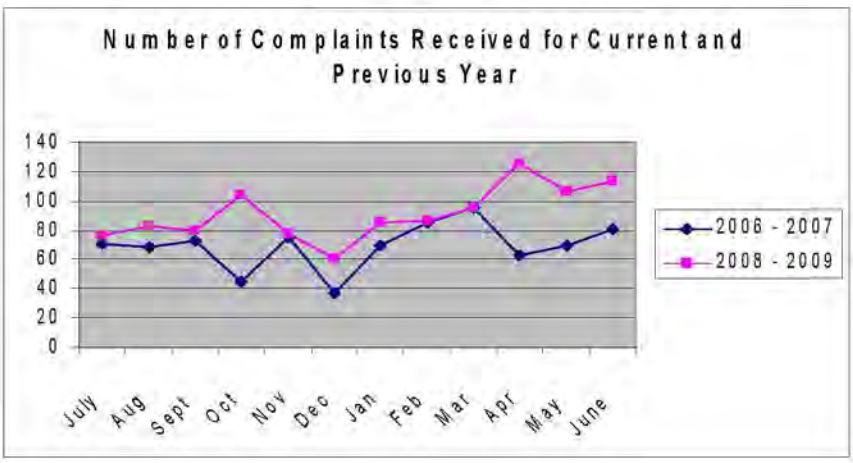
September 2008

CONTENTS

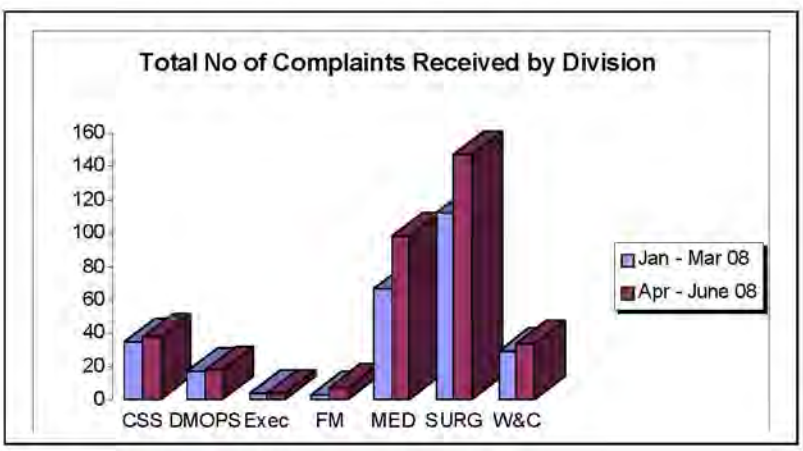
COMPLAINTS – Aggregated Report



The number of complaints received per year has increased to 918: previously 859



The number of complaints received ranges from 60 per month to 126, with an average of 91 per month for the year 2008 – 2009, compared to 80 per month for the year 2006 - 2007



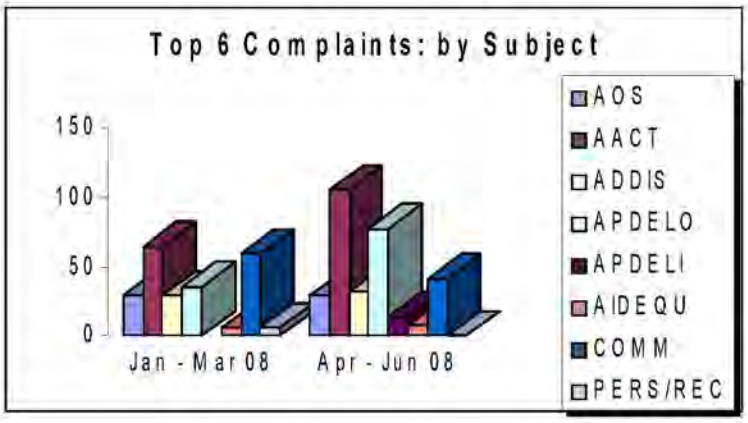
It should be noted that no complaints were received by MOD

However, it should be noted that overall the number of complaints is steadily increasing.

Jul – Sept 07: 239
Oct – Dec 07: 241
Jan – Mar 08: 266
Apr – Jun 08: 345

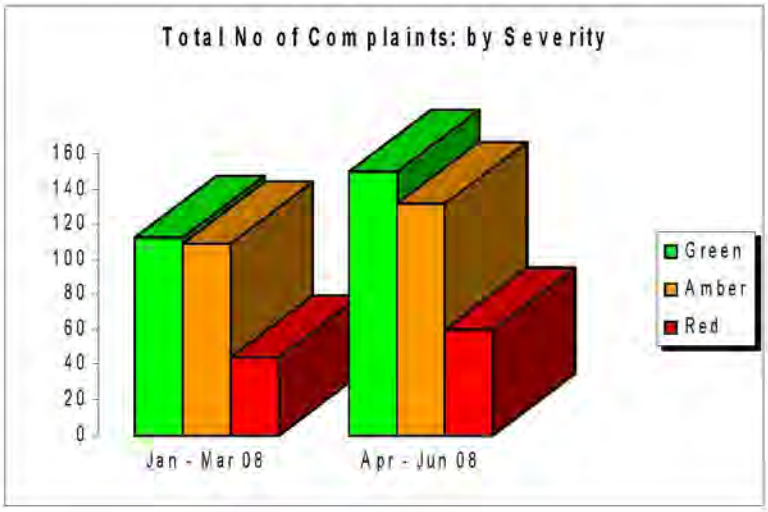
Complaints as a Percentage of Clinical Activity

	Jan – Mar 08	Apr - Jun 08
Medicine	0.16%	0.20%
Surgery	0.15%	0.19%
W&C	0.14%	0.20%



Key	
AOS	Attitude of staff
AACT	All aspects of clinical treatment
ADDIS	Admission / discharge
APDELO	Appt delay / cancellation: o/pt
APDELI	Appt delay / cancellation: i/pt
AIDEQU	Aids and equipment
COMM	Communication
PERS/REC	Personal Records

For the quarter April to June 2008 the top 6 complaints as a percentage of the total complaints received were as follows: 9.5% for AOS, 34% for AACT, 10% for ADDIS, 25% for APDELO, 4.5% for APDELI, and 13% for COMM. The remaining complaints received form the balance of 4%. The subject of the top 3 complaints remains the same.



	Jan – Mar 08	Apr – Jun 08
Green	113	150
Amber	109	132
Red	44	60

Time taken to close complaints

	Jan		Feb		Mar		Apr		May		Jun	
	No	%	No	%	No	%	No	%	No	%	No	%
Complaints received	85		86		95		126		106		113	
Acknowledged within 2 working days	85	100	86	100	85	100	126	100	106	100	113	100
Total Closed within 25working days	71	**84**	64	**74**	81	**85**	104	**83**	89	**84**	85	**75**

Backlog – the current situation

Days over	Now Closed	Reasons for Delay		Days over	Still Open	Reasons for Delay
1–10	19	13 Late responses 3 Late signing 2 Complex complaints 1 Pressure of work		1– 10	7	7 Late responses
11-20	12	12 Late responses		11-20	4	4 Late responses
21-30	2	2 Complex complaints		21 -30	Nil	
31-40	4	4 Late responses		31- 40	Nil	
41-50	Nil			41 – 50	Nil	
50+	Nil			50+	Nil	

Healthcare Commission (HCC) status: 1 July 2004 – present

	1 July 04 – 30 June 08
Number of PHT complaints referred to HCC	120
Number of PHT responses sent to HCC	120
Number of PHT outstanding responses to HCC	0
Outcomes	
Number referred back for further local resolution	88
Number requiring no further action by PHT	24
Number for which PHT still awaiting comment from HCC	6
Number rejected by HCC	2

Please Note:
We have been notified that 2 additional complaints have been referred to the HCC in this reporting period.

Health Service Ombudsman

The Trust has been notified that one complaint is under consideration by the Health Service Ombudsman. The Trust response was sent on 4 April 2008 and we await the outcome.

LITIGATION

Claims Closed

Date of Incident	Division	Specialty	Synopsis	Outcome	Comments
April					
07/11/2204	FM	Hot/SMH	Claimant alleged he was assaulted by a Security Officer in 2004	Settled for £11,500	Security now managed by CSL. No other complaint about security officer involved but he has been made aware of reasons for settling the claim
31/10/2003	Medical	Emerg	Alleged delay in diagnosing and treating fracture neck vertebra	Settled for £12,000	Incident discussed with doctor involved to ensure appropriate future practice
10/08/2004	Medical	Gen Med	Failure of cot sides -> claimant fell out of bed	Dropped	Whole episode review: treatment appropriate
20/03/2006	Medical	Oncology	Alleged re-emergence of tumour following removal of kidney. **This was previously the subject of a complaint**	Dropped	Whole episode review: treatment appropriate
05/04/2005	Surgical	Ortho	Claimant underwent THR at RHH during which the femur was split. **This was previously the subject of a complaint**	Dropped	This is a recognised complication of the procedure
01/07/2005	Surgical	Ortho	Claimant alleged failure to provide postoperative care, as he was a known risk for developing MRSA	Dropped	Whole episode review: treatment appropriate
03/07/2006	Surgical	Ortho	Claimant suffered a punctured lung during an ulna nerve decompression. **This was previously the subject of a complaint**	Dropped	Recognised risk of procedure but all anaesthetists have been reminded to document risks
23/10/2006	Surgical	Gastro	Claim for misdiagnosis of pancreatic cancer	Dropped	Whole episode review: treatment appropriate
10/05/2007	Surgical	Theatre	Alleged dislocation of knee during surgical procedure. **This was previously the subject of a complaint**	Dropped	Whole episode review: treatment appropriate
03/09/2002	W&C	Obs/mat	Alleged failure to perform C-section -> hypoxia and now suffers from cerebral palsy	Dropped	Whole episode review: treatment appropriate
MAY					
27/08/2005	DMoP	Rehab	Fall from commode -> fractured pelvis	Dropped	Whole episode review: treatment appropriate
24/07/2003	Surgical	Ortho	Claimant alleged treatment for fractured right wrist fell below accepted standard -> 10" scar on right wrist	Dropped	Whole episode review: treatment appropriate
15/11/2004	Surgical	Gen Surg	Alleged missed prescription of Voltarol following removal of stone from bile duct. **This was previously the subject of a complaint**	Settled for £5,000	Error by junior doctor – signature illegible
31/03/2006	Surgical	Gen Surg	Alleged inappropriate prescribing of Volatarol	Dropped	Whole episode review: treatment

			to patient on Warfarin -> bowel problems -> surgery		appropriate
23/08/2001	W&C	Obs/mat	Pt admitted to NICU. Parents informed she had had cerebral bleed	Dropped	Whole episode review: treatment appropriate
JUNE					
09/11/2000	Medical	Renal	Claimant alleged she was discharged from ITU too early following ERCP -> cardiac arrest -> brain damage	Dropped	Whole episode review: treatment appropriate
05/02/2007	Medical	Gen Med	Claimant alleged deterioration in eyesight was due to blood pressure falling too low. **This was previously the subject of a complaint**	Dropped	Investigation identified that inappropriate given by junior doctor without discussion with senior doctor, which may have led to deterioration in eyesight
05/11/2007	Medical	Gen Med	Claimant alleged that following several attempts to perform lumbar puncture she developed severe lumbar puncture headache about which she had not been warned	Settled for £2,000	Doctor involved has been made aware.
01/09/1996	Surgical	Ortho	Alleged delay in hip surgery -> additional pain and suffering. **This was previously the subject of a complaint**	Settled for £2,500	Agreed there was a delay of approx 2 months. Treatment was 4 years ago: waiting times now improved and adhered to
22/02/2004	Surgical	Ortho	Alleged delayed diagnosis of ischaemic bowel	Settled for £67,5000	No specific actions required but outcome highlights problems when transferring seriously ill, undiagnosed patients from one ward to another
08/-7/2004	Surgical	Gen Surg	Allegedly contracted MRSA and died	Dropped	Whole episode review: treatment appropriate
14/02/2006	Surgical	Urology	Alleged delays in anaesthetic and respiratory assessments -> permanent catheter. **This was previously the subject of a complaint**	Settled for £8,000	Acknowledged delay due to breakdown in communication
16/02/2007	Surgical	Max Fax	Chair collapsed under pt -> back injury	Settled for £2,000	One off occurrence: chair not faulty
14/02/2001	W&C	Obs/mat	Alleged sub-standard care	Dropped	Whole episode review: treatment appropriate
09/06/2002	W&C	Obs/mat	Mother advised not to come to hospital -> breech birth at home -> death of baby. **This was previously the subject of a SUI**	Settled for £62,500	Recommendations made and implemented
12/06/2004	W&C	Child	Full details never received	Dropped	None required
25/07/2004	W&C	Obs/mat	Alleged unnecessary delays in diagnosing and treating spina bifida	Dropped	Whole episode review: treatment appropriate
04/04/2005	W&C	Gynae	Alleged concerns re postoperative care	Settled for £3,000	Agreed that CT scan should have been performed earlier
10/11/2005	W&C	Obs/mat	Alleged failure to provide acceptable care at time of birth -> HIE. **This was previously the subject of a SUI**	Settled for £20,000	Recommendations made and implemented

Potential Claims (i.e. request for copy records from solicitors, who are investigating potential claims against the Trust)

Claim Date	Division	Specialty	Synopsis
APRIL			
28/04/2008	CSS	Diag Imag	Pt taken from ward to imaging room without assistance of ward staff. Fell between wheelchair and scanning table -> fractured hip. **This was previously the subject of a complaint**
22/04/2008	Medical	Emerg	Alleged failure to diagnose fractured scaphoid bone in 2005: not identified until 2007
29/04/200	Medical	MAU	Claimant alleges that, despite requesting assistance, he had to walk to toilet unaided -> tripped over paint pots -> injury
29/04/2008	Medical	Gen Med	Claimant concerned that relative not properly assessed before being allowed to walk to toilet -> fell. **This was previously the subject of a complaint**
14/04/200	Surgical	ENT	Alleged delay in diagnosis of brain tumour
17/04/2008	Surgical	Ortho	Claimant underwent knee replacement in 2006 -> degree of angulation -> second operation
01/04/2008	W&C	Gynae	Claimant alleges she caught scabies whilst on gynae ward
29/04/2008	W&C	Child	Claimant alleges child's treatment not appropriate **This was previously the subject of a complaint**
MAY			
02/05/2008	Medical	Emerg	Claimant alleges there was refusal to x-ray shoulder -> undiagnosed fracture
09/05/2008	Medical	Emerg	Claimant unhappy with management of fractured wrist. **This was previously the subject of a complaint**
19/05/2008	Medical	Emerg	Alleged failure to diagnose hairline fracture of left humeral head. **This was previously the subject of a complaint**

07/05/2008	Surgical	Gen Surg	Alleged significant bleeding following angioplasty -> renal failure. **This was previously the subject of a complaint**
15/05/2008	Surgical	Gen Surg	Claimant suffered possible MI following surgery. Details not yet known
16/05/2008	Surgical	Ortho	Needlestick injury sustained by contract worker
JUNE			
25/06/2008	Medical	Emerg	Alleged hip not x-rayed following fall. On readmission x-ray revealed fractured hip -> THR
25/06/2008	Medical	Resp	Alleged failure to drain pleural fluid -> permanent, untreatable respiratory condition. **This was previously the subject of a complaint**
02/06/2008	Surgical	Ortho	Alleged failure to warn of risks prior to spinal surgery
02/06/2008	Surgical	Gen Surg	Alleged delayed diagnosis of appendicitis -> septicaemia -> colostomy
13/06/2008	Surgical	Gen Surg	Alleged negligent removal of appendix + discharge issues following infection
24/06/2008	Surgical	Gen Surg	Alleged perforation of bowel during procedure to remove adhesions **This was previously the subject of a complaint**
02/06/2008	W&C	Obs/maty	Alleged denial of C-section -> hemiplegia
09/06/2008	W&C	Obs/maty	Claimant alleges she was encouraged to deliver before fully dilated -> emergency C-section

NB: The inclusion of reference to the fact that certain claims were previously the subject of a complaint or an SUI is new: this does not mean that the Trust has had a sudden increase in the number of complaints or SUIs that progressed to litigation. We will continue to include this reference and monitor the situation accordingly.

Total claims received

	Apr – Jun 07		Apr – Jun 08
Potential clinical negligence	19		21
Employer liability	8		2
Public liability	1		2
TOTAL	**28**		**25**

Inquests

	Apr – Jun 07		Apr – Jun 08
Coroner request for report	44		21
Staff required to attend inquest	19		8

The continued decrease in the number of requests for reports made by the Coroner in this quarter is due to staffing problems in his office, as a result of which he held no inquests in the reported three months. He has now appointed an additional member of staff and the number of inquests held and reports requested is rising once again.

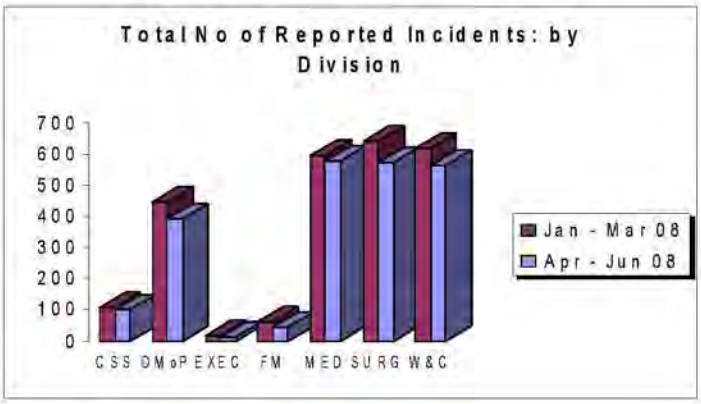
Small Claims

CLAIMS PAID	
April - June 2008	
DMoPS	
Dentures	396.00
Repair to hearing aid	130.00
Clothing	35.00
TOTAL	**£561.00**
MEDICAL	
Clothing	24.00
Dentures	194.00
Glasses	15.00
Reimbursement of travel expenses	42.80
TOTAL	**£275.80**
SURGICAL	
Dentures	570.00
Clothing	100.00
Hearing aid	795.00
Reimbursement of travel expenses	13.60
TOTAL	**£1478.60**
WOMEN & CHILDREN	

CLAIMS NOT PAID: April – June 2008		
Amount	**Items**	**Reason for non-payment**
194.00	Dental fees	Dental treatment not undertaken by PHT
45.00	Travel expenses	Patient believed, incorrectly, they were entitled to hospital transport
30.00	Clothing	Patient deceased
00.00	Money	Family aware pt holding money, did not remove
2,990.00	Hearing Aid	Patient deceased.
300.00	Dentures	Patient deceased
130.00	Mobile phone	Patient left phone on bed and left ward
15.00	Money	Patient deceased
525.00	Clothing/money/car fob	Investigation revealed pt had left jacket and contents in night club
120.00	Loss of earnings	No proof of loss of earnings received
45.00	Petrol	Patient claimed did not receive appointment cancellation – no liability for postal system

Total small claims paid = £ 2315.40
Total small claims not paid = £ 4494.00

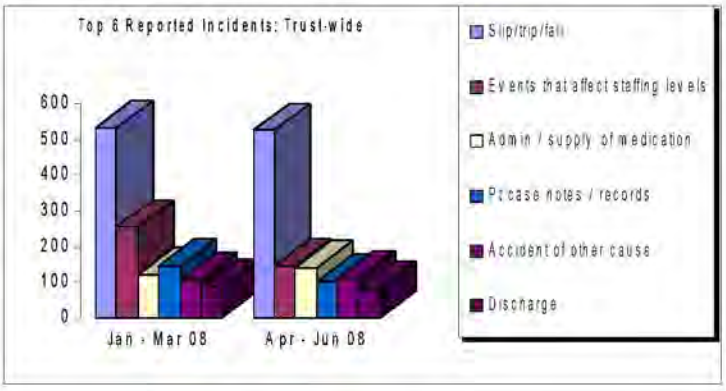
INCIDENTS – Aggregated Report



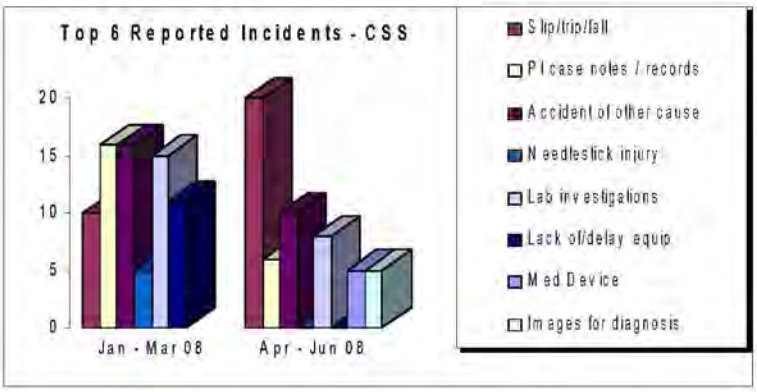
A total of 2273 incidents were reported in the quarter Apr - Jun 08 compared to 2494 in the previous quarter

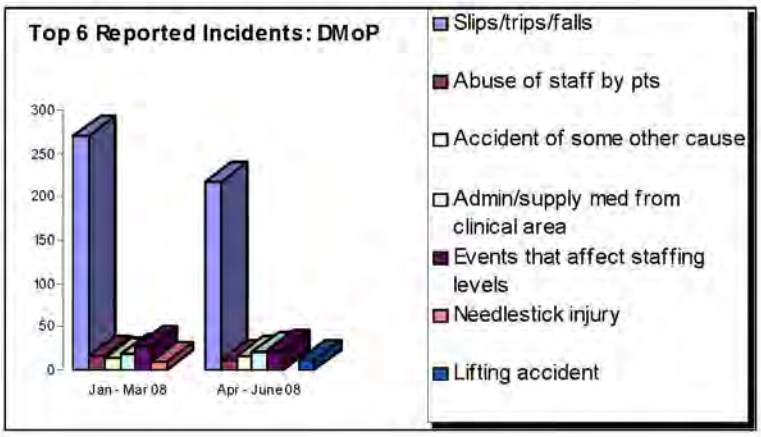
Reported Incidents as Percentage of Clinical Activity

	Jan – Mar 08	Apr – Jun 08
Medicine	1.4	1.3
Surgery	0.8	0.75
W&C	3.0	3.4



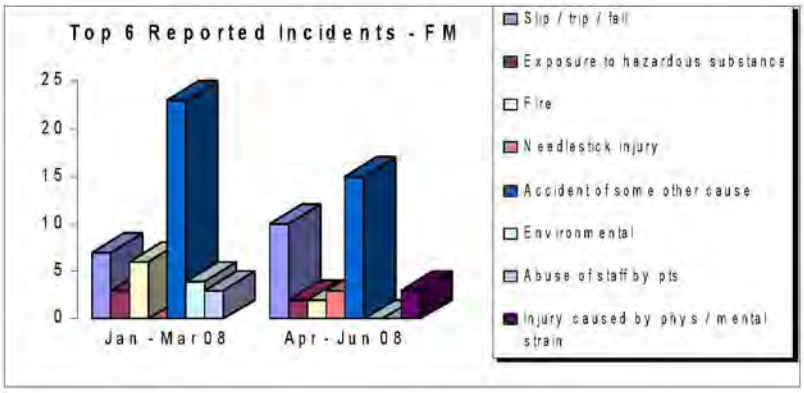
The graph opposite demonstrates that the top 6 reported incidents have remained largely similar over both quarters.

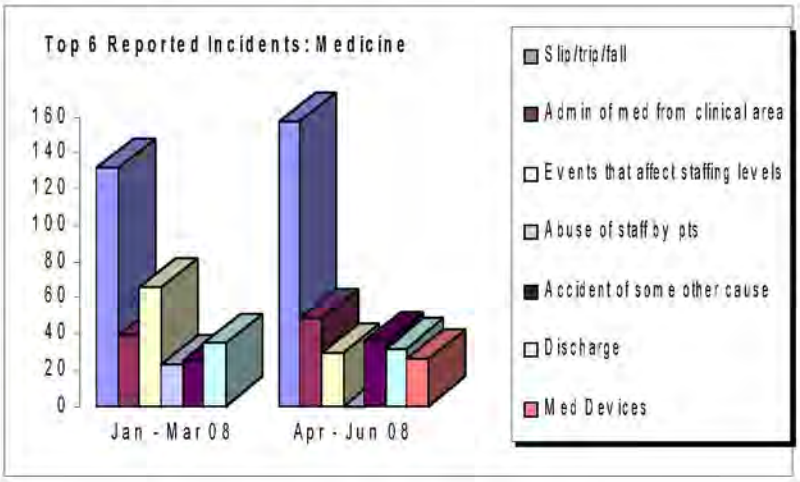




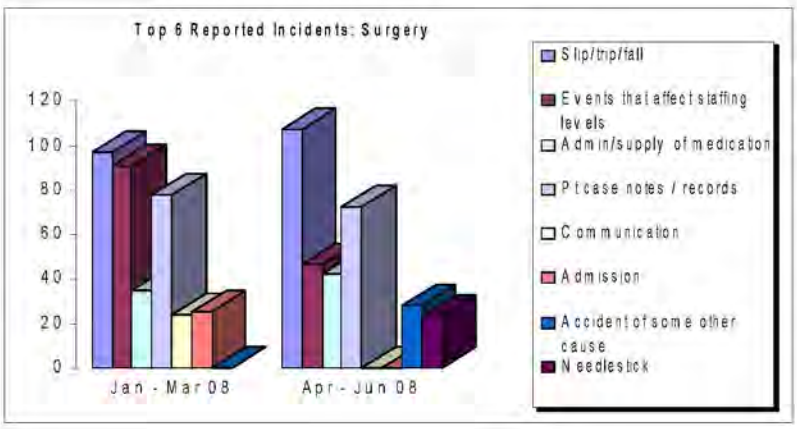
These graphs demonstrate that slips/trips/falls has been the most reported incident in both quarters.

No graph has been produced for the Executive Division, as there were only 12 reported incidents



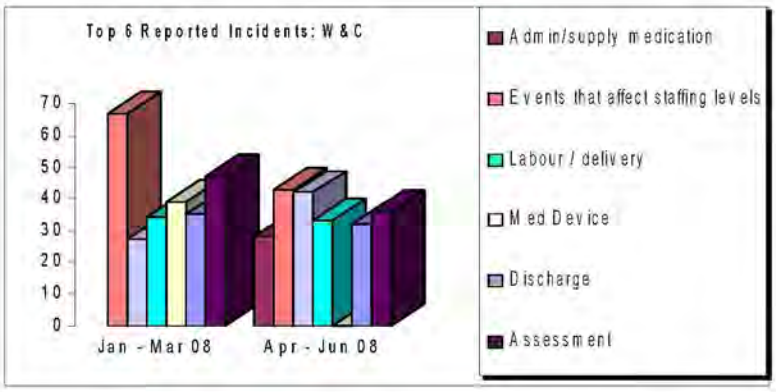


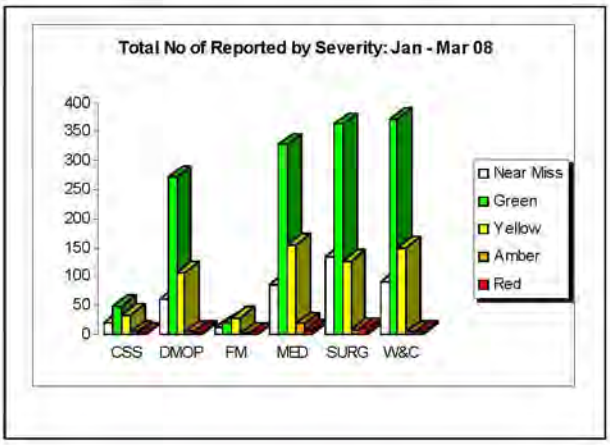
Slips/trips/falls and medication errors remain two of the top three reported incidents and have done so for the past 10 quarters

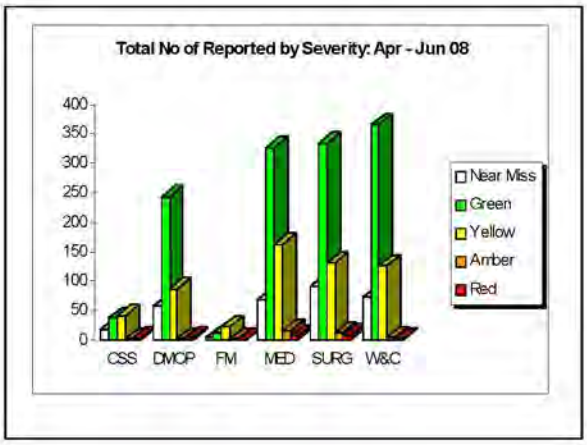


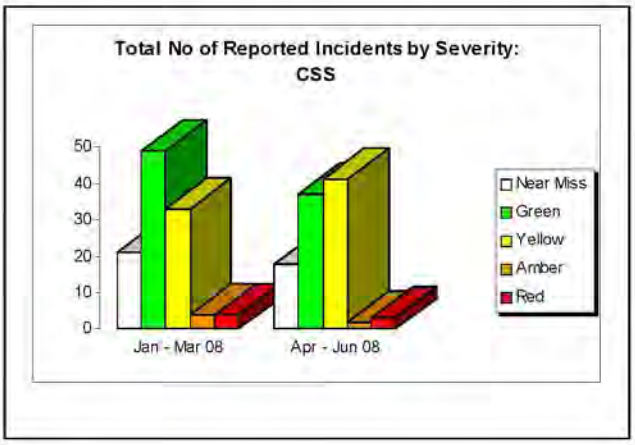
Slips/trips/falls remain the top reported incidents in both quarters and have been so in the last 10 quarters

However, it is interesting to note that issues concerning the availability of patient case notes rose significantly in the last quarter and remains similarly high in this quarter

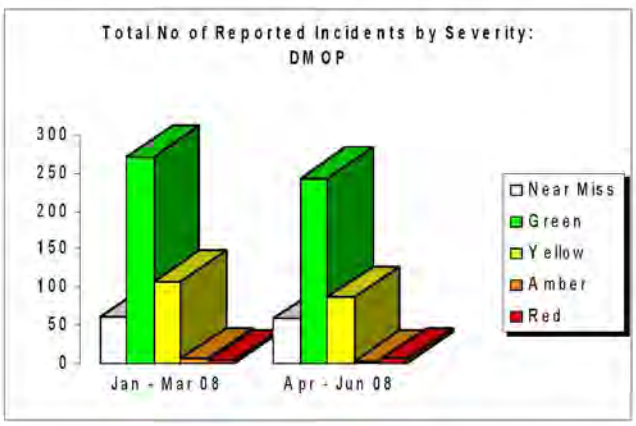




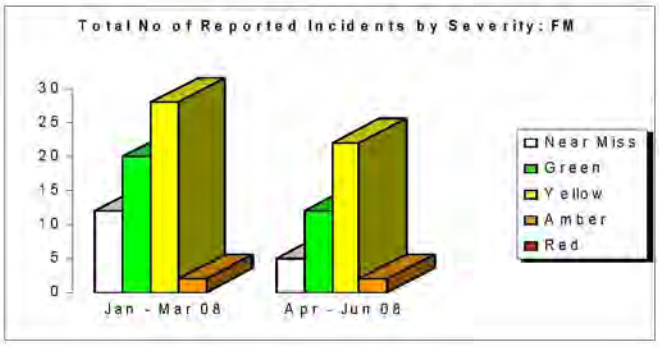




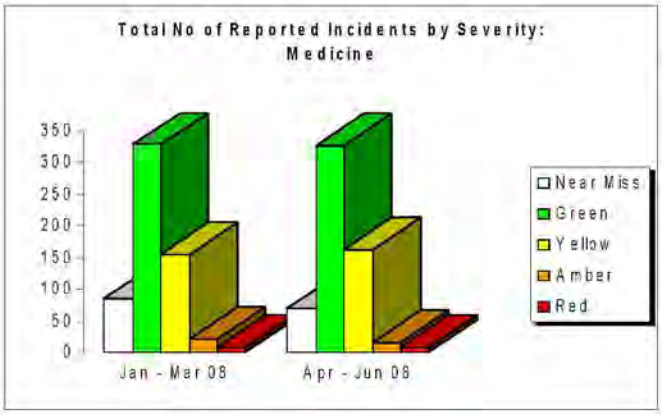
	Jan – Mar 08	Apr – Jun 08
Total reported incidents	111	99
Red	4	2
Amber	4	2
Yellow	33	41
Green	49	37
Near Misses	21	18



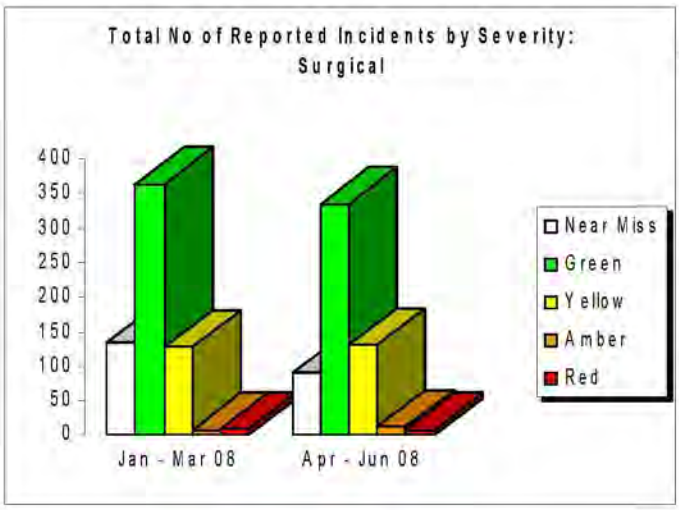
	Jan – Mar 08	Apr - Jun 08
Total reported incidents	448	394
Red	3	5
Amber	5	2
Yellow	107	86
Green	272	243
Near Misses	76	58



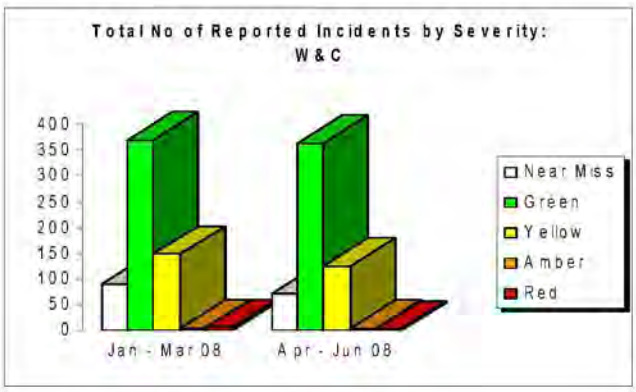
	Jan – Mar 08	Apr – Jun 08
Total reported incidents	62	42
Red	0	0
Amber	2	2
Yellow	28	22
Green	20	12
Near Misses	12	5



	Jan – Mar 08	Apr – Jun08
Total reported incidents	596	579
Red	7	7
Amber	20	16
Yellow	155	162
Green	328	326
Near Misses	86	69



	Jan – Mar 08	Apr – Jun 08
Total reported incidents	642	577
Red	10	8
Amber	8	12
Yellow	127	130
Green	363	334
Near Misses	134	91



	Jan – Mar 08	Apr - Jun 08
Total reported incidents	620	568
Red	5	2
Amber	4	4
Yellow	149	125
Green	371	365
Near Misses	91	72

SERIOUS ADVERSE EVENT SUMMARY

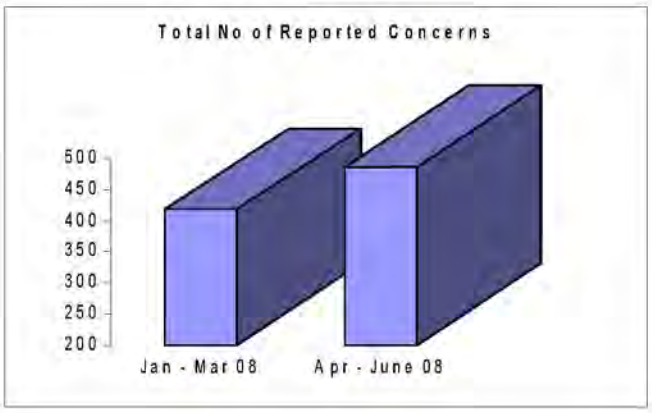
A Serious Adverse Event is one which, for whatever reason, is classified as major or catastrophic: commonly known as a 'red' incident. They are classified as major/catastrophic according to outcome, number of patients involved, effect upon Trust services or litigation costs.

All Serious Adverse Events, or potential Serious Adverse Events, are investigated in line with Trust protocol

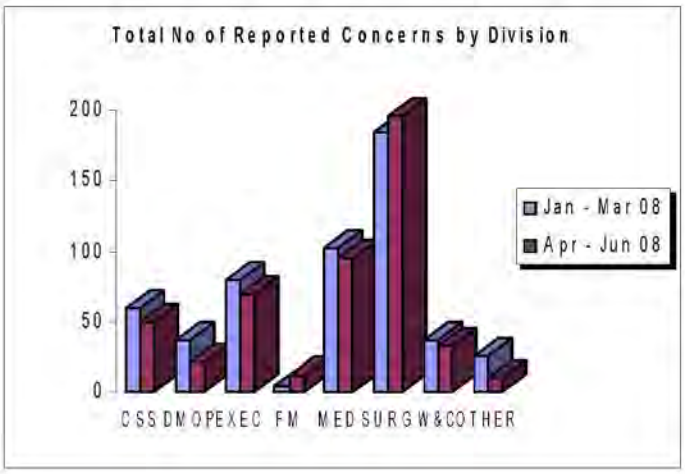
January – March 08			April – June 08	
Division	**Brief Summary**		**Division**	**Brief Summary**
CSS	1 x MRSA (Ultrasound staff not told of pt's status)		CSS	Body of pt left out of fridge over the weekend -> early decomposition
CSS	Child underwent CT examination of inner ear, intended for another pt		CSS	Two bodies not reconstructed before moving from mortuary to funeral home
CSS	Radiation dose greater than intended delivered to thoracic spine		DMoPS	3 x C Difficile
CSS	Unintended radiation delivered to lumbar instead of thoracic spine		DMoPS	Pt fall -> fractured skull
DMoPS	1 x MRSA 2 x C Difficile		DMoPS	Pt died 15 mins post arrival at SMH
Medical	3 x MRSA 2 x C Difficile		Medical	2 x MRSA 3 x C Difficile
Medical	Whilst performing CPR nurse received shock from pt's internal defibrillator -> loss of sensation and function in left hand		Medical	Suspected medication error: further investigation indicates not as serious as originally expected
Medical	Pt complained to local press that she had been left on a trolley in MAU for 3 days		Medical	Pt found dead in bed
Surgical	4 x MRSA		Surgical	5 x MRSA 1 x C Difficile
Surgical	Pt underwent lap choley -> clips fell off -> haemorrhage. Pt recovered well and discharged		Surgical	Pt died one day following a total knee replacement
Surgical	Pt drank chlorhexidine solution left by bed for routine use in MRSA avoidance programme. Transferred to DCCQ until stabilised and returned to TAB. Pt identified as having alcohol dependency.		Surgical	Pt died two days following a total knee replacement
Surgical	Pt suffered aortic bleed following donor nephrectomy. Pt recovered and discharged		W&C	1 x MRSA
Surgical	Following ear surgery pt outlied to DSU. Pressure bandage slipped but went unnoticed. Possible long-term hearing problems.		W&C	Alleged breach of pt confidentiality: actually refers to PCT who are investigating
Surgical	Pt discharged from HNU following medical review. Returned to ED 10 hours later in cardiac arrest. Resus unsuccessful. Pt had cardiac history and was an unstable diabetic			
Surgical	Pt underwent eye surgery with post-op follow up changed from 3 weeks to 5 days. Given appt for 3 weeks -> complication -> ? affected eye sight long-term			
Surgical	Wandering pt had been assisted back to bed. Later found on floor -> CT scan -> sub-dural haematoma. Pt had required specialing but not possible due to staffing levels			
W&C	2 x MRSA			
W&C	Infant admitted with bronchilitis -> deteriorated and required stabilisation and transfer to PICU. CT scan revealed a cerebral air embolism, following which treatment withdrawn and infant died. Uncertain whether embolism occurred whilst in the care of PHT or SUT			
W&C	Pt had (+) pregnancy test -> vaginal bleeding. GP diagnosed miscarriage, deputy GP diagnosed endometritis; SCAST felt unnecessary to take pt to ED. Finally diagnosed in ED with ruptured ectopic -> removal of 1 tube			
W&C	Pt suffered burns during an HTA procedure			

PATIENT ADVICE AND LIAISON SERVICE

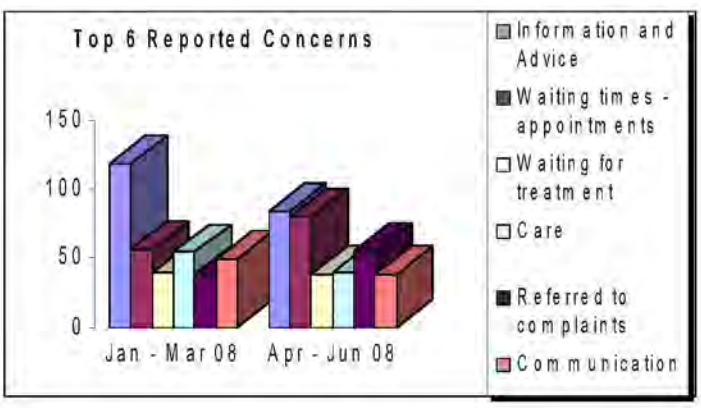
PALS continues to play a significant role in the patient and relative experience within the Trust, with 486 concerns being reported this quarter, against 418 the previous quarter, demonstrating an increase of 15%



This figure represents a 15% increase on the previous quarter



Of the Reported concerns	Jan – Mar 08	Apr – Jun 08
CSS	59	50
DMoP	37	21
Executive	79	70
FM	4	12
Medical	102	95
Surgical	185	196
W & C	37	32
Other	28	10



Top 6 Reported Concerns	Jan – Mar 08	Apr – Jun 08
Care	54	40
Communication	49	38
Referred to Complaints	38	55
Information & Advice	119	84
Waiting for appts	56	80
Waiting for treatment	40	38

PALS have dealt with many varied calls and emails from patients, carers, relatives and members of the public, requesting information and advice. Examples are as follows:

- Enquiry as to how to make a private donation to the Trust
- Advice on how to obtain copies of health records
- Staff requested information and advice regarding Power of Attorney
- Information about Clostridium Difficile
- Information on how to develop a patient survey/comment card

Health Information Centre (HIC)

The Health Information Centres provide information leaflets on a range of health topics and services and the HIC at Queen Alexandra Hospital is the initial point of contact for PALS

Total No of Contacts with HIC - QAH	
Jan – Mar 08	Apr – Jun 08
600	613

PLAUDITS

The recording of plaudits continues to provide the Board with a more balanced representation of patient opinion on the services provided and it is unfortunate that not all specialties have the resources to capture the number of plaudits received – as positive gestures clearly continue to be far greater than the number of complaints received.

Ward/Dept	No		Ward/Dept	No
Alton Wards	182		Haematology	58
Colposcopy	134		HNU	79
DCCQ	62		MAU	54
Dermatology	18		Maternity/Labour Ward	289
DMoPs	118		Macmillan Centre	56
D Wards	119		NICU	57
ED	35		Oncology	221
F3	55		Radiology	13
Fertility	47		Radiotherapy	145
G4	14		Renal	30
General Surgery + SAU	189		Respiratory High Care	12
GU Med	25		RHH	141
Gynaecology	13		W&C Division (other)	56
TOTAL	**2,222**			

Even this snapshot demonstrates that the Trust received far more plaudits than complaints in this quarter 345 complaints compared to 2222 plaudits.

In addition

- The Rheumatology Department received:
  - Positive feedback from the Osteoporosis study day and the 'Living Well with Paget's Disease' evening event
  - Positive feedback about the osteoporosis clinic held in May and June and the 'Love Your Bones' event
  - 6 positive feedback reports regarding the patient advice and information line
  - 2 thank you letters and an email commending the Clinical Nurse Specialist

ORGANISATIONAL LEARNING

Changes made or to be made in the light of complaints, incidents and PALS include:

- Protocol for the management of mortuary visits
- Checklist devised to ensure all end of day mortuary procedures are followed
- Working group to redesign paediatric admission notes
- Use of paediatric 'triggers' to ensure appropriate reporting of serious untoward incidents
- Review and roll out of bereavement packs in W&C division
- Current information leaflet on HTA in gynaecology reviewed
- Pre-printed consent form for HTA being implemented
- New CT request form introduced into oncology, to allow specific timescales to be inserted
- Follow-up appointments to review CT scan given at time CT scan is booked, thus patients leave hospital knowing dates of both appointments
- Cardiology are implementing a system of 'emergency' clinics for patients who have previously had their appointment cancelled due to staff sickness.
- Patients who are referred for a second opinion to either oncology or gynaecology are brought back to MDT clinic with the decision the following week.

RECENT AND FUTURE DEVELOPMENTS

There have been three major developments that should be noted.

Complaints

Further to the Trust's participation in the 'Early Adopter' programme (as noted in last quarter's report), members of the Trust have been attending and presenting at conferences and workshops to progress the trial of the new complaints process and share ideas with other 'Early Adopter' Trusts nationwide. The new process will involve a two-stage complaints system focused on local resolution and thorough investigation and then, if the complaint remains unresolved, referral to the Health Service or Local Government Ombudsman. The Department of Health hopes that the new arrangements will make the whole experience of making a complaint more user-friendly and far more responsive to patients' needs. The emphasis will be on learning from complaints and effective and robust resolution, feeding the results into service improvement.

Whilst the new process is designed to be more personal and flexible for the complainant, it should be noted that it has considerable resource implications for the Complaints Department and the Trust as a whole: these implications will need to be considered as the programme develops.

Legal Services

There has recently been a strengthening of one of the Coroner's rules (Rule 43) which will have an impact on all NHS Trusts. Under this rule, in any cases where the Coroner considers there is a risk that other deaths may occur for similar reasons he has the power to request the organisation to take appropriate action. As of 17 July, organisations are under a statutory duty to provide a written response, with details of any actions taken, or proposed to be taken, or provide an explanation as to why no action is proposed. On receipt of the response, the Coroner has a duty to send that response to the Lord Chancellor and interested parties.

Therefore, healthcare organisations will need, more than ever, to ensure that any failings identified from serious untoward incident (SUI) investigations have clear and achievable action plans. Where possible, those steps should already have been taken by the time an inquest is heard and thus illustrate to the Coroner that the risk of recurrence has been satisfactorily reduced, thus negating the need for a Rule 43 recommendation.

It was already normal practice for the Legal Services Department to send a copy of the Trust's SUI investigation report prior to an inquest if it was available and on more than one occasion the Coroner has commented that he was pleased to see that the Trust had already taken action(s). However, the amendment to Rule 43 now makes it

imperative that SUI reports and the associated actions are completed (or action plan for longer term actions provided) prior to an inquest.

Serious Untoward Incidents

The Strategic Health Authority was invited to undertake a review of the Trust's serious untoward incident reporting processes. That review took place on 24 July 2008 and involved examination of documentation and interviews with a number of senior Trust staff.

The review team consisted of the:

- Clinical Governance and Patient Safety Manager SCSHA;
- Deputy Chief Nurse/Head of Clinical Standards SCSHA;
- Head of Health Improvement SCSHA;
- Head of Clinical Standards PCPCT; and
- Director of Nursing& Operations, Basingstoke & North Hants NHS Foundation Trust

The Terms of Reference were to review the Trust's:

- Reporting processes for Serious Untoward Incidents, gaining an understanding of how they are identified, reported and managed;
- Root Cause Analysis process and identify how this can be strengthened if necessary;
- Risk Management processes and identify any gaps in the system; and
- Complaints procedure and its interface with the Serious Untoward Incident process.

A report from the SHA was promised within one month of the review: end of August 2008. Information on the outcome will be provided once the report has been received.