Department of Health

Consultation on Framework for Learning & Improving from Patient Safety Incidents

Response from the Commissioner Designate for Victims of Crime for Northern Ireland

June 2025

1. General Comments

1.1 The Commissioner Designate welcomes the opportunity to provide input into this consultation as part of the Serious Adverse Incident Redesign Programme.

1.2 The Framework for Learning and Improvement from Patient Safety Incidents overlaps with the remit of this office, which is concerned with amplifying the voices and experiences of victims of crime in Northern Ireland.

1.3 The Commissioner for Victims of Crime Office (CVOCO) has engaged with several victims of crime where the crime has been as a result of a health-related patient safety incident. The Commissioner Designate therefore welcomes any efforts at addressing some of the identified shortcomings and the desire to learn and improve the systems where they overlap with criminal justice.

2. Specific Comments

Vision & Scope

2.1 CVOCO broadly welcomes the approach being adopted including the vision centred around the introduction of a Regional Framework with a focus on learning and improvement and framed within a culture of safety, openness and compassion.

2.2 The Commissioner Designate would, however, like to flag concerns regarding the narrow remit of some of the definitions being used in the consultation document and the risk that such definitions will exclude key stakeholders.

2.3 The Patient Safety Incident definition does not include members of the public that are harmed by patients under the care of the health system. We have seen from high profile cases across the UK and beyond, that members of the public with no direct relationship to the patient, can be placed at risk of harm by patients, in particular patients receiving mental health care. This type of incident should be factored into the definition from the perspective of future proofing.

2.4 CVOCO welcomes the definition of 'All those Affected', which includes victims and their families that may be affected by a patient safety incident. It is important to acknowledge that victims of such an incident can be any member of the public and is not confined to staff, patients and the extended families.

2.5 The Commissioner Designate therefore wishes to express concern regarding the chosen definition of a victim: '*A victim must be a close relative or someone acting lawfully on behalf of the "patient" and who witnessed the Patient Safety Incident or its immediate aftermath.'* This limited definition does not reflect the day-to-day reality of patient safety incidents and presupposes who a victim will be. As stated above, a victim and victim's family can be from outside of this narrowly defined cohort. It is essential that victims of a crime by a perpetrator who is under the care of the HSC system are included under 'All those Affected' regardless of who they are. If the Department are reluctant to include victims of crime under their definition of victim 'in a healthcare sense' then they should include a separate category which covers victims of crime who may or may not be patients. Members of the public directly affected by an adverse incident can provide valuable learning and insight, which should not be overlooked due to sitting outside of certain debateable terminology or definitions.

Framework Themes

2.6 CVOCO welcomes the proposed Framework and related themes and is encouraged by the intention not just to focus on learning but also to effectively implement and embed the learning in practice across the HSC system.

2.7 The Commissioner Designate is particularly supportive of 'Engagement, Involvement and Support of All those Affected' as a theme but would urge that this should include members of the public (or their families) harmed in a Patient Safety Incident. This will demonstrate a desire to learn from previous incidents and will ensure a more holistic approach to learning and improvement is taken. Learning from the Cawdery case and the subsequent Coroner's inquest[1] highlights the need for such a holistic approach.

[1] Judiciary NI, Coroner Maria Dougan Inquest, 2023 Inquests touching upon the deaths of Lillian Majorie Cawdery and Michael Julien Hope Cawdery.pdf

2.8 CVOCO also welcomes the theme around 'Engagement, Involvement and Support of Staff Affected' and believe that this is an area that is not as strong as it should be under the current arrangements. It is as important to involve staff and share findings with staff that contributed after a review has been completed as it is before and during a review. This is a critical element of the learning and improvement focus as well as the openness and honesty values of the proposed Framework and redesign process.

Broader Approach

2.9 The Commissioner Designate is supportive of the approach for each HSC organisation being required to develop a Patient Safety Incident Learning & Improvement Plan. As specified in the consultation, it is vitally important that these plans are reviewed and updated on an annual basis.

2.10 CVOCO welcomes the regional standards for conducting patient safety incident reviews and is encouraged by their outcomes focus. The monitoring and evaluation of reviews against these standards with built-in feedback from all those affected, including staff involved, will be critical to their successful implementation.

2.11 The current criteria for an SAI Review has a lower threshold than the proposed approach and has the following trigger point: *'serious self-harm or serious assault (including homicide and sexual assaults)'*[2], whether that be on other service users, staff or members of the public, by a service user in the community who has a mental illness or disorder.

2.12 The proposed approach sets out patient safety incidents where a comprehensive review will be mandated at Annex C and includes:

- Deaths of patients in police custody which have involved nurse led healthcare;
- Suspected Mental Health Related Homicides[3]

[2] 'HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents - November 2016 Version

[3] When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event. (Independent investigation of adverse events in mental health services – NHS England)

It does not include serious assault or sexual assault.

2.13 Given the Programme for Government priority on ending violence against women and girls, CVOCO would like to see sexual assault being considered as a mandatory trigger-point for a comprehensive patient safety incident review.

2.14 Additionally, there is a fine line between a serious assault that results in homicide and one that does not. The Commissioner Designate therefore believes that a serious assault by a patient under HSC care in the community should also be considered as a trigger-point for a review.

If you would like to discuss any of these points in further detail, please contact the office via:

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