Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: ATISN 11993

28 February 2018

Dear ,

ATISN 11993 –Serious incidents and never events reported to Welsh Government by Hywel Dda University Health Board

Thank you for your request which I received on 31 January 2018. You asked for the numbers and categories of Serious Incidents and Never Events reported to Welsh Government over the past five years by Hywel Dda University Health Board.

The Welsh Government holds the information you have requested and it is attached at Annex A.

NHS organisations in Wales are required to report and investigate all Serious Incidents and Never Events. This process supports a culture of openness, transparency and learning in order to prevent mistakes from re-occurring.

You may find it helpful to be aware of our definition of a Serious Incident and Never Event. A Serious Incident is defined as an incident which occurred in relation to NHS Wales funded services and which results in unexpected or avoidable death or harm, or where the incident affects the organisation's ability to continue to deliver health services. A never event is defined as a largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

It should be noted that where there are less than 5 serious indicants or never events reported, the information has been redacted under Section 40(2) of the Freedom of Information Act 2000. The rationale for this is that due to the small number of incidents there is a potential risk of identifying individuals if this was disclosed. This information is protected by the Data Protection Act 1998, as its disclosure would constitute unfair and unlawful processing and would be contrary to the principles and schedules 2 and 3 of the Act. This

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

exemption is absolute and therefore there is no requirement to apply the public interest test. The Data Protection Act 1998 defines personal data as data which relates to a living individual who can be identified solely from that data or from that data and other information which is in the possession of the data controller.

The request you sent me contains personal information about you - for example, your name and address. I will only use this personal information in accordance with the Data Protection Act 1998 to deal with your request and any matters which arise as a result of it. I will keep your personal information and all other information relating to your request for three years from the date on which your request is finally closed. Your personal information will then be disposed of securely.

Any information released under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 will be listed in the Welsh Government's Disclosure Log:

http://wales.gov.uk/about/foi/responses/?lang=en

If you are dissatisfied with the Welsh Government's handling of your request, you can ask for an internal review within 40 working days of the date of this response. Requests for an internal review should be addressed to the Welsh Government's Freedom of Information Officer at:

Information Rights Unit,
Welsh Government,
Cathays Park,
Cardiff,
CF10 3NQ

or email: FreedomOfInformationOfficer@gov.wales

Please remember to quote the ATISN reference number above.

You also have the right to complain to the Information Commissioner. The Information Commissioner can be contacted at:

Information Commissioner's Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF.

However, please note that the Commissioner will not normally investigate a complaint until it has been through our own internal review process.

Yours sincerely,

ATISN 11993 –Serious incidents and never events reported to Welsh Government by Hywel Dda University Health Board

2013/14

Incident type	Number of incidents
Delay in treatment	(Less than 5)
Inappropriate admission	8
Infant death	(Less than 5)
Infection control	19
Medication error	(Less than 5)
Patient fall	5
Patient mis-identification	(Less than 5) (Never Event)
Radiation error	(Less than 5)
Self harm	(Less than 5)
Suspected suicide	13
Unexpected death	(Less than 5)

2014/15

Incident type	Number of incidents
Alleged abuse (sexual / physical / racial / verbal) - staff on patient	(Less than 5)
Delay in diagnosis	(Less than 5)
Delay in treatment - WAST patient handover	(Less than 5)
Healthcare associated pressure ulcer – community	15
Healthcare associated pressure ulcer – hospital	12
Infant death	(Less than 5)
Infant still born	(Less than 5)
Infection control - death (certificate) as a result of HCAI	(Less than 5)
Infection control - hospital capacity/outbreak/ward closure	5
Infection control - transmission of infectious diseases	(Less than 5)
Medication error – administration	(Less than 5)
Other	(Less than 5)
Patient fall	(Less than 5)
Radiation error – general	(Less than 5)
Self harm	(Less than 5)
Suspected suicide – actual	5
Suspected suicide – attempted	(Less than 5)
Treatment / procedure error	(Less than 5)
Underage admission to adult mental health ward	10
Unexpected / unexplained death	6
Wrong Surgery - incorrect limb / site / procedure	(Less than 5) (Never Event)

2015/16

Incident type	Number of incidents
Absconding of detained/restricted mental health patient	(Less than 5)
Alleged abuse (sexual / physical / racial / verbal) - patient on patient/staff	(Less than 5)
Alleged abuse (sexual / physical / racial / verbal) - staff on patient	(Less than 5)
Alleged homicide – actual	(Less than 5)
Breach of DPA / confidentiality	(Less than 5)
Delay in treatment - general	(Less than 5)
Healthcare associated pressure ulcer – community	12
Healthcare associated pressure ulcer – hospital	10
Infant death	(Less than 5)
Infant still born	(Less than 5)
Infection control - death (certificate) as a result of HCAI	7
Infection control - hospital capacity/outbreak/ward closure	(Less than 5)
Infection control - severe / potential harm	(Less than 5)
Infection control - transmission of infectious diseases	(Less than 5)
Other	(Less than 5)
Patient fall	(Less than 5)
Radiation error – general	(Less than 5)
Radiation error - incorrect limb / site	(Less than 5)
Radiation error - patient misidentification	(Less than 5)
Self harm – community	(Less than 5)
Significant disruption to provide service - ward / unit closed not infection related	(Less than 5)
Suspected suicide – community	11
Treatment / procedure error	(Less than 5) (Never Event)
Underage admission to adult mental health ward	12
Unexpected / unexplained death	(Less than 5)

2016/17

Incident type	Number of incidents
Absconding of detained/restricted mental health patient	(Less than 5)
Alleged abuse (sexual / physical / racial / verbal) - patient on patient/staff	(Less than 5)
Alleged abuse (sexual / physical / racial / verbal) - staff on patient	(Less than 5)
Alleged homicide – actual	(Less than 5)
Breach of DPA / confidentiality	(Less than 5)
Delay in treatment – general	(Less than 5)
Healthcare associated pressure ulcer – community	55
Healthcare associated pressure ulcer – hospital	7
Infant death	(Less than 5)
Infant still born	(Less than 5)
Infection control - death (certificate) as a result of HCAI	8
Infection control - hospital capacity/outbreak/ward closure	(Less than 5)
Infection control - transmission of infectious diseases	(Less than 5)
Other	(Less than 5)
Patient fall	23
Radiation error - incorrect limb / site	(Less than 5)
Radiation error - Incorrect type of investigation	(Less than 5)
Radiation error - patient misidentification	(Less than 5)
Self harm - in-patient	(Less than 5)
Suspected suicide – community	10
Suspected suicide - in-patient	(Less than 5)
Underage admission to adult mental health ward	8
Unexpected / unexplained death	13
Wrong Surgery - incorrect limb / site / procedure	(Less than 5) (1 x Never Event)

2017 – 31 January 2018

Incident type	Number of incidents
Absconding of detained/restricted mental health patient	(Less than 5)
Breach of DPA / confidentiality	(Less than 5)
Healthcare associated pressure ulcer – community	61
Healthcare associated pressure ulcer – hospital	9
Infant death	(Less than 5)
Infant still born	(Less than 5)
Infection control - death (certificate) as a result of HCAI	(Less than 5)
Medical equipment – failure	(Less than 5)
Medication error – administration	(Less than 5)
Other	(Less than 5)
Patient fall	25
Self harm – community	(Less than 5)
Suspected suicide – community	12
Treatment / procedure error	(Less than 5) (Never event)
Underage admission to adult mental health ward	8
Unexpected / unexplained death	14
Wrong Surgery - incorrect limb / site / procedure	(Less than 5)