**SERIOUS INCIDENT / CLINICAL REVIEW PROCESS CHECKLIST**

**Appendix B**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Date of******Incident:*** |  | ***DatixWeb******Incident******Form No:*** |  | ***SII/CR/ NCR/LR No:*** |  |
| ***Date Risk******Manager notified of******incident:*** |  | ***Date reported to******CCG:*** |  | ***STEIS No:*** |  |
| ***Person responsible for******investigating******incident and status:*** |  | ***Executive******Director commissioning Inquiry/Review******:*** |  |
| ***Risk Lead*** |  |
| ***Description of incident and reasons for setting up inquiry/review:*** |
| ***Is this incident a ‘NEVER EVENT’?*** | ***YES*** *(Please see over)* | ***NO*** |
| **Inquiry/Review type:**Serious Incident Inquiry:60 working days *For Pressure Ulcers*Clinical Review Local Review Non-clinical Review  | ***Does this report follow:*** Incident Form  Complaint  Litigation (or intended)  Other (please state) ………………………………………………………………………………………………………… |
| ***Draft copy of report sent to Litigation Manager:*** | ***Date:*** | ***Final copy of report/statements sent to Litigation******Manager*** | ***Date:*** |
| **Copy of report to:** | **Date:** | **Full Report**(Please tick) | **Summary****Report**(Please tick) |
| Clinical Risk Group |  |  |  |
| Exit meeting | ***Meeting Date:*** |  |  |  |
| Clinical Management Board |  |  |  |
| Recommendation Leads |  |  |  |
| Directorate Management Teams |  |  |  |
| ***Target date for completion of******inquiry/review:*** |  | ***Risk Managers******Signature:*** |  |
| ***Date for******submission to CCG:*** |  | ***Date signed:*** |  |

**Never Events:**

AUTHOR : HEAD OF RISK MANAGEMENT DATE OF NEXT REVIEW: AUGUST 2021

SERIOUS INCIDENT REQUIRING INVESTIGATION POLICY

VERSION 2.0

AUGUST 2018

1. Wrong site surgery 

2. Wrong implant/prosthesis 

3. Retained foreign object post-procedure 

4. Mis-selection of a strong potassium containing solution 

5. Wrong route administration of medication 

6. Overdose of Insulin due to incorrect abbreviations or incorrect device 

7. Overdose of methotrexate for non-cancer treatment 

8. Mis-selection of high strength midazolam during conscious sedation 

9. Failure to install functional collapsible shower or curtain rails 

10. Falls from poorly restricted windows 

11. Chest or neck entrapment in bedrails 

12. Transfusion or implantation of ABO-incompatible blood components or organs 

13. Misplaced Naso- or oro-gastric tubes 

14. Scalding of patients 

15. Unintentional connection of a patient requiring oxygen to an air flowmeter 

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| --- |
| **PANEL MEMBERS** |
|  | **Name/Title** | **Date Panel request letter sent** | **Agreed to be on panel?** | **Date panel pack sent** | **Meeting availabili ty** |
| **Chair** |  |  | Yes / No |  |  |
| 2 |  |  | Yes / No |  |  |
| 3 |  |  | Yes / No |  |  |
| 4 |  |  | Yes / No |  |  |
| 5 |  |  | Yes / No |  |  |
| 6 |  |  | Yes / No |  |  |
| 7 |  |  | Yes / No |  |  |
| 8 |  |  | Yes / No |  |  |

AUTHOR : HEAD OF RISK MANAGEMENT DATE OF NEXT REVIEW: AUGUST 2021

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AUGUST 2018

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| **WITNESS STATEMENTS** |
| Request witness statements and send copy of patient notes and Guidance Notes for Witnesses(appendix 5).*(ensure state a deadline date of 10 – 14 days, or before date of first meeting)* |
|  | **Witness name/title** | **Date****letter sent** | **Date statement received** | **Date statement sent to** | **Date letter attend** | **Date sent draft report for** | **Date comments received** | **Date sent final report** |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |

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