



# **PCC Health Committee Briefing Paper - Serious Adverse Incidents**

April 2026

**Your Voice,  
Our Journey**

[www.pcc-ni.net](http://www.pcc-ni.net)

## **Introduction**

1. PCC acknowledges and welcomes the significant work that the Department of Health has undertaken in reviewing the Serious Adverse Incident Framework in Northern Ireland. PCC notes the recently published Consultation Analysis Report on the proposed Framework for Learning and Improvement from Patient Safety Incidents. This is a comprehensive analysis report, which the PCC is currently working through. This brief provides the Health Committee with an overview of the work carried out by PCC in this area up to the point of the public consultation. PCC is keen to continue to engage constructively with the Department and the public on the implementation phase of this project.

## **PCC Advocacy Support Related to SAIs**

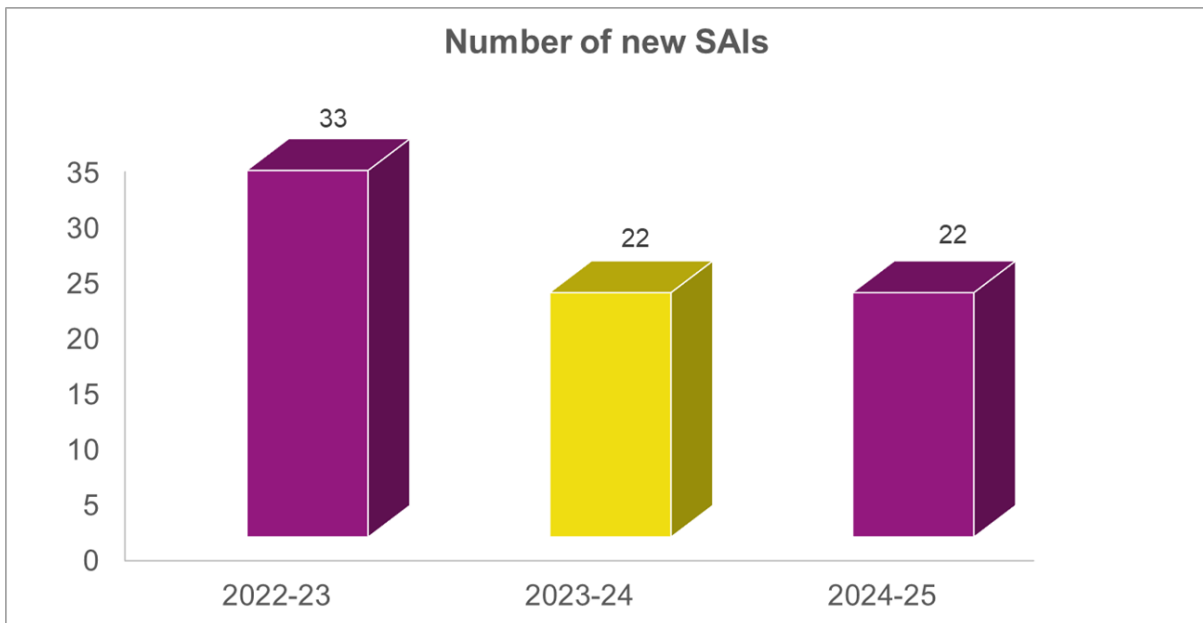
2. The PCC is the only organisation which provides independent<sup>1</sup> advocacy support for clients during SAI investigations. PCC does so under its statutory role to provide assistance, by representation or otherwise, to individuals who have issues in health and social care. The PCC is not resourced to provide independent advocacy support in SAIs. The provision of support to families in a SAI process is provided by Senior Practitioners within the PCC. Service Managers will link families with particular Senior Practitioners, depending on the level of the SAI and the programme of care, to provide the best possible support. The PCC's continued development of working relationships with colleagues in the five HSC Trusts has served to improve the support provided to families.
3. Increased understanding of the role of the PCC and developing relationships can ensure case issues are escalated to Senior Managers in Trusts, if the SAI process is not running to the satisfaction of the families involved and in accordance with expected procedure.

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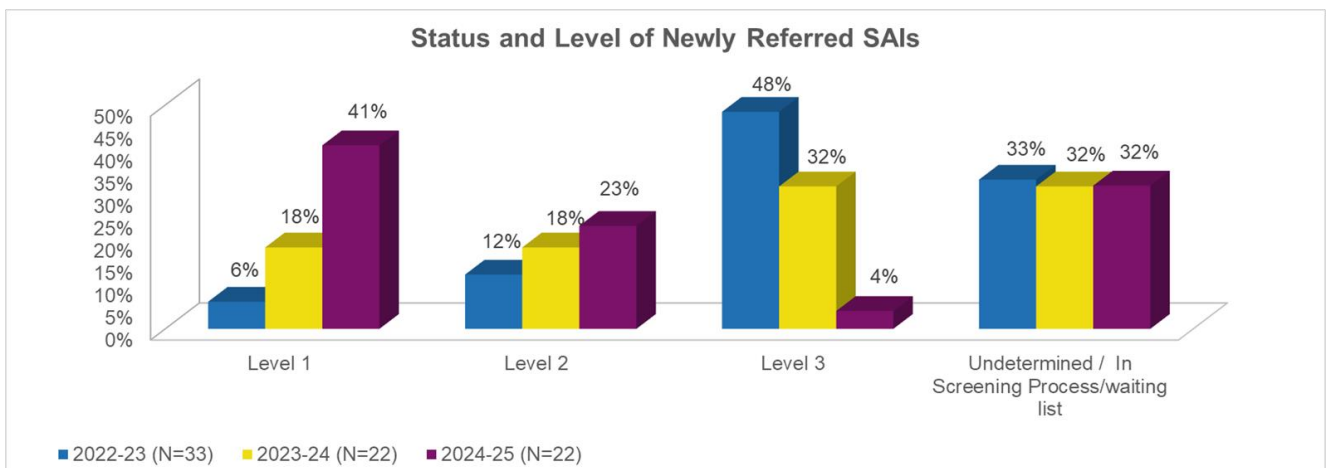
<sup>1</sup> Independence understood in financial, structural and psychological terms.

4. Complex case meetings chaired by a Service Manager in the PCC allow Senior Practitioners an opportunity to discuss particular cases, seek advice and peer support, as well as seek escalation both within the PCC and within Trusts, if they are encountering challenges.

5. The following chart shows the number of new SAI cases over recent years PCC have supported.



6. The chart below demonstrates the status, and level, of the 22 SAIs newly referred to the PCC in 2024-25 compared to previous years.



7. There was an increase in the number of Level 1 SAIs, from 18% in 2023-24 to 41% in 2024-25. There was also a significant decline in the number of Level 3 SAIs from 32% in 2023-24 to 4% in 2024-25.
8. Through the 22 new SAI cases opened in 2024-25, the PCC supported 34 individuals. This includes the individuals who raised the case and other family members. Several SAI cases have remained open for a period of years as investigations continue. When we account for SAI cases opened before this reporting period that have not yet closed, there were 42 SAI cases open at the end of 2024 -25 (Level 1 – 15; Level 2 – 7; Level 3 – 14; Undetermined Level – 6).
9. The combined total of open and closed SAI cases supported in 2024-25 was 60, with 76 people supported. Placing the level of PCC support to the public in a regional perspective, during the period 1 April 2024 - 31 March 2025, SPPG received 592 SAI notifications from across HSC Organisations.

## **PCC Policy Position and Engagement**

### **PCC Engagement on Serious Adverse Incidents Framework**

10. In 2023, the Department of Health (DoH) established a redesign structure to support the development and introduction of a new Serious Adverse Incident (SAI) framework for Northern Ireland. The PCC have been involved with the Department's SAI Redesign Development Group since 2023, providing advice on engaging the public, feedback based on engagement with the public and learning based on PCC's advocacy role.
11. PCC subsequently set up a SAI Engagement Platform of individuals who had in-depth experience and knowledge of the current SAI process to directly inform this redesign process. The insights provided by the Engagement Platform are reflective of their lived experience.

12. Our SAI Engagement Platform provided direct feedback to the DoH's policy development work. The Engagement Platform also provided detailed written feedback to departmental officials on their proposals on two occasions, including one to HSC Trust Boards, see **Appendix 1**. The Engagement Platform provided a response to the public consultation and assessed how they might contribute in any implementation phase of a new SAI framework.

### **PCC Report - Serious Adverse Incidents Procedure: An Overview Report**

13. In 2024 PCC produced a [Serious Adverse Incidents Procedure: An Overview Report](#).<sup>2</sup> The report provided an overview of our assessment of the current state of the SAI Review system in Northern Ireland. The information contained in this report was based on our engagement with those affected by SAIs, and our broader organisational experience, including how it developed in providing independent advocacy support in SAIs, and reflected evidence PCC has provided in recent Public Inquiries.

14. In this report we:

- Outlined PCC's advocacy practice model;
- Demonstrated a member of the public's journey through the SAI process with the PCC;
- Highlighted the need for a regional independent advocacy model which is consistent with the recommendations of the Hyponatraemia Inquiry Report;
- Pointed out the benefits of advocacy including its role in assurance;
- Emphasised that Trusts should invest in training for staff in advocacy and the complaints process;
- Stated that learning from SAIs should be shared regionally and implementation should be tracked.

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<sup>2</sup> PCC (2024) 'Serious Adverse Incidents Procedure an Overview Report'. Accessed here: [pcc-serious-adverse-incidents-procedure-an-overview-report-november-amendment.pdf](#)

## PCC Response to the Framework for Learning and Improvement from Patient Safety Incidents Consultation

15. PCC also submitted an [organisational response to the Framework for Learning and Improvement from Patient Safety Incidents Consultation](#)<sup>3</sup> in 2025.

16. In our response we emphasised:

- There is currently a considerable lack of trust in the existing process amongst the public. Building trust and maintaining it, must be a key priority for the Department of Health and HSC system with any new process;
- The initial investigation stage needs to be proportionate, robust, transparent and consistent;
- The investigation should establish what happened;
- Numerous documents were referenced in the proposals, but not consulted upon, these documents will influence how future SAIs will be conducted;
- There is a need for a Regional Approach in the new Framework;
- There is a need to establish a regional independent advocacy model, which reflects the recommendation from the Inquiry into Hyponatraemia-Related Deaths (IHRD);
- The importance of independence and assurance in carrying out SAIs;
- Oversight and Governance arrangement issues such as the proposed framework seemingly delegate interpretative flexibility to HSC Trusts.
- That consideration should be given as to how systematic contributions from those with lived experience and the voice of the public can be established as part of the regional oversight and assurance model, which links to a key PCC ask for greater patient voice in HSC Governance and Assurance mechanisms.

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<sup>3</sup> PCC (2025) 'PCC response to Framework for Learning and Improvement from Patient Safety Incidents Consultation' Accessed here: [sai-framework-pcc-consultation-response\\_final.pdf](#)

17. PCC also facilitated an [online consultation](#)<sup>4</sup> on the Framework for Learning and Improvement from Patient Safety Incidents Consultation at the request of DoH during the consultation period. This online event was attended by individuals who represented a range of experiences and backgrounds, including members of the public with lived experience of the current SAI process, those with a general interest, members of the voluntary and community sector, HSC staff, HSC leaders, healthcare regulation and PCC Council members. At the opening of the online conversation, DoH officials gave a presentation on the context, background, and intentions of the new policy framework and consultation. Participants were then split into breakout rooms with conversations facilitated by a PCC member of staff, and a DoH representative listening in.

18. PCC identified key themes from the conversations which included:

- Transparency, Trust and Accountability not just in words, but in actions, communication, and outcomes;
- A new procedure should be independent from HSC Trusts and have oversight;
- The Framework should move from being 'guidance' to a 'requirement' on organisations;
- The issue of timescales, both the length of time it takes to conduct a SAI and delays to the process;
- Sharing Learning and Prevention of incidents;
- Compassion, Trauma-informed practice and access to Independent Advocacy Support;
- Acknowledgement that change is needed and the system is currently not working;
- The move away from "blame culture" which they hoped would encourage staff to speak up was welcomed;
- Recognition of the of "all those affected" rather than just "patient harmed" in a SAI.

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<sup>4</sup> PCC (2025) 'Engagement on Framework for Learning and Improvement from Patient Safety Incidents Consultation' Accessed here: [sai-consultation-event-report-final-version.pdf](#)

## Regionalisation of Independent Advocacy

19. The importance of advocacy services was recognised by the Inquiry into Hyponatraemia-Related Deaths (IHRD) report<sup>5</sup>, with its recommendations outlining the need for service users, and families, to have access to independent advocacy support. Recommendation 37 (iv) being: 'Trusts should seek to maximise the involvement of families in SAI investigations and in particular: a fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases'.

20. The availability of independent advocacy assists in creating a culture of openness and transparency and plays a fundamental role in governance, assurance and addressing inequality.

21. PCC believe that appropriately supporting independent advocacy services provides a level of assurance that HSC Trusts and organisations are committed to being learning organisations, committed to meeting their Statutory Duty of Quality, are appropriately invested in the Duty of Candour and, most importantly, to protecting patients<sup>6</sup>.

15. Advocacy:

- Safeguards people who can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social and environmental circumstances that make them vulnerable.
- Empowers people who need a stronger voice by enabling them to express their own needs and make their own decisions.

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<sup>5</sup> The Inquiry into Hyponatraemia-related Deaths Report Full-Report.pdf

<sup>6</sup> PCC (2025) *PCC response to the Being Open Framework consultation*. Accessed here: [being-open-framework-pcc-response.pdf](#)

- Enables people to gain access to information, explore and understand their options, and to make their views and wishes known.
- Speaks up on behalf of people who are unable to do so for themselves.

16. Advocacy services are not currently commissioned on a regional basis, to an agreed, or, required standard, with related training, support and governance mechanisms. The PCC expects, and we believe the public expect, that organisations providing advocacy services should be **independent of service providers i.e. structurally, financially and psychologically independent**. The availability and accessibility of independent advocacy assists in creating a culture of openness and transparency, and plays a fundamental role in governance, assurance and addressing inequality.

## Conclusion

22. PCC are still considering the [Consultation Analysis Report of the Framework for Learning and Improvement from Patient Safety Incidents](#)<sup>7</sup> in terms of its impact on both members of the public going through an SAI review and PCC operations. We continue to emphasise the importance of public participation at the implementation stage of the new Patient Safety Incidents process. PCC considers that further and ongoing engagement with those with lived experience is vital and critical to the success of any new SAI procedure.

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<sup>7</sup> Department of Health (2026) 'Serious Adverse Incident Redesign Programme Framework for Learning and Improvement from Patient Safety Incidents Consultation Analysis Report' Accessed here: [Consultation Analysis Report Serious Adverse Incident Redesign Programme. Framework for Learning and Improvement ~ February 2026](#)

## Appendix 1

# Patient and Client Council Engagement Platform - Serious Adverse Incident Review briefing sent to HSC Trust Boards

## The Fundamentals

The fundamental starting point for any new policy must be the objective of delivering a robust investigation, to a consistent standard, which factually establishes what happened. There can be no genuine learning, meaningful accountability or referral, if the policy, procedure and practices do not robustly and consistently establish what happened in a given safety incident.

## Independent investigations and reviews

Based on our lived experiences of the current SAI review process, we consider it of paramount importance that those carrying out Patient Safety Incident investigations and reviews are independent of the Trusts involved. The importance of independent investigations is a long-established principle and practice in other equivalent spheres, and is of principal importance to ensure public trust in the process. Investigations need to be independent, and be seen to be independent, to maintain public trust in the HSC system. Independence also provides assurance to Trust Boards

## Participation of those affected

### **Prior to Harm being Caused:**

If anyone raises safety concerns, including risk of harm to a patient or others, prior to harm occurring then an immediate review must be carried out by all those involved. This must include everyone concerned who may be affected or involved whether Health Care Professional or not. For example, patients, family members, PSNI, Social Workers, Carers, Probation Service, and Lay Staff may all legitimately raise concerns. All opinions must be treated equally and if unanimous agreement cannot be reached to the contrary then it must be assumed safety is in jeopardy and a Patient Safety Incident called.

### **After Harm has been Caused:**

It must be clearly understood that **all** those affected have a right to know how and why they or their family member was harmed, whether directly or indirectly by a Patient Safety Incident. It must therefore be clearly understood that a PSI Review is not solely about learning, it is also about providing the truth to all those affected and ensuring that they get all the support they need. Those affected have the right to be involved in deciding whether a PSI Review takes place, the level of independence, and the Terms of Reference, they also

have the right to be fully engaged throughout the Review if they so wish, and have the right to comment on the draft Report and have their views either incorporated or recorded in the final Report.

### **Quality of initial investigations and reviews**

Ensuring investigations are carried out independently and to a regionalised standard also requires dedicated resources and trained staff to be allocated to Patient Safety Incident Reviews. This position is supported by the RQIA Review of the systems and processes for learning from Serious Adverse Incidents in Northern Ireland, as amended May 2023<sup>8</sup>. Careful consideration should be given to the dedicated and regionalised resources required to fulfil any new policy and practice introduced for patient safety reviews. The starting point of this approach needs to be a baseline review of existing resources expended on SAIs within each Trust and by the SPPG.

### **Independent Assurance**

Based on our lived experience, and such recent cases as that related to the Southern Trust<sup>9</sup>, we have limited confidence in the existing mechanisms designed to provide assurance that SAI reviews are being carried out appropriately and to the appropriate standard. Trusts should not be responsible for providing such assurance. The potential pitfalls of self-assurance, self-assessment and self-declaration are well established, and evidenced by our own lived experiences. Trust Boards should receive assurances that regional patient safety incident review Standards and Principles are being met, through a meaningful evaluation/assurance mechanism, independent of them.

### **Governance and Accountability**

If we are serious about delivering genuine learning and improvements, Trusts should consider it to be in their own interests to have independent investigations/reviews and be the recipients of regional, independent, standardised and transparent assurance reports of patient safety reviews. Such an approach should give Boards confidence that patient safety reviews are being carried out appropriately in their Trust and are capable of providing those affected with a factual understanding of what happened and meaningful implementable learnings for the Trust. Boards should consider what they are and should be accountable for. Boards should be accountable to the Department and the Minister for ensuring staff report and are candid about patient safety incidents and are supported to do so; that staff co-

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<sup>8</sup> RQIA (2022) 'Review of the Systems and Processes for Learning from SAIs in NI' Accessed here: <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rqia-review-systems-processes.pdf>

<sup>9</sup> BBC News (2024) 'We had to fight for answers around dad's death' - BBC News Accessed here: <https://www.bbc.co.uk/news/articles/c93y0d0wlrdo>

operate fully with any investigation and review and are supported to do so; and for evidencing that the Trust has appropriately considered any patient safety reports and evidenced the implementation of the learnings emanating from independently produced reports, the quality of which has been assured by a third party. In cases of unexpected death, of either a patient or others, where an Inquest may be possible, the Trust Board should have confidence that all reports comply with the evidential requirements of the Coroners Act (Northern Ireland) 1959.

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