Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient safety incident response plan

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Forward

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. PSIRF replaces the previous Serious Incident Framework and fundamentally changes our patient safety landscape.

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them". Aidan Fowler, National Director of Patient Safety, NHS England

The Chelsea and Westminster NHS Foundation Trust Patient Safety Incident Response Policy and Plan describe the Trust's vision for safety learning and the processes by which we will respond to patient safety incidents. The core aims of this programme of work are to deliver:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on system improvement

This plan represents more than a simple procedural change; this is not a case of doing the same thing but calling it something different. The introduction of PSIRF signifies a transformation in how we think about and respond to patient safety incidents.

Under the previous Serious Incident Framework, significant focus was given to how we identify, report and investigate incidents resulting in severe harm or death. During the three years prior to PSIRF rollout (2020-2023), more than 52,000 patient safety incidents were reported within the Trust and of these, 286 comprehensive investigations were undertaken (0.5% of the total incidents reported). The energy focused on delivering these investigations, limited the time available to learn thematically from the other 99.5% of patient safety incidents reported. PSIRF replaces the previous framework with a learning structure that focuses on the systems and culture required to deliver continuous improvement in patient safety through our response to all patient safety incidents.

Under PSIRF our entire patient safety incident response approach has been designed and led collaboratively for the betterment of our patients, staff and local community. The Trust has launched a comprehensive training programme to ensure we meet our PSIRF ambitions.

PSIRF offers us the opportunity to learn, improve, and promote safe, effective, and compassionate care for our patients, their families and carers whilst also protecting the well-being of our staff.

Introduction

This patient safety incident response plan (PSIRP) sets out how **Chelsea and Westminster Hospital NHS Foundation Trust** (CWFT) intends to respond to patient safety events reported by staff, patients, families and carers. This activity is a key part of our work to continually improve the quality and safety of the care we provide. This plan is intended to guide our incident response activity over the next 12 to 18 months; change and development of our approach during this period is expected. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

A PSIRP is a requirement of each provider of NHS-funded care. This document should be read alongside the national Patient Safety Incident Response Framework (PSIRF) 2022 and our Patient Safety Incident Response Policy (available via our website).

The ambition that drives activities within this plan are to:

- Prevent avoidable harm
- Deliver sustainable safety learning insights
- Steer quality and safety improvements in our services
- Reduce the likelihood of patient safety events recurrence

Our plan will help us improve the efficacy of our local patient safety incident responses by:

- Refocusing Patient Safety Incident Investigations (PSIIs) towards a systems approach and the rigorous identification of interconnected causal factors and systems issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value from the above approach

The plan is underpinned by our Trust policies on incident reporting and investigation available to all staff via our organisation's intranet.

Transition to and implementation of the Patient Safety Incident Response Framework (PSIRF), including the agreement and operational use of this incident response plan, was commenced under version one of this plan from April 2024. Version two of this plan looks to continue the spread and adoption of PSIRF across the Trust from October 2025 until the next scheduled review date.

Our services

Chelsea and Westminster Hospital NHS Foundation Trust is one of the top ranked and top performing hospital Trusts in the UK. We employ more than 6,000 staff over our two main hospital sites, Chelsea and Westminster Hospital (CW) and West Middlesex University Hospital (WM), and across a number of community-based clinics within North West London.

We pride ourselves on providing outstanding care to a community of more than 1.5 million people. Both hospitals have emergency departments (A&Es), where more than 300,000 patients were treated annually. The Trust runs one of the largest maternity service in England, delivering approximately 10,000 babies every year. Our specialist care includes our; Centre for Gender Surgery, burns, paediatric inpatient and outpatients, specialist HIV, and sexual health services.

We aspire to provide locally-based and accessible services, enhanced by world-class clinical expertise. Our excellent financial and operational performance is a source of great pride to us—it is nationally recognised and sees us simultaneously achieving our financial plan while continuing to be one of the best performers against the national access standards for accident and emergency (A&E), referral to treatment (RTT) and cancer.

Through the North West London Integrated Care System, we work as a wider health system to drive improvements to care, and to deliver integrated care in Hammersmith and Fulham, Hounslow, West London and beyond.

Our core services include:

- Full emergency department (A&E) services supported by separate on-site urgent care centres (UCCs) and comprehensive ambulatory emergency care (AEC) services
- Emergency assessment and treatment services including critical care and a surgical assessment unit (SAU)—the Trust has designated trauma and stroke units at each site
- Acute and elective surgery and medical treatments, such as day and inpatient surgery and endoscopy, outpatients, services for older people, acute stroke care and cancer services
- Comprehensive maternity services, including consultant-led care, midwife-led birth centres, community midwifery support, antenatal care, postnatal care and home births—there is a specialist neonatal intensive care unit (NICU) at CW, a special care baby unit (SCBU) at WM, a cross-site specialist fetal medicine service, and a private maternity service at CW
- Children's services including emergency assessment, a 24/7 paediatric assessment unit (PAU), and inpatient and outpatient care
- HIV and sexual health services
- Diagnostic services, including pathology and imaging
- A wide range of therapy services, including physiotherapy and occupational therapy
- North West London Pathology - one of the largest NHS pathology providers in the UK, serving and jointly owned by three London NHS trusts (Imperial, CWFT & Hillingdon)
- West London Children's Healthcare - acute and specialist services for children and young people across CWFT and Imperial are managed through a unified leadership structure

Clinical services are also provided in the community and we have a range of visiting specialist clinicians from tertiary centres who provide care locally for our patients. For some highly specialised services, patients may have to travel to other trusts.

In September 2022, we formalised our partnership with the three other acute NHS trusts in North West London as an acute provider collaborative. This included the appointment of a chair in common to all four trusts. We have developed our PSIRF plans and policies collaboratively to maximise opportunities for shared learning and improvement.

Further information relating to our services can be found on our website.

Defining our patient safety incident profile

To define our key patient safety risks and planned responses we took a collaborative approach that involved the following stakeholders:

- Patient groups through cross-site engagement events
- Staff through webinars and away days
- Senior leaders through divisional governance boards
- Commissioners / ICS / Health Watch
- Partner organisations through acute provider collaborative

We have further developed our understanding and insights over the past 18 months, including regular discussions and engagement through the Trust's patient safety group, as well as discussion at the executive management board (EMB) and quality committee.

Our key patient safety issues, and risks were identified from the following data sources:

- Review and analysis of incident reporting data
- Further thematic review of incident reporting data
- Key themes from complaints / PALS / claims and inquests
- Key themes and issues from committees and sub-groups with a remit relating to aspects of quality and patient safety (such as medicine safety group, falls steering group etc.)
- Our risk registers
- Themes noted through learning from mortality reviews and mortality surveillance group
- Stakeholder discussions (such as with acute provider collaborative colleagues)

The insights obtained from analysis of the above data sources were used to inform our local priorities for learning responses within our plan.

We recognise that our plan is not a static document. Our patient safety incident profile will therefore be assessed on an on-going basis to ensure we are capturing emerging trends, hotspots, and new patient safety risks; these emerging risk areas will be escalated to our monthly Patient Safety Group as appropriate. Both EMB and the quality committee will receive and provide challenge to assurance in the Trust's response and learning from patient safety incidents.

Defining our patient safety improvement profile

Following review of our quality and safety data, pre-existing CWFT safety improvement programmes were considered. These improvement programmes will drive and support the Trust's PSIRF ambitions and provide ownership of further development of organisation-wide safety improvement plans. These plans are monitored through sub-groups of the Patient Safety Group and Clinical Effectiveness Group respectively, both of which provide assurance reports to our executive management board and quality committee.

Each of these safety improvement programmes has defined metrics for improvement and overarching plans. The following improvement programmes, aligned to the delivery of our PSIRF ambitions, have been identified:

- Improving outcomes and reducing the risks related to hospital associated thrombosis
- Reducing harm associated with inpatient falls; with an initial focus on falls risk assessment
- Reducing the risk of harm when undertaking invasive procedures by embedding the National Safety Standards for Invasive Procedures (NatSSIPs2)
- Reducing infection transmission; with an initial focus on improving standards of infection prevention and control practice
- Reducing medication errors and medication-related harm (moderate and above)
- Improving recognition and escalation of deteriorating patients (sepsis)
- Reducing the risk of patients experiencing pressure damage during their admission
- Reducing the risk of harm in maternity care with a focus on fetal monitoring
- Improving documentation and information governance practices; with an initial focus on improving the quality of electronic handover

In addition, the Trust identifies key safety improvement programmes within its annual Quality Account (accessible via our website). Each of the improvement priorities identified within the Quality Account is led by a Senior Responsible Officer and overseen by the Chief Nursing Officer. The following safety improvement priorities were identified for 2025/2026 to complement existing programmes of work in the Trust:

- Improving the identification and management of deteriorating patients through implementation of the Paediatric Early Warning Score (PEWS)
- Developing and sustaining a maternity safety learning culture through more personalised, and more equitable care standards (Single Delivery Plan)
- Improving the early recognition and screening of patients with dementia

We are also working with our acute provider collaborative partners on a number of these priority areas. Many of our local programmes of work are aligned with collaborative work streams, which are focused on streamlining and ensuring consistent processes and reporting across our four acute trusts. For example, the aim to standardise the way we work to improve patient outcomes has resulted in shared guidelines for managing acute deterioration and suspected sepsis in adults, aligning all four trusts with the updated national guidance, which shifts the emphasis from screening to continuous observation and targets high risk patients.

Our patient safety incident response plan: national requirements

Some events that may occur in healthcare require a specific type of response as set out in national policies or regulations. This may include review or referral to another body or team, depending on the nature of the event.

Table 1 (below) sets out the local or national mandated responses to patient safety events:

	National Patient Safety Event Priority	Required response	Lead body for response
1	Incidents that meet the Never Event List (2018)	PSII	CWFT
2	Deaths clinically assessed as thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	CWFT
3	Maternity and neonatal incidents meeting the Maternity Investigation programme criteria or Special Healthcare Authority (SpHA) when in place e.g. incident meeting Each Baby Counts criteria	Referred to Maternity & Newborn Safety Investigations (MNSI) or Special Health Authority (SpHA) for independent patient safety incident investigation	MNSI (or SpHA)
4	Child deaths	Refer for Child Death Overview Panel review May require locally-led PSII (or other response) in addition to panel review	Child death overview panel CWFT if PSII (or other learning response as required)
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) May require locally-led PSII (or other response) in addition to panel review	LeDeR Programme CWFT if PSII (or other learning response as required)
6	Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child	Refer to your local designated professionals for child and adult safeguarding

	Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response, including confirmation of method to be used. See: Guidance for managing safety incidents in NHS screening programmes	CWFT
8	Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations.	PPO or IOPC
10	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Locally-led PSII (by lead organisation)	CWFT
11	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

Our patient safety incident response plan: local focus

Not all patient safety incidents require a comprehensive investigation (e.g. a PSII) but may instead benefit from different types of learning response to gain insight or address queries from the patient, family, carers or staff. Where this is the case, CWFT will consider other learning response techniques such as an after action review, mortality review or thematic review. Further information relating to learning response tools can be found on the national PSIRF website NHS England » Patient Safety Incident Response Framework.

Our local priorities outlined in table 2 below provide a list of key patient safety risks and themes which have been identified for pre-defined learning responses. This list has been developed based on the following criteria:

Potential for harm / future harms:

- People: physical, psychological, loss of trust (including impact on patients, family & caregivers)
- Service delivery: impact on the quality and delivery of healthcare services; impacts on service capacity
- Public confidence: including political attention and media coverage.

Potential for learning and improvement

Likelihood of occurrence:

- Persistence of the risk
- Frequency
- Potential to escalate

These pre-defined responses DO NOT mean these are the only events the Trust will be responding to; we will continue to review and respond to every incident report, ensuring the most appropriate learning response is being initiated. No harm and low harm incidents, not defined as a local priority within our plan, will follow our local incident management policy for local review and learning will be used to inform ongoing areas of improvement at local, divisional or trust-wide level.

A review of safety learning across each division and service is undertaken on a quarterly basis via the Patient Safety Group to ensure trends and themes are robustly identified and used to inform our existing local priorities and approach to PSIRF.

For West London Children's Healthcare (WLCH), in addition to the national requirement for every child death to go through a regional panel and Trust mortality review processes, it has been agreed that a PSII will only be required when escalated via the CWFT process for proportionate decision making – see appendix 1.

In addition to the relevant local priorities identified in table 2 below, WLCH will also be focusing learning responses and their specific safety improvement programmes on streamlining of paediatric pathways and the management of sepsis in paediatrics.

For the next 12-18 months from October 2025, Table 2 (below) sets out our local priorities:

Theme	Description of safety incident	*Planned response*	*Improvement route*
Escalation	Incidents resulting in moderate harm, severe harm, death as escalated by divisional leads *(response type will interact with themes identified below***)*	***Initial Incident Review (IIR), learning response agreed at IIRG****	*PSG** to inform our understanding of contributory factors to inform safety improvement plan*
Falls	Patient falls resulting in severe harm or death	***IIR, Learning response agreed at IIRG***	*Create safety actions and feed these into Falls Steering Group*
Diagnosis & Diagnostics	Delayed diagnosis of cancers and delays within diagnostic pathways	***PSII or Thematic Review***	*Create safety actions and feed these into Cancer Board & PSG*
Treatment	Sub-optimal escalation / response to a deteriorating patient	***PSII or Thematic Review***	*PSG and relevant group confirmed on completion of PSIIs*
Surgical	Delay / failure to recognise complication of treatment or procedure resulting in severe harm or death	***IIR, Learning response agreed at IIRG***	*PSG and relevant group confirmed on completion of PSIIs*
Appointments	Issues with patient appointment management (including follow-up)	***IIR, Learning response agreed at IIR Group***	*Create safety actions and feed these into Patient Access Group*
Medication	Controlled drug incidents resulting in moderate / severe harm or death	***IIR, Learning response agreed at IIRG***	*Create safety actions and feed these into Medicine Safety Group*
Pressure ulcers	Pressure damage >2 and unstageable hospital acquired	***IIR, Learning response agreed at IIRG***	*Create safety actions and feed these into Pressure Ulcer Group*
Maternity cases (that do not meet MNSI criteria)	Maternity incidents resulting in severe harm or death or as escalated by divisional leads	***IIR, Learning response agreed at IIRG***	*Create safety actions and feed these into Local Maternity Services Network (LMNS)*
Infection, Prevention & Control (IPC)	Healthcare acquired infections (HCAI) and issues with infection control procedures	***HCAI Learning Response for Outbreaks***	*Create safety actions and feed these into IPC Group*
Discharge	Delayed discharge of medically optimised	***IIR, Learning response agreed at IIRG***	*Create safety actions and feed these into Clinical Effectiveness Group*

** Initial Incident Review Group*
*** Patient Safety Group*
**** These incidents will continue to be managed in accordance with our Incident Management policy*

Types of incident response

The Patient Safety Incident Response Framework (PSIRF) does not mandate a single model of incident response (with the exception of national priorities and Never Events); instead it is for the Trust to determine the most appropriate response type.

The Trust will utilise a range of potential responses including; comprehensive Patient Safety Incident Investigations (PSIIs), thematic review into previous learning, After Action Reviews (AARs) with those involved; or we may determine that no individualised response is needed.

By carefully determining when an individualised response is needed (or not needed) the Trust will be able to make the best use of its resources to focus safety improvement efforts in areas where they will have the most benefit. Types of incident response include (but are not limited to):

Initial Incident Review (IIR)
IIRs are a process used to gather additional information about an event, which includes consideration of:

- compassionate engagement with people involved with / affected by an incident
- proportionate decision making and events alongside the Patient Safety Incident Response Plan (appendix 1)
- systems-based review and learning from an incident
- identifying and providing assurance of immediate improvement actions being taken

The IIR can be used as a stand-alone learning response where actions can feed into existing safety improvement programmes of work.

Patient Safety Incident Investigation (PSII)
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients. All PSIIs are reported externally and will be notified to the ICB accordingly.

After Action Review (AAR)
AAR is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It is a structured, professional discussion involving the staff who may be directly involved. It aims to capture learning from such events to avoid failure and promote success for the future. The AAR objectives are:

- To ensure the AAR focuses not on accountability but on learning
- To set out the responsibilities of staff participating in AAR
- To explain how AAR works and the requirements to carry out a successful review
- To provide assurance of the governance around shared learning from AAR

Cases matching a local priority will be considered for AAR at the weekly Initial Incident Review Group (appendix 1).

Multi-Disciplinary Team (MDT) Review
MDT reviews are an in-depth discussion of one or multiple patient safety incidents. They provide a structured, professional discussion involving senior staff representation from different disciplines.

The purpose of an MDT review is to:

- Identify learning from one or multiple patient safety incidents
- Agree the key contributory factors and system gaps in patient safety incidents
- Explore a safety theme, pathway or process
- Gain insight into 'work as done' in a health and social care system

Thematic review
A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use a combination of qualitative (e.g. incident reports, open text survey responses, and information sourced through conversations and interviews) and quantitative data (e.g. operational metrics, closed survey responses, audit, and other numerical information sources) to identify safety themes and issues.

Thematic review will be undertaken in the following ways:

- Collating data from different datasets (for example incidents, complaints, claims, and operational performance) to inform the on-going development of the Trust's patient safety incident response plan.
- Analysing a patient safety theme to identify issues and trends using qualitative and, sometimes, quantitative data.
- Triangulating and synthesising data to inform or assess the impact of patient safety improvement plans.
- Thematic reviews will be scheduled across the year to ensure there is sufficient time for participation, understanding and cascade of learning via our safety groups and committees.

PITSTOP Debrief
A PITSTOP is a structured process whereby a team comes together when needed so they can continue to work safely and effectively. It is intended to be brief, and most importantly supportive and encouraging.

PITSTOP can be led by any senior manager who will act as the Trust's safety culture champion.

The aims of the PITSTOP are:

- To provide a safe, supportive, inclusive and collaborative environment
- To allow everyone to share (but sharing is not compulsory) without providing space for arguments, accusations or criticism

- To ensure kindness and encouragement are at the centre of the process
- To empower everyone to share their experiences of the event without judgement, regardless of their role

These learning response processes and how they will be applied by divisions at CWFT will be described in detail within our Incident Management Policy; we expect our approach to incident responses to develop further as we embed PSIRF.

Training for staff on the use of these and other templates is being offered through NHSE accredited training providers, acute provider collaborative networks, patient safety specialists and through shared learning from early adopters.

Leading our response to patient safety incidents

The following groups will steer our response to patient safety incidents and ensure we deliver our PSIRF aims and objectives within an environment that has been collaboratively crafted, created and nurtured. Individual staff, teams, patients, service users, families and carers can then begin to flourish through our:

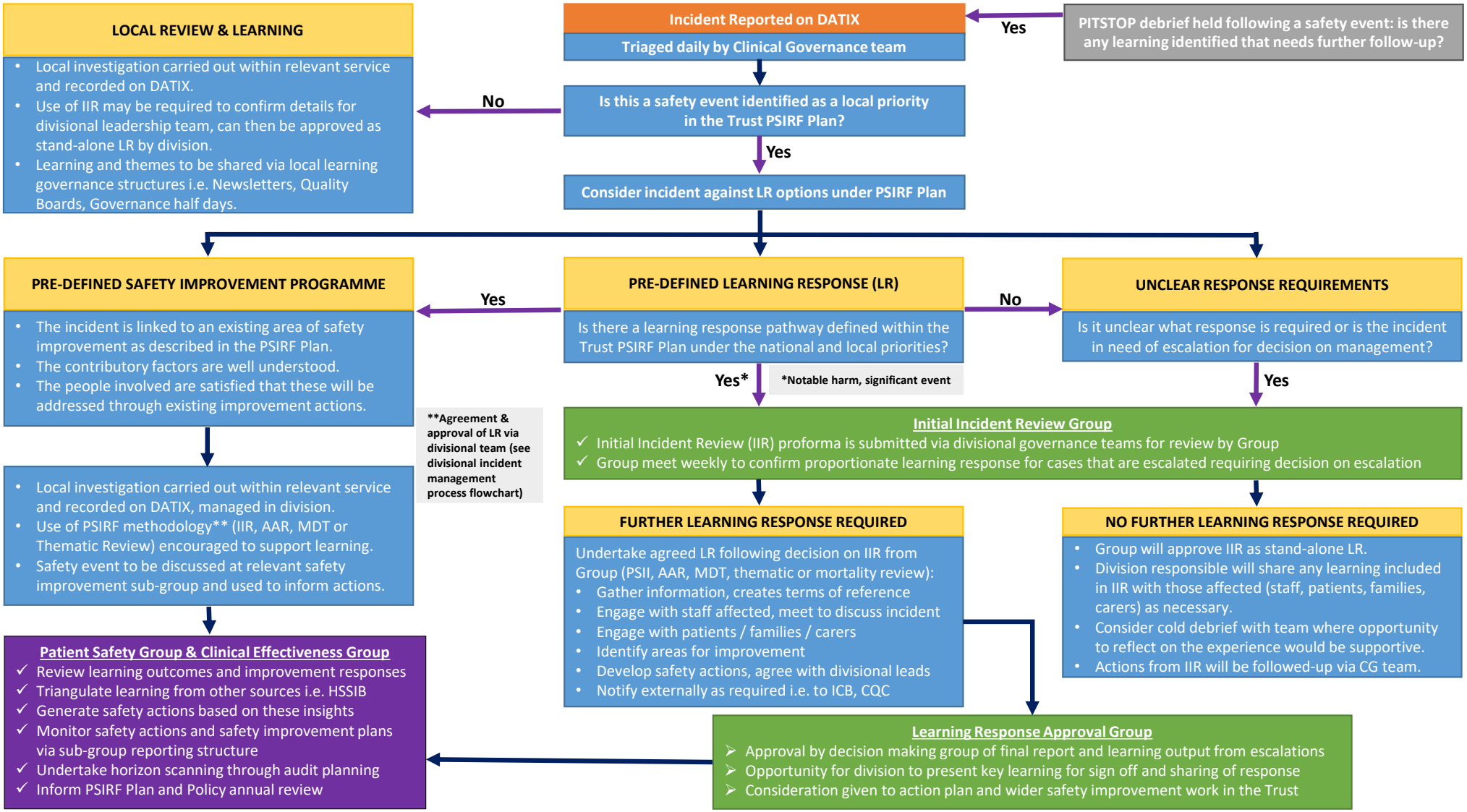
- Continuous learning and improvement culture
- Supportive, psychologically safe teamworking ethos
- Empowerment of everyone to speak up and get involved in safe care delivery

Accountabilities for delivery of this plan are set out in Table 3 (below) and are demonstrated in Appendix 1.

Group	Purpose
Initial Incident Review Group (IIRG) Frequency: weekly Co-chaired by the Chief Nursing Officer and Chief Medical Officer with membership from across our clinical divisions.	Leads on proportionate incident response decision making (supported by IIRs), in line with the Patient Safety Incident Response Standards. The purpose of the group is to review and direct responses for newly reported safety events with a focus on: • Incidents requiring comprehensive PSII response (as defined by the national priorities or local PSIRP) • Incidents that have been reported as leading to moderate, severe or fatal harm • Incidents where additional concerns have been raised by those involved • Incidents that are linked to recurring themes or hotspots • Incidents that are being escalated through divisional teams

Learning Response Approval Group (LRAG) Frequency: weekly Co-chaired by the Chief Nursing Officer and Chief Medical Officer	Reviews the outcomes of our PSIIs and other learning responses initiated by the IIRG. The purpose of the group is to provide an opportunity to: • Review PSIIs and learning responses to scrutinise and assess report content including robustness of investigation and recommendations • Make recommendations to PSG for the progression of safety actions and improvements • Provide executive sign-off for learning response reports that require external sharing i.e. ICB or coroner
Patient Safety Group (PSG) Frequency: monthly Chaired by the Chelsea Site Medical Director with members from across our clinical divisions. *(*Some actions will be monitored via Clinical Effectiveness Group which also occurs monthly and is chaired by the West Middlesex Site Medical Director)*	Brings all our safety learning work streams together and provides challenge to sub-groups demonstrating assurance of our safety learning approach. The purpose of this group* is to: • Review learning response and improvement response outputs, including potential safety actions, contributory factors and triangulate with other data • Review of progression and barriers to completion of safety actions and improvement plans • Review learning outputs from across the Trust (irrespective of response type) to ensure emerging trends, issues and hotspots are being robustly identified • Identify opportunities for adoption and spread • Where applicable, generate safety actions based on insight and prioritise • Inform the review and updates of this document

Appendix 1 - Incident response decision making process



Glossary – meaning of terms we have used

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with divisions and specialist risk leads and partners supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSA – Patient safety audit

A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guideline).

PMRT - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care; Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Deaths thought more likely than not, due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local Learning from Deaths plan or following reported concerns about care or service delivery.