



Patient Safety Incident Response Plan 2026/28

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Introduction

This patient safety incident response plan sets out how University Hospitals of NHS Trust (the Trust) intends to respond to patient safety incidents over a period of 2 years. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on reporting, management, review and learning from incidents (B30/2024) and the Trust patient safety incident response policy (B16/2024).

Our Patient Safety Incident Response Plan (PSIRP) is integral to the implementation of PSIRF and aligns with the UHL vision to be leading in healthcare and trusted in communities and the strategic priorities; high-quality care for all; being a great place to work; partnerships for impact, and research and education excellence.

<https://www.uhleicester.nhs.uk/about/trust/mission-vision-values/>

This PSIRP is also a key part of Continuous Improvement Culture Development and supporting strategy which outlines how we will develop our Improvement culture across the Trust by placing the patient first when designing and improving our systems and services, whilst investing and developing our staff so our Trust can continue to improve.

| UHL Strategic priority | PSIRF theme |
|-----------------------------------|---|
| High quality care for all | The PSIRF is all about improving patient safety and aligning this with quality improvement work, which is an integral part of quality and is at the forefront of everything we do. |
| Being a great place to work | The PSIRF includes a whole framework for meaningful engagement and involvement of patients, families and staff following a patient safety incident. We will be working on creating a just and restorative learning culture for staff when an incident occurs. |
| Partnerships for impact | In seeking those in-depth insights into our safety systems across the local healthcare system, PSIRF will help us reduce unwanted variation and feed those insights into continuous improvement work. |
| Research and education excellence | The essence of PSIRF is about building capability within all staff groups with the provision of the required patient safety training to be able to respond and learn from patient safety incidents. Consideration of research to support further understanding of our local priorities. |

Our services



University Hospitals of Leicester NHS Trust (UHL/the Trust) was established on 1st April 2000, from a merger of three previously separate hospitals - Leicester Royal Infirmary, Glenfield Hospital, and Leicester General Hospital.

Our organisation is formed of seven Clinical Management Groups ('CMGs') that are supported by several corporate directorates. The Clinical Management Groups are:

- Cancer, Haematology, Urology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Clinical Support and Imaging
- Renal, Respiratory and Cardiovascular
- Intensive/Critical Care, Theatres, Anaesthesia, Pain and Sleep
- Women's and Children's

The corporate directorates are:

- Corporate Medical
- Corporate Nursing
- Corporate Operations
- Finance
- People and Organisational Development
- Estates and Facilities
- Communications and Engagement
- Information Management and Technology
- Corporate and Legal Affairs
- Reconfiguration, strategy, transformation

The CMGs and corporate directorates are overseen by our Trust Leadership Team and Trust Board.

Aims and Objectives of PSIRF at UHL

There are four overarching aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based which support the development and maintenance of an effective patient safety incident response system. Specific objectives have been set in order to ensure that we meet the overarching aims of PSIRF:

Figure 1. Overarching aims and objectives for PSIRF at UHL

| Overarching Aims | Objectives |
|---|--|
| <p>1. Compassionate engagement and involvement of those affected by patient safety incidents</p> | <ul style="list-style-type: none"> • Develop a climate that supports a just and restorative learning culture and an effective learning response to patient safety incidents • Respond to patient safety incidents purely from a patient safety perspective • Support and involve staff affected in patient safety incident responses, for better understanding of the issues and contributory factors • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting Duty of Candour |
| <p>2. Application of a range of system-based approaches to learning from patient safety incidents</p> | <ul style="list-style-type: none"> • Recognise that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component • There is no remit to apportion blame or determine liability, preventability or cause of death in a response to a patient safety incident conducted for the purpose of learning and improvement. |
| <p>3. Considered and proportionate responses to patient safety incidents</p> | <ul style="list-style-type: none"> • Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement |

4. Supportive oversight focused on strengthening response system functioning and improvement

- Reduce the number of duplicate investigations into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors
- Aggregate and confirm validity of learning and improvements by basing PSIs on a small number of similar repeat incidents
- Consider the safety issues that contribute to similar types of incidents
- Better measurement of improvement initiatives based on learning from incident response.
- Develop system improvement plans across aggregated incident response data to produce systems-based improvements

Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into improvement workstreams over a period of years. We have a monthly Executive-led Patient Safety Committee and a Patient Safety Learning and Improvement Committee that allows triangulation of themes from incidents, learning from death reviews, patient feedback (complaints/PALS), inquests and claims.

In November 2025, we identified the period 1st April 2023 to 31st June 2025 for our thematic data analysis. Over a period of four months, we undertook a comprehensive analysis of our current patient safety risk profile across all services within UHL.

Stakeholder engagement

A collaborative stakeholder workshop was held in November 2025 that involved UHL and integrated care system (ICB) colleagues and one of our Patient Safety Partners to generate our second PSIR plan local safety priorities. The stakeholders presented their top themes, followed by discussion of what could be the agreed themes for our local priorities in the second PSIR plan. The following key themes were identified:

- Communication failures
- Delays and timeliness
- Medication safety
- Care fundamentals and dignity
- Handover and transitions of care
- Environment and flow
- Recognition and escalation

The stakeholder workshop culminated in producing a set of priority areas which required further discussion and refinement by the Patient Safety Specialists, taking into account current priorities and improvement to date. The next stage of the process was to engage with CMG colleagues to agree the focus for our improvement work and local PSIs. This was completed by requesting feedback on a draft set of priorities from those staff that had attended the workshop.

Data sources

To define our patient safety response profile, we drew data from a variety of sources. The UHL patient safety risks were identified through the following data sources for 2023-25:

- Analysis of three years' of Datix incident data (including prevented incidents)
- Detailed thematic analysis of learning themes from our PSIs
- Key themes from complaints, PALS concerns, claims & inquests
- Key themes identified from specialist committees (e.g. deteriorating patient, falls, pressure ulcers)
- Themes from the Learning from Deaths reviews
- Key themes from medication safety incidents
- Key themes from the learning from MNSI investigations and perinatal mortality reviews
- Key themes from risks on the risk register
- Key themes from Infection Prevention incidents
- Key themes from Safeguarding reviews and LeDeR reviews
- Key themes from clinical audit

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshop, we also considered any new and emergent risks relating to operational pressures and changes in demand that the historical data does not reveal.

Defining our patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- Existing Transformation Programme priorities
- Existing Patient Safety Improvement Programme priorities eg deteriorating patient
- Perinatal Safety Improvement Programme
- Trust-wide quality improvement projects registered on UHL Audit & QI Programme (AQIP)
- Trust-wide operational improvement work eg Criteria led discharge
- ICS operational improvement projects eg virtual wards
- National Patient Safety Improvement Programmes eg maternity and neonates improvement programme
- East Midlands Patient Safety Collaborative Programmes

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative learning culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below:

| Patient Safety Incident Type | Required Learning Response | Lead body for response |
|--|--|------------------------|
| Incidents meeting the Never Event criteria | Patient Safety Incident Investigation (PSII) or proportionate response (interim consultation on Never Event framework guidance) | UHL |
| Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII) | Patient Safety Incident Investigation (PSII) | UHL |
| Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria. | Refer to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) for independent patient safety incident investigation | MNSI |
| Death of a person with learning disability | Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death | LeDeR programme |

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| Child death | Refer to Child Death Review process. If incident meets the learning from deaths criteria for PSII. | Child Death Overview Panel/UHL |
| 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 (incidents meeting the learning from deaths criteria) | Patient Safety Incident Investigation (PSII) | UHL |
| Incidents in NHS screening programmes | Refer to local screening quality assurance service for consideration of locally led learning response | UHL |
| Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence | Refer to local authority safeguarding lead via UHL Safeguarding Lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards | UHL |
| Hospital acquired infections resulting in harm | Refer to Infection Prevention Team and use of appropriate learning response | UHL |
| Incidents meeting the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) | Refer to the relevant Medical Physics Expert and use of appropriate learning response | UHL |

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|--|---|-----|
| Incidents meeting criteria for reporting to the Human Tissue Authority (HTA) | Refer to designated HTA lead and use of appropriate learning response | UHL |
| Transfusion incidents meeting criteria for Serious Hazards of Transfusion (SHOT) reporting | Refer to designated Blood Transfusion lead and use of appropriate learning response | UHL |

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our data insights, based on the review of incidents and stakeholder engagement process we have determined that the Trust requires 5 patient safety priorities as local focus. We have selected this number due to the breadth of services that the Trust provides. The local patient safety incident investigation (PSII) priorities link to the improvement priorities but are specific areas that we feel we would want to examine further to inform our improvement work by undertaking a PSII. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors that also featured as broader themes from our analysis work.

We will use the outcomes of PSII's to inform our patient safety improvement planning and work.

UHL Local Priorities

Trust wide patient safety improvement priorities

Based on the thematic work undertaken, the following priorities for improvement are being undertaken. These areas represent key themes across multiple data sets, but also where we already have good insight into system contributory factors.

| Priority | Definition | Executive Lead/Owner | Clinical/Operational Leads | Known contributory factors | Improvement focus |
|---|--|----------------------|---|--|---|
| 1. Delays in escalation & deterioration management | Improve early recognition and timely escalation for acutely unwell patients | Chief Nurse | Deteriorating Patient Board Chair; Sepsis Leads; Heads of Nursing & Midwifery, Clinical Directors | Cultural and practical barriers to incorporating family and carer concerns. | Implementation of the three aims of Martha's Rule - further clarity and communication on role and responsibilities |
| | | | | Identification of sepsis can be challenging due to vague symptoms which can mirror symptoms of other conditions. | Development of adult and paediatric sepsis guidelines and training programmes. Skin perfusion made a mandatory observation |

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|---|--|--------------------------------|--|--|--|
| | | | | There is limited oversight or assurance around patient monitoring outside of patient safety incident reports to provide a safety II and proactive approach to driving improvement. | To develop and implement a deteriorating patient performance dashboard based on the monitoring, recording, recognition and escalation of acutely unwell patients. Train staff on family/carer escalation pathways. |
| 2. Harm from inappropriate care location | Reduce risk from outlying patients and care in corridor care spaces | Chief Operating Officer | UEC Transformation Board; Flow Managers; ED Clinical Leads; CMG Triumvirates | Patients with vulnerabilities being outlied and moved at all hours of the day and night | Set a 'redline' policy for night-time moves of vulnerable patients. Expand flow coordination teams and escalation protocols. Monitor crowding patient safety and experience metrics and corridor care usage. Implement real-time bed management tools. |
| 3. Delay in diagnosis and /or treatment | Ensure timely senior review and reliable | Medical Director | Clinical Directors, Heads of Service; CMG | Unwarranted variation in ward round processes | EPR programme, aim to achieve a single patient record by 2028. Ward round checklist and time-bound senior review. |

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|--|--|---|---|---|--|
| (ward rounds, handovers) | handovers that progress care | | Q&S Leads; EPR Clinical Champions | Unwarranted variation in medical handover processes | Structured handover in EPR. Implement use of SBAR. |
| 4. Failure to act on results post discharge/outpatients | Ensure timely review and actioning of test results after discharge or outpatient visits | Medical Director | Pathology & Radiology Leads; Clinical Directors; Heads of Service; ACP lead; EPR Team | Speciality unwarranted variation in results management | Implementation of order comms into outpatients. Consideration of implementing digital alerts and reminders in EPR. Assign clear accountability for result review. Regular audits and closed-loop communication checks. Consideration of how EPR patient portal can support results management. |
| 5. Delay/omission of time-critical medication | Improve safe and timely administration of essential medicines (incl. anticoagulation) | Chief Pharmacist & Chief Nurse | Medicines Optimisation Committee; Ward Pharmacy Leads; Digital Medicines Team | Staff and patient knowledge of anticoagulation medication safety | Development of staff education programme. Development of patient information (working with Patient Safety Partner) |
| | | | | Electronic prescribing system could provide better functionality to improve time critical medicine safety | Development work with E-Meds to provide solution for paused medications and a reminder to review medication |
| | | | | There is limited oversight or assurance around | Work to agree indicators and develop a medication safety dashboard. |

| | | | | | |
|--|--|--|--|--|--|
| | | | | <p>the administration of time critical medication outside of patient safety incident reports to provide a safety II and proactive approach to driving improvement.</p> | |
| | | | | <p>Absence/inconsistency in standards for patient identification</p> | <p>Implement Scan4Safety for medicine administration into inpatient areas.</p> |

Local patient safety incident investigation (PSII) priorities (linked to our improvement priorities)

The following local patient safety incident investigation priorities represent specific safety challenges where the organisation does not have confidence it has comprehensive insight into the contributory system factors. These link to the improvement priorities but are specific areas that we feel we would want to examine further to inform our improvement work by undertaking a PSII.

| Priority no. | Priority | Speciality | No. of PSII's planned |
|--------------|--|--------------------------------|-----------------------|
| 1 | Delays in escalation and managing deterioration of a patient linked to need to transfer cross site for care | All areas, including Maternity | 1 |
| 2 | Harm or potential for harm relating to a patient not being in appropriate care location due to significant operational pressures and/or crowding in ED | All areas, including Maternity | 2 |
| 3 | Delay in diagnosis or treatment of a patient with a focus on ward round, senior review and handovers | All areas, including Maternity | 2 |
| 4 | Failure to review/act on results after an inpatient discharge or outpatient appointment | All areas, including Maternity | 2 |
| 5 | Delay or omission in administration of time critical medicine for a vulnerable patient (eg dementia, end of life, mental illness) | All areas, including Maternity | 2 |

Through all our PSII's there will be two golden threads in our terms of reference: -

Communication - exploring communication between colleagues, areas, organisations and communication with patient and/or family members.

Empowerment – exploring how we could better empower the patient, family members and our colleagues.

Learning responses for other patient safety incidents (not agreed as local priorities for PSII)

| Patient Safety Incident | UHL Planned Response | Oversight of themes & improvement work |
|---|--|---|
| Inpatient falls resulting in a bone fracture or haemorrhage | Immediate safety huddle and use of appropriate learning response | Falls Steering Group Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee |
| Healthcare associated pressure injury | Use of appropriate learning response | Pressure Ulcer Prevention Group Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee |
| Hospital acquired infections resulting in death | Statutory duty of candour and use of appropriate learning response | Trust Infection Prevention and Control Committee |
| Maternity or neonatal incident with poor outcome (not meeting HSIB referral criteria) | Rapid review and use of appropriate learning response. | Perinatal Assurance Committee Quality Committee |
| Incident resulting in moderate or severe harm to patient | Statutory duty of candour and use of appropriate learning response | Patient Safety Committee |
| All other patient safety incidents | Validation of facts at local level by managers review or immediate safety huddle, local action and shared learning and/or use of appropriate learning response | Patient Safety Committee |
| Identified and emerging increase in incidence of subject of theme which has potential for harm or has caused harm | Thematic review or consider PSII | Patient Safety Committee |

For any incident not meeting the PSII criteria, or any other criteria, we will use a proportionate learning response tool to enable a systems-based review. For lesser or no harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix A - National Learning Response types

| Patient Safety Review (PSR) Type | Methods | Objective |
|--|------------------|---|
| Incident recovery Immediate measures taken to: <ul style="list-style-type: none"> • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carer • Determine the likelihood and severity of an identified risk | Immediate action | To take urgent measures to address serious and imminent: <ul style="list-style-type: none"> • discomfort, injury, or threat to life • damage to equipment or the environment. |
| | Risk assessment | To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied |
| | Timeline mapping | To provide a detailed documentary account of what happened in the style of a 'chronology' |
| | Work system scan | A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (ie barriers and facilitators). |
| Team reviews Post-incident review as a team to: <ul style="list-style-type: none"> • Identify areas for improvement • Celebrate success • Understand the expectations and | Debrief | An unstructured, moderated discussion The simplest and most informal method to gain understanding and insight soon after an incident (debriefs held |

| | | |
|---|--|---|
| <p>perspectives of all those involved</p> <ul style="list-style-type: none"> • Agree actions • Enhance teamwork through communication and collaborative problem solving | | immediately after an incident are known as 'hot' debriefs). |
| | Immediate Safety Huddle (Swarm huddle) | <p>Proactive: a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans.</p> <p>Reactive: triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions</p> |
| | After action review | <p>A 'cold' structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions:</p> <ol style="list-style-type: none"> 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt? |

| | | |
|--|--|---|
| <p>Systematic reviews</p> <p>To determine:</p> <ul style="list-style-type: none"> • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient | <p>Multidisciplinary team (MDT) tabletop review</p> | <p>An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.</p> |
| | <p>Case note review (e.g. Structured Judgement Review)</p> | <p>To determine whether there were any problems with the care provided to a patient by a service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)</p> |
| | <p>Mortality review</p> | <p>A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients</p> |

| | | |
|-------------------|----------------------|--|
| | Specialised reviews | For example, falls, pressure ulcers, IPC reviews |
| Monitoring | Audit | Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both) |
| | Survey | Is the combination of questions, processes and methodologies that analyse data about others. It aims to determine insights about a group of people. |
| | Appreciative Inquiry | Is a positive-focused approach, which looks at what's going right in order to solve problems |

Appendix B - Glossary of terms

PSIRF - Patient Safety Incident Response Framework

This is a national framework applicable to all NHS providers outside of primary care. 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.

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 collaborative approach with the CMGs and specialist process leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation

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.

AAR – After action review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review

Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

Immediate Safety Huddle - Used within Healthcare in the UK and US, an immediate collective or SWARM huddle approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis, take any required immediate actions and to support those immediately involved.

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