Guidance for Maternity, Infant and Child Incidents reported onto the Strategic Executive Information System (STEIS)

1. Introduction

1.1 The reporting of Serious Incidents is detailed in the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and the NHS South of England Process for Reporting and Learning from Serious Incidents Requiring Investigation. These documents cover the types of incident to be reported, by whom, the grade of the incident (in some cases the type of incident dictates the grading), the quality of root cause analysis reports and the monitoring of the timescales that provider and commissioners should adhere to.

1.2 The reporting of maternity, infant and child related incidents is however a complex area involving a number of agencies coupled with parallel statutory responsibilities. This guidance is intended to clarify the reporting requirements for incidents that occur within the South of England. It covers:

- The type of incidents that should be reported on the Strategic Executive Information System (STEIS);
- Who should report incidents on the Strategic Executive Information System (STEIS);
- Timescales for reporting and investigating an incident;
- Closing incidents on the Strategic Executive Information System (STEIS).

1.3 The terms used throughout this document are defined in appendix 1.

2. When to report – the types of incidents that should be reported onto the Strategic Executive Information System (STEIS)

2.1 The following types of maternity, infant and child incidents should be reported onto the Strategic Executive Information System (STEIS). This is in line with the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and the NHS South of England Process for Reporting and Learning from Serious Incidents Requiring Investigation.

Incident Category	Description
Child Abuse (family) **(Grade 2 incident)**	To be reported where a local multi agency /organisational review has identified a failure in the duty of care by a health professional or organisation. To be reported when this has been a factor in a child death or a child has suffered significant injuries either in the past as a missed opportunity or currently.
Child abuse (institutional) **(Grade 2 incident)**	Abuse or neglect of one or more children by one or more perpetrators in an institutional setting where there is a health professional linked to the institution (this would include a school, nursery, child minder etc) and children who are looked after in a residential setting or an inpatient in a health care setting.
Child Abuse (multiple) **(Grade 2 incident)**	Networked abuse of one or more children by one or more perpetrators and where multiple complex and abuse procedures are initiated, e.g. paedophile ring, child trafficking etc.
Child Death **(Grade 2 incident)**	All unexpected and/or unexplained child deaths up to the age 4 years and 364 days. Unexpected death of a child aged 5 to 17 years and 364 days (where natural causes are not suspected) should be reviewed within 48 hours if: • they are known to additional health care providers; • or where it has been agreed, following the initiation of the rapid response process, that further exploration of the circumstances is required urgently. This includes all children in an institutional setting, e.g. school, youth offenders setting, respite care or secure unit. The death of any child on a child protection plan or looked after child must be reported.
Child Serious Injury	Where there is permanent harm or injury that occurs in a healthcare setting or where healthcare is delivered ***and*** the injury is related to the healthcare delivery that does not involve safeguarding or abuse.
Maternity services - intrapartum death	Unexpected intrapartum death during labour regardless of gestational age where service or clinical factors may have contributed.
Maternity services - intrauterine death	Any intrauterine death at 24 weeks and above where service or clinical factors may have contributed to the outcome.

Incident Category	Description
Maternity services - maternal death (Grade 2 incident)	Any death which occurs during pregnancy or within 42 days of birth, ectopic pregnancy or abortion which is directly or indirectly related to these conditions.
Never Event – Maternal death **(Grade 2 incident)**	Maternal death due to post partum haemorrhage after elective Caesarean section
Maternity services - unexpected neonatal death.	Unexpected death of a baby aged 0-28 days. The requirement is to report unexpected death as the death of a neonate that was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. If there is any doubt, the designated paediatrician for the unexpected death should be consulted. If doubt persists, the incident should be reported until evidence suggest otherwise.
Maternal unplanned admission to ITU	An unexpected admission to an Intensive Care Unit during pregnancy or within 28 days following birth (either flu or pregnancy related) where service or clinical factors may have contributed.
Suspension of maternity services	Any time a decision is made to suspend maternity services regardless of outcome or when the maternity services tries to suspend services and is unable to due to no other units being able to accept transfers.
Unexpected admission to NICU (Neonatal Intensive Care Unit)	Infants > 37 completed weeks of gestation that have a sudden and unexpected collapse following delivery or in the early postnatal period of a previously well infant requiring intensive care (positive pressure ventilator support).
Admission of all under 16s to adult mental health ward	Any such admission should be reported.
Admission of under 18s to adult mental health wards	To be reported when such an admission is not in accordance with the Mental Health Act and makes no specific provision for the needs of the young person.
Safeguarding Vulnerable Child **(Grade 2 incident)**	Any such incident should be reported.
Serious Case Reviews **(Grade 2 incident)**	The initiation of a Serious Case Review is to be reported. An existing STEIS record may be used if this was a health incident and has already been reported. If a case is discussed at the Local

Incident Category	Description
	Safeguarding Children's Board and does not reach the threshold for a Serious Case Review but a local management review involving one or more healthcare organisations/IMR is agreed then this should be reported on the Strategic Executive Information System.
A child with complex care needs failing to obtain their assessed and agreed package of care	To be reported when the health of a child is put at risk.
Allegations against a healthcare worker **(Grade 2 incident)**	All allegations against a health professional or non-professional within the NHS or other providers of NHS care are to be reported following the reporting of the allegation to the local authority designated officer.

3. Who should report maternity, infant and child related incidents on the Strategic Executive Information System (STEIS)

3.1 In all cases, the safety of the child / siblings is paramount. Children should be made safe before reporting the incident. However, it is important that reports are timely and consistent.

3.2 When reporting an incident, the premise of *'right first time'* should prevail in that the organisation who will undertake the majority of the investigation should be the one to report onto the Strategic Executive Information System (STEIS). This may affect the timing of the reports onto the system. Section 4 deals with this issue.

3.3 Deciding on which organisation reports the incident may be complex and differs depending on the circumstances. Appendix 2 details a number of common scenarios and references who should report the incident. Organisations should contact NHS South of England for advice if there is any doubt on who should report a specific incident.

4. Timescales for reporting and investigating an incident

4.1 The National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation states that a reportable incident should be reported within 48 hours from the time the incident is known. However, safeguarding incidents are an exception to this as the full extent of the incident is sometimes not clear until after the initial strategy meeting. Therefore, unless there is media attention, safeguarding incidents should be reported within 48 hours of the strategy meeting taking

place. Where an incident has received media attention, this should be reported immediately as detailed in the NHS South of England Process for Reporting and Learning from Serious Incidents Requiring Investigation.

4.2 If an unexpected child death incident is reported where there are clearly unexplained circumstances / safeguarding concerns (see definitions in appendix 1), these should be reported within the 48 hour timeframe from when the death is known.

4.3 A death which was originally believed not to be suspicious and not therefore reported follows the Child Death Overview Panel (CDOP) process. The Child Death Overview Panel (CDOP), with a fuller picture of the evidence, may decide that there are safeguarding issues and that it should be referred to the Local Safeguarding Children Board Serious Case Review Panel. The panel may then determine that the incident meets the criteria for a Serious Case Review. In this case, the incident should then be reported onto the Strategic Executive Information System (STEIS) and the date of knowledge of the incident will be the date of the referral to the serious case review panel of the Local Safeguarding Children Board.

4.4 The National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation states:

- **Grade 1 incidents** requiring Level 2 (comprehensive) investigations should be completed in up to 45 working days;
- **Grade 2 incidents** requiring Level 2 (comprehensive) investigations should be completed in up to 60 working days;
- **Grade 2 incidents** requiring Level 3 (Independent) investigations should be completed in up to 26 weeks.

4.5 Serious Case Reviews would fall into the Grade 2 / Level 3 category.

4.6 Reporting organisations and Primary Care Trust Commissioners should agree the level of investigation required by making reference to the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and the NHS South of England Process for Reporting and Learning from Serious Incidents Requiring Investigation.

4.7 The Strategic Executive Information System (STEIS) should be kept up to date with relevant information when it becomes available. Reporting organisations and Primary Care Trust Commissioners should review each report within the Strategic Executive Information System (STEIS) on a regular basis, as a minimum every two months.

5. Closing incidents on the Strategic Executive Information System (STEIS)

5.1 Primary Care Commissioners should follow the processes detailed in the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and the NHS South of England Process for Reporting and Learning from Serious Incidents Requiring Investigation when closing incidents on the Strategic Executive Information System (STEIS).

5.2 To close an incident the following must have been completed:

- Investigation, Root Cause Analysis or Serious Case Review Report completed;
- Action plan from the root cause analysis to be logged by the Primary Care Commissioner and managed via the local performance management system;
- The Root Cause/Lessons Learned field on the Strategic Executive Information System (STEIS) completed. If there are no lessons to be learnt for health, for example if there has been little involvement or the care provided has been appropriate, a statement along the lines of 'Systems and processes (or care) have been reviewed and they were found to be effective. There are no recommendations in relation to this incident'.

5.3 Incidents that involve Serious Case Reviews should not be closed on the Strategic Executive Information System (STEIS) until the Serious Case Review has been completed and published on the Local Safeguarding Children Board website. On occasion this will mean waiting until any other processes such as court case or Coroner's inquests have also been completed. In these cases the term 'STOP THE CLOCK' should be entered in the comments section of the Strategic Executive Information System (STEIS) report to enable it to be recognised as a report where closure will be delayed.

Appendix 1

Definitions

Neonate

A child aged between 0 to 28 days.

Unexpected death

Death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death.

Unexplained circumstances

Factors in the environment, history or examination which may give rise to concern about the circumstances surrounding the death. **Examples:** non-accidental injury, environment which highlights issues of neglect.

Please note these examples are not exhaustive.

Appendix 2

Scenarios detailing who should report an incident on to the Strategic Executive Information System (STEIS)

The examples detailed below are not an exhaustive list. Each incident should be dealt with on its own merits. Some examples illustrate specific scenarios, others are more generic. If in doubt, contact the NHS South of England for further advice.

Scenario 1 – unexpected unexplained child death

All deaths of children are reported to the Child death Overview Panel. The rapid response team will investigate the incident and review the care.

If the child is known to the health service (for example under the care of a health visitor or an inpatient in an acute trust) then the organisation whose care the patient was under at the time of the incident will report the incident on to the Strategic Executive Information System (STEIS) as a child death and undertake the investigation. Following the investigation, if there are no suspicious circumstances and no safety lessons to be learned, the Primary Care Trust Commissioner will request that the incident be deleted from the Strategic Executive Information System (STEIS) by the Strategic Health Authority (paragraph 4.3 of this guidance also applies).

N.B. If the child is under 5 years of age, they should be known to their health visitor and as such all cases should be reported for this age group.

Scenario 2 – unexpected explained child death

Example A: a road traffic accident; meningococcal sepsis.

If there are no safeguarding concerns then the incident will be reported to the Child Death Overview Panel but not to the Strategic Executive Information System (STEIS). If there are safeguarding concerns then the Primary Care Trust Commissioner will ensure that the incident is reported onto the Strategic Executive Information System (STEIS) by the appropriate organisation.

N.B. If the child is under the age of 5 years, then this should be reported on the Strategic Executive Information System (STEIS). If the child is over 5 years old an investigation should be undertaken to check if the child is known to another health provider for example CAMHS or disability services. The findings of this investigation will determine if a report is made.

Example B: the (seemingly deliberate) suicide of an adolescent

If the child has been in contact with health services then the report to the Strategic Executive Information System (STEIS) and subsequent investigation should be made by the main provider of those services e.g. the relevant mental health trust.

If the child has not had contact with health services, then the Commissioner should make the report onto to the Strategic Executive Information System (STEIS) and investigate the circumstances of the death. If it subsequently transpires that there are no safeguarding issues then a request will be made to the Strategic Health Authority to delete the record from the Strategic Executive Information System (STEIS)

Scenario 3 – expected and unexplained child death - for example a child expected to die but the cause of death is not explained by the condition (e.g. a malignancy) who dies earlier than is expected or in unexplained circumstances)

In this scenario, the incident should be reported on to the Strategic Executive Information System (STEIS) as a child death by the organisation whose care the patient was under. Following the investigation, if there are no suspicious circumstances and no safety lessons to be learned, the investigation is referred to the Child Death Overview Panel and the Primary Care Trust Commissioner will request that the incident be deleted from the Strategic Executive Information System (STEIS) by the Strategic Health Authority (paragraph 4.3 of this guidance also applies).

Scenario 4 – expected and explained child death - for example a child with malignancy who dies in appropriate circumstances

In this scenario, the incident does not need to be reported on to the Strategic Executive Information System (STEIS) as long as the assessed and agreed package of care has been delivered appropriately.

Scenario 5 – unexpected child death pronounced within an emergency department –

For example a child is brought into the emergency department of an acute trust. The child either requires life saving treatment and subsequently dies or is pronounced dead on arrival

Assumption

The care of the child by the attending staff is within guidelines and there is nothing to suspect the care of the child in the emergency department was substandard (if the standard of care is suspect, the acute trust will report as a patient safety incident).

Outcome

The child death is reported to the rapid response team by the emergency department. The acute trust will report the death to the Child Death Overview Panel and the primary care trust child protection lead who will ensure that the incident is reported onto the Strategic Executive Information System (STEIS) by the primary care commissioner. The primary care trust child protection lead will make enquiries into the child's situation and ensure that an investigation is undertaken. The investigation will involve the acute trust; however the lead investigating authority is the primary care trust commissioner. If there are child safeguarding issues, the incident will be reported to the Local Child Safeguarding Board. Investigations by the Primary Care Trust Commissioner can be undertaken in conjunction with any reporting to other bodies unless specifically prohibited by the Police.

Following the investigation, if there are no suspicious circumstances and no safety lessons to be learned, the investigation is referred to the Child Death Overview Panel and the Primary Care Trust Commissioner will request that the incident be deleted from the Strategic Executive Information System (STEIS) by the Strategic Health Authority (paragraph 4.3 of this guidance also applies).

Scenario 6 – suspected child abuse whilst under the care of an NHS organisation

The incident will be reported on to the Strategic Executive Information System (STEIS) as Child abuse (institutional) by the organisation whose care the child is under.

Scenario 7 – suspected child abuse in the community –

For example, not known to health services but has died or has suffered significant injuries as a result of abuse

This is dependent on how the abuse is uncovered. If it has been discovered by a health worker then it should be reported on the Strategic Executive Information System (STEIS). Where a case is discovered by other agencies, a report on the Strategic Executive Information System (STEIS) will not be necessary, unless either a Serious Case Review is initiated (any Serious Case Review should be reported on STEIS) or there are alleged failings by health agencies or there is media interest in any healthcare provided.