Clinical: Adverse Events
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COUNTIES MANUKAU HEALTH

14 March 2019

[redacted]

E-mail: [redacted]

Dear [redacted]

**Official Information Act (1982) Request**

I write in response to your Official Information Act request dated 27 February 2019. You requested the following information:

- **Copies of all critical incident reports last three months of 2018 - October 1st to December 31st 2018.**
- **Detail of each critical incident report including: date of incident, description of event, review findings and recommendations/ actions.**

Each year, any healthcare related serious adverse events are reported to the Health Quality & Safety Commission New Zealand by all District Health Boards. The HQSC also complete an annual "Learning for Adverse Events" Report. The latest reports, which were published in December 2018, are publicly available and can be found on their website:

- www.hqsc.govt.nz/our-programmes/adverse-events/projects/adverse-events-reports/adverse-events-report-2017-18/

As part of CM Health's commitment to providing safer care for patients, we review all serious adverse events that occur in our organisation. The purpose of reviewing these is to determine the underlying causes of the event so that improvements can be made to the systems of care to reduce the likelihood of such events occurring again.

Serious adverse events reviews at CM Health are undertaken according to the following principles:

- Establish the facts: what happened, to whom, where, how and why.
- To look for improvements in the system of care rather than apportion blame to individuals.
- To establish how recurrence may be reduced or eliminated.
- To formulate recommendations and an action plan.
- To provide a report as a record of the review process.
- To provide a means of sharing learning from the incident.

The latest CM Health report is published and publicly available. This can be viewed at:

- www.countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/CM-Health-Serious-Adverse-Events-Report-2017-2018.pdf

Adverse events are often complex, and require investigation and review, which can take time (typically months), and need to consider the complexity of each clinical situations, sometimes with independent review. The Critical Incident Reports that form the basis on these investigations reports include significant details about individuals, with who we also work to ensure consent for release of information occurs. This is because the detail relating to the individuals would be sufficient to enable their identification. The withholding of this information until that consent process is complete is necessary to protect the privacy of those individuals concerned, who are at the centre of the reviews.

Investigation of incidents occurring between Oct-Dec 2018 is not yet complete, and therefore at this time we are unable to provide copies of reports. Any incidents investigations that are determined to meet the criteria of a serious adverse event will have details included in our 2018/19 report, to be released in December 2019.

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
**Chief Executive**