Lothian NHS Board

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Your Ref
Our Ref 12022

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Dear

FREEDOM OF INFORMATION – SIGNIFICANT ADVERSE EVENT REVIEWS

I write in response to your request for information in relation to *significant adverse event reviews.*

Question:

- *I am looking for information about serious adverse event reviews that have been carried out by your health board in the last three and a half years. Can you provide me with the following information for the time periods:*
  - *2023*
  - *2024*
  - *2025*
  - *1 January 2026 to the date of this request*

For each year, please provide:

1. The total number of Serious Adverse Event Reviews (SAERs) undertaken by the Health Board.

Answer:

There were 2,910 Significant Adverse Events (Major Harm & Death)* reported by NHS Lothian for the period 01/01/2023 to 07/10/2026 (Date of FOI) broken down by Type of Review and Calendar Year.

Type of Review	2023	2024	2025	2026
Level 1 SAE Review	87	81	54	43
Level 2 Comprehensive Case Review (CCR)	0	0	0	≤5
Falls Review	200	170	195	132
Pressure Ulcer Review	28	25	27	20
Pressure Ulcer developed outwith NHS Lothian Care	23	20	9	≤5
Perinatal Mortality Review Tool (PMRT)	42	47	51	36
Maternity/Neonatal Comprehensive Case Review	≤5	≤5	7	11
Child Death Review	24	30	17	11
Child Death Review - other Board	0	7	≤5	≤5
Structured Mortality Review (pre 01.09.26)	36	46	57	34
Theatre & Anaesthetics Review (pre 01.09.26)	14	16	17	≤5

Local Adverse Event Review (pre 01.09.26)	46	71	65	31
Local Case Review (Mental Health) (pre 01.09.26)	179	200	185	140
Expanded Local Case review (Mental Health) (pre 01.09.26)	16	20	9	≤5
Hospital Acquired Infection (HAI) Death (pre 01.09.26)	15	14	7	≤5
Case Note / Tabletop Review (pre 01.04.23)	21	0	0	0
Cath Lab Death (pre 01.04.23)	≤5	0	0	0
Other - Type of Review to be decided	0	0	0	24

In NHS Lothian, all events where a person is harmed or there was potential for harm are recorded on DATIX. NHS Lothian classifies Serious Adverse Events (SAEs) as those resulting in a severity of Major Harm or Death. All SAEs are reviewed for learning and an improvement plan put in place and implemented if relevant.

Please note that we record and review all unexpected deaths, including people who have been in touch with substance misuse or mental health services in the 12 months prior to their death. It should also be noted that all children's deaths, whether expected or not, including those in the community, who may have had no previous contact with children's health services, are recorded and reviewed. These events will be included in the figure and in the table above.

* Major Harm defined as – Intervention required to sustain life / long term incapacity or disability requiring medical treatment and/or counselling (e.g. All fractures with exception of fingers and toes)

To protect the identity of the individuals involved any figure of 5 or less has not been shown in the table above. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018).

Question:

2. *The total number of Serious Adverse Event Reviews (SAERs) undertaken by the Health Board which were carried out following a death.*

Answer:

There were 1446 Death Serious Adverse Events reported by NHS Lothian for the period 01/01/2023 to 07/10/2026 (Date of FOI) broken down by Calendar Year.

Severity - level of harm	2023	2024	2025	2026
Harm to a person -death	380	408	369	289

Question:

3. *The total number of reviews in Q1 and Q2 that had recommendations in each of the years specified.*

Answer:

Information is not recorded in a way that would allow this question to be answered without reading through all 2910 adverse events.

Question:

4. *I am also looking to quantify the number of suicide reviews, which are not covered by the figures on SAERs above*
   For each year, please provide:
   - *The total number of suicide reviews **that are not covered by the previous question** undertaken by the Health Board.*
   - *The total number of suicide reviews **that are not covered by the previous question** undertaken by the Health Board which were carried out following a death.*
   - *The total number of reviews in Q1 and Q2 that had recommendations in each of the years specified.*

Answer:

All Suicides are already included in the above data.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive