LC Paper No. CB(2)1764/11-12(01)

Our ref: FH/H/1/5 Pt 93
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12 April 2012

Ms Elyssa Wong
Clerk to Panel
Panel on Health Services
Legislative Council Secretariat
Legislative Council Complex
1 Legislative Council Road
Central, Hong Kong

Dear Ms Wong,

Handling of medical incidents in public hospitals

At the Panel meeting held on 9 January 2012, the Hospital Authority (HA) was requested to provide information on the trend of each category of sentinel and serious untoward events since the implementation of the Advanced Incidents Reporting System (AIRS) in 2004 (item 9 of the list of follow-up actions (LC Paper No. CB(2)1286/11-12(02) refers). I now attach the relevant information at ***Annex*** for your reference please.

As can be seen from the ***Annex***, while there may be fluctuation in the number of individual sentinel and serious untoward events over the reporting period, the overall figures remain largely steady.

Yours sincerely,

(Ms Angela Lee)
for Secretary for Food and Health

Encls.

c.c. Chief Executive, Hospital Authority (Attn: Mr Fred Chan)

Annex

Number of Sentinel Events in HA
(1 October 2007 to 30 September 2011 [Note])

	Reportable Sentinel Events	**From 1 Oct 07 to 30 Sept 08** (12 months)	**From 1 Oct 08 to 30 Sept 09** (12 months)	**From 1 Oct 09 to 30 Sept 10** (12 months)	**From 1 Oct 10 to 30 Sept 11** (12 months)
1.	Surgery / interventional procedure involving the wrong patient or body part	5	10	5	3
2.	Retained instruments or other material after surgery / interventional procedure	10	13	12	18
3.	ABO incompatibility blood transfusion	1	0	0	1
4.	Medication error resulting in major permanent loss of function or death	0	0	1	1
5.	Intravascular gas embolism resulting in death or neurological damage	0	0	1	0
6.	Death of an inpatient from suicide (including home leave)	25	15	11	20
7.	Maternal death or serious morbidity associated with labour or delivery	1	2	2	1
8.	Infant discharged to wrong family or infant abduction	1	0	0	0
9.	Other adverse events resulting in permanent loss of function or death (excluding complications)	1	0	1	0
	Total Number	**44**	**40**	**33**	**44**

Number of Serious Untoward Events in HA
(1 January 2010 to 30 September 2011 [Note])

	Reportable Serious Untoward Events	**From 1 Jan 10 to 30 Sept 10** (9 months)	**From 1 Oct 10 to 30 Sept 11** (12 months)
1.	Medication error	72	88
2.	Patient misidentification	9	9

Note: HA first piloted the AIRS in Prince of Wales Hospital in 2004 for the reporting of medical incidents. The system was rolled out to include all hospitals and clinics in April 2007. Subsequently, the territory-wide Sentinel Event Policy was implemented in 1 October 2007 and was updated as Sentinel and Serious Untoward Event Policy in 1 January 2010. Territory-wide statistics on the two types of reportable events are hence available from the respective effective dates.