Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

Deputy Peadar Tóibín
Aontu
Dáil Éireann
Leinster House
Kildare Street, Dublin 2

30th July, 2025

Re: PQ 41106/25

Dear Deputy Tóibín,

Thank you for your question:

To ask the Minister for Health the number of adverse incidents that were recorded in each CAMHS region 2018 to 2025; and the nature of adverse incidents.

I refer to your parliamentary question above which has been referred to HSE Quality and Patient Safety Incident Management for response. I can provide incident data recorded on the National Incident Management System (NIMS).

Incident Reporting in the HSE

The HSE is actively encouraging incident reporting by its staff. High levels of incident reporting, in particular near-miss reporting and no harm incident reporting, are a good indicator for a positive patient safety culture. Whilst there are flaws in relation to incident data, it can be a good indicator for risks in the health and social care system. Importantly, incidents provide an opportunity for learning and improvement.

Over the last number of years the HSE has been driving and encouraging incident reporting through a number of strategies. Primarily, it is a HSE policy requirement for all staff to report incidents as set out in the HSE Incident Management Framework. Additionally, the HSE has established a national platform to share learning from patient safety incidents 'Patient Safety Together (PST)'. PST is freely accessible to all. It closes the loop on incident reporting and demonstrates to staff (and the public) that reporting incidents leads to learning and improvement on a national scale. Another key area the HSE has been focusing on is a Just Culture and psychological safety as described in the Incident Management Framework. Furthermore, the HSE and State Claims Agency work collaboratively to improve the actual incident reporting system, NIMS, to make it more user-friendly and intuitive for staff to use and therefore report incidents more easily. The direct electronic incident reporting function (ePOE) of incidents onto the system by frontline staff has now been rolled out at over 30 sites with many more sites lined up for its roll-out. Such national initiatives are further enhanced by local work to improve patient and staff safety, report incidents and encourage a positive safety culture.

Incident data

Whilst the HSE continues to pursue strategies for improving incident reporting, it is recognised that there are a number of factors that impact this. As such it is not intended as a data collection point. Primarily it aids as a system that helps incident management, learning from such events and indicate risks.

There are data limitations and anomalies of the NIMS incident data that include potential duplication of incidents, variance in reporting and limited data validation, etc.

The data included in this response was extracted on the 23rd July 2025 for HSE statutory services - it does not include voluntary services. It includes all person related incidents (patients, staff, external) and near-misses (excluding property, motor crash or dangerous occurrence incidents) for the six HSE Regions for community locations. We note you refer to CAMHS regions and for this we include an additional table on divisions, with Mental Health being included. We note detail on CAMHS services alone is not available.
The majority of incidents had no harm or low level harm reported. NIMS is a live system and records are updated constantly which means that there can be variation in data depending on when it is extracted.

Table 1: Severity Rating: Incidents on NIMS by HSE Community Services in 2018-2025 (only January-June for 2025).

	Severity					
Year	Negligible	Minor	Moderate	Major	Extreme	Grand Total
2018	42,525	5,590	2,723	22	322	51,182
2019	39,905	6,410	2,255	37	325	48,932
2020	36,763	6,545	3,044	26	477	46,855
2021	35,230	7,079	2,827	39	382	45,557
2022	40,162	9,055	2,956	40	322	52,535
2023	39,837	8,165	2,512	52	299	50,865
2024	39,768	8,350	2,730	43	246	51,137
2025	19,897	4,005	1,168	20	94	25,184
Grand Total	**294,087**	**55,199**	**20,215**	**279**	**2,467**	**372,247**

Table 2: Incident Hazard (the nature of adverse incident): Incidents on NIMS by HSE Community Services in 2018-2025 (only January-June for 2025).

Hazard Type	2018	2019	2020	2021	2022	2023	2024	2025	Grand Total
Clinical Care	6,030	5,835	5,215	5,630	5,617	7,377	8,852	5,456	50,012
Exposure to Behavioural Hazards	25,846	23,888	21,219	19,905	21,391	23,803	23,155	10,797	170,004
Exposure to Biological Hazards	286	268	2,981	4,144	9,164	3,246	2,493	499	23,081
Exposure to Chemical Hazards	189	180	154	117	102	88	118	43	991
Exposure to Physical Hazards	18,816	18,751	17,272	15,742	16,249	16,316	16,381	8,380	127,907
Exposure to Psychological hazards	13	8	12	9	7	26	127	8	210
(blank) and data error	≤5	≤5	≤5	10	≤5	9	11	≤5	42
Grand Total	**51,182**	**48,932**	**46,855**	**45,557**	**52,535**	**50,865**	**51,137**	**25,184**	**372,247**

Table 3: Community Division: Incidents on NIMS by HSE Community Services in 2018-2025 (only January-June for 2025).

Division	2018	2019	2020	2021	2022	2023	2024	2025	Grand Total
Primary Care	3,237	3,022	3,020	3,142	3,961	4,153	4,616	2,856	28,007
Mental Health	20,078	17,942	16,025	16,006	18,253	18,003	18,330	8,702	133,339
Older Persons	15,474	16,122	16,357	15,409	18,757	17,022	17,972	8,941	126,054
Disability Services	11,574	11,123	10,741	10,367	10,886	10,778	9,479	4,413	79,361
Health & Wellbeing	49	50	24	56	60	83	66	10	398
(blank), legacy, corporate and data errors	770	673	688	577	618	826	674	262	5,088
Grand Total	**51,182**	**48,932**	**46,855**	**45,557**	**52,535**	**50,865**	**51,137**	**25,184**	**372,247**

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Table 4: HSE Region: Incidents on NIMS by HSE Community Services in 2018-2025 (only January-June for 2025).

Region	2018	2019	2020	2021	2022	2023	2024	2025	Grand Total
HSE Dublin and Midlands - HSE - Community - Kildare/ West Wicklow/ Dublin West/South City/South West/Laois/Offaly/ Longford/Westmeath	9,783	8,354	7,671	6,773	8,975	9,001	9,404	4,509	64,470
HSE Dublin and North East - HSE - Community - Dublin North/ Dublin North City /Dublin North West/Cavan/Monaghan/ Louth/Meath	8,993	8,512	8,462	8,758	9,129	9,000	8,918	4,000	65,772
HSE Dublin and South East - HSE - Community - Wicklow/ Dun Laoghaire/ Dublin South East/South Tipperary/Carlow/Kilkenny/ Waterford/Wexford	8,927	9,029	9,155	8,728	8,867	9,608	9,663	5,882	69,859
HSE Mid West - HSE - Community - Clare/Limerick/ North Tipperary	3,635	3,738	3,371	3,376	4,482	3,674	3,912	1,767	27,955
HSE South West - HSE - Community - Cork/Kerry	7,277	7,346	7,383	6,841	7,618	6,163	6,505	3,149	52,282
HSE West and North West - HSE - Community - Galway/ Roscommon/Mayo/Donegal /Sligo/Leitrim/West Cavan	12,567	11,953	10,813	11,081	13,464	13,419	12,735	5,877	91,909
Grand Total	**51,182**	**48,932**	**46,855**	**45,557**	**52,535**	**50,865**	**51,137**	**25,184**	**372,247**

The types of clinical care incidents can vary from incidents such as a pressure ulcer, medication incident, etc.

I trust this clarifies the matter but please do contact me if you require any further information.

Yours sincerely

Loretta Jenkins
General Manager
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