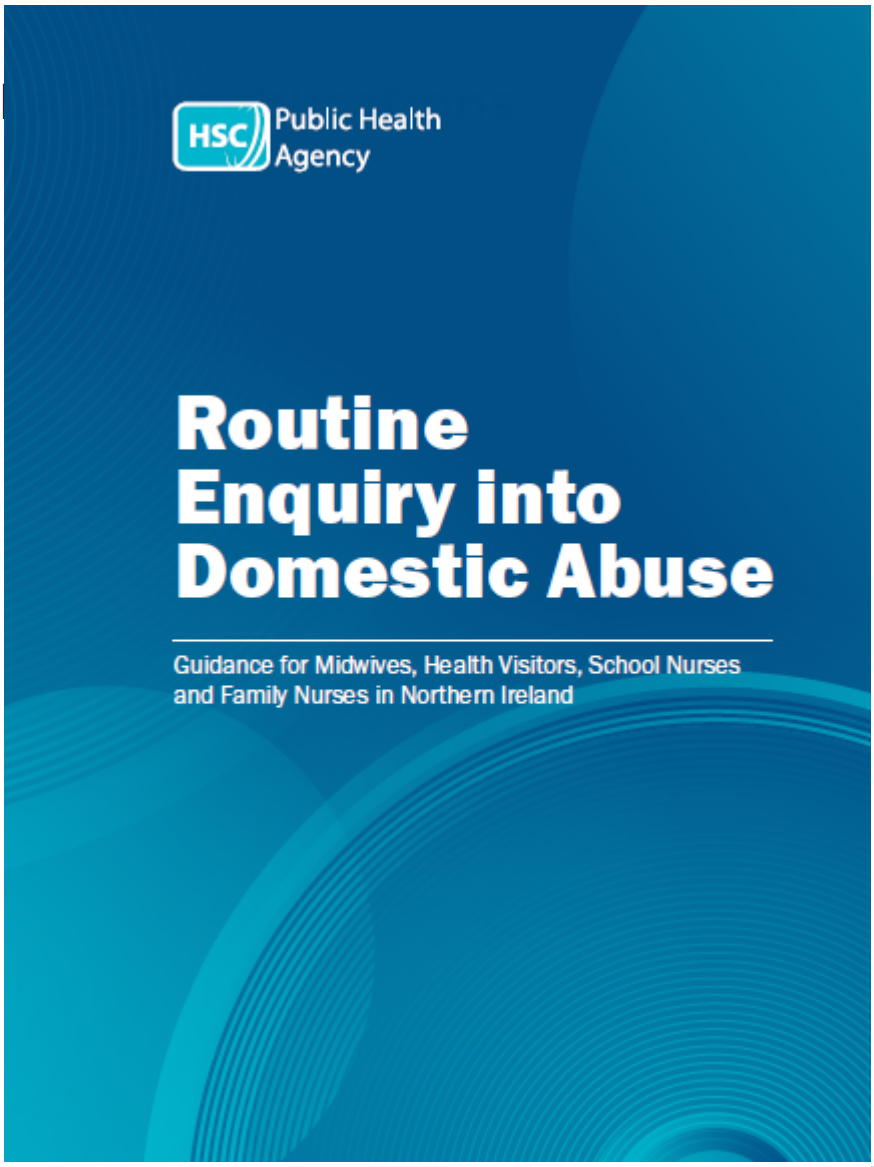
HSC
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Routine
Enquiry into
Domestic Abuse
Guidance for Midwives, Health Visitors, School Nurses
and Family Nurses in Northern Ireland

3+ Review

Guidance for Pre-school Education Teachers and Leaders

Health and Education Working in Partnership to Support Pre-school Children

Version 5

Date Issued: December 2025

Reducing the risk of sudden infant death

A tool for midwives, family nurses and health visitors

The death of a baby or child is perhaps the most devastating event that can happen to a family. Thankfully unexpected child deaths are rare, but unfortunately they do happen and it is important that we do everything we can to prevent avoidable deaths where possible.

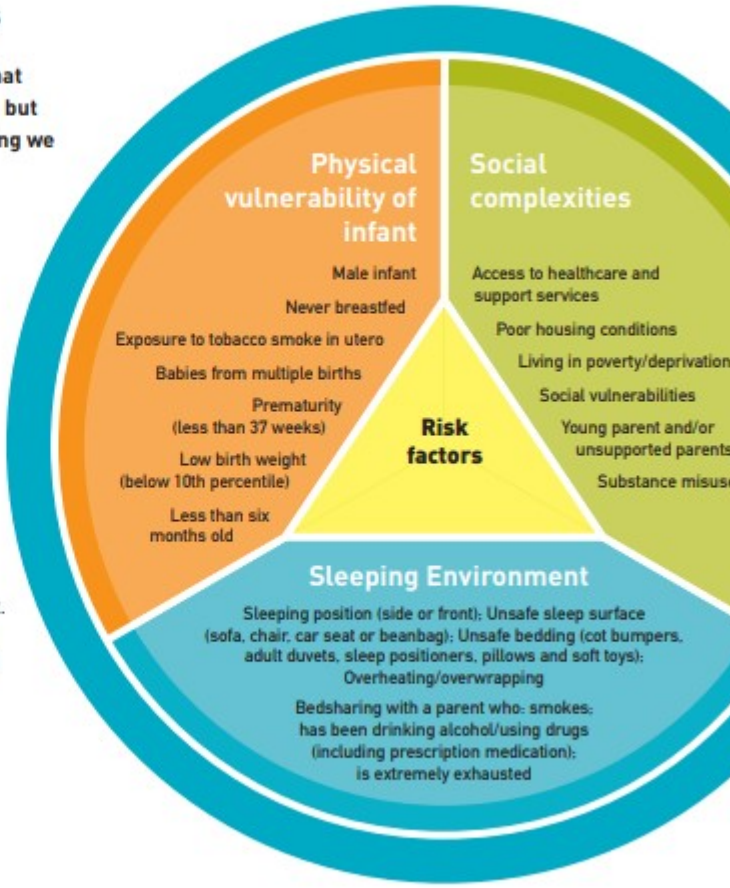
Safer sleep advice is not consistently followed or understood by parents/carers.

This risk assessment tool has been developed using the evidence base regarding sudden infant death and associated risk factors. It is intended that midwives, family nurses. health visitors and neonatal nurses use the tool to identify any concern regarding risks or sleeping practices. This should create opportunities to:

- have honest conversations with parents/carers based on their individual circumstances;
- discuss evidence-based measures to promote safer sleeping practices and reduce risks;
- observe baby's sleep environment as part of the risk assessment.

This tool may also be used by GPs, social workers and others working in other settings who have opportunities to assess the sleeping environments of infants and reinforce safer sleeping messages.

Risk Assessment Tool



HSC Public Health Agency

Public Health Agency
12-22 Linenhall Street, Belfast BT2 8BS.
Tel: 0300 555 0114 (local rate).
www.publichealth.hscni.net

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LEARNING MATTERS

EDITION 26
JANUARY 2026

IN THIS EDITION

Welcome to edition 26 of the Learning Matters Newsletter produced by the System Learning, Transformation and Governance Team, PHA. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise the need to utilise a variety of methods to share learning, therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Retention of catheter following accidental patient removal

Summary of Event

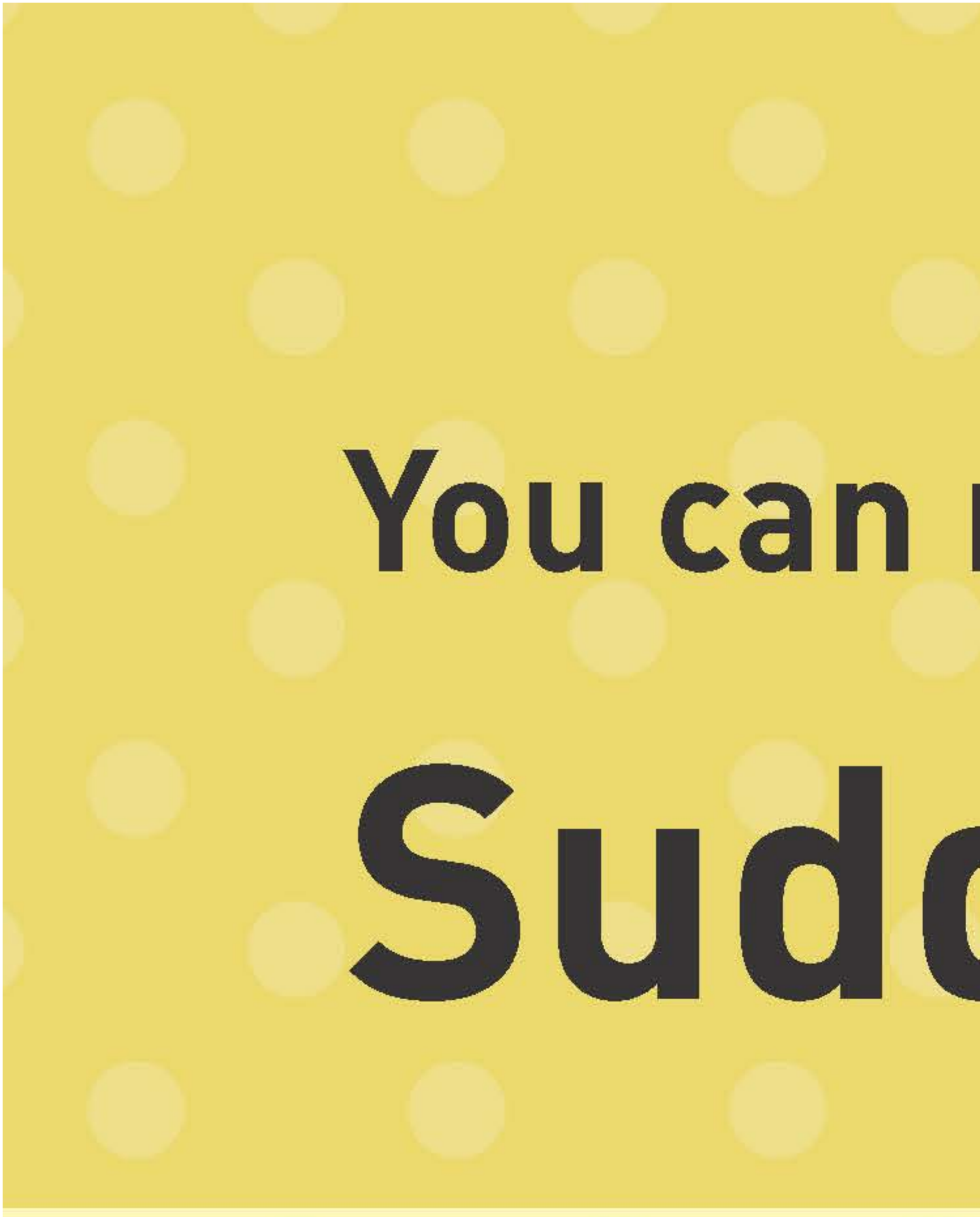
Two Serious Adverse Incidents (SAIs) were reported related to retention of part of a plastic tube from a urinary self-retaining catheter (SRC).

Patient A was admitted following a fall at home. They were diagnosed with an acute kidney injury (AKI) for which an SRC was inserted as part of the management plan. Patient A became agitated and began pulling on their catheter, resulting in them accidentally pulling it out. The catheter was not fully inspected by staff at the time of its removal. A complaint was later received from Patient A's family stating that Patient A had deteriorated at home after discharge, complaining of pain coupled with reduced mobility. Patient A then passed a piece of plastic when going to the toilet which appeared to be part of a catheter.

Patient B was admitted after being knocked down by a car. Due to the nature of the injuries plus immobility, a self-retaining catheter (SRC) was inserted. Patient B was transferred to Ward X and over the course of the next 10 days became very agitated, secondary to head injury and acute delirium. They required 1:1 supervision to maintain safety with deprivation of liberty (DOL) safeguards in place, and they required pharmacological management of their agitation.

Patient B's urinary catheter was removed following a rehabilitation review, as this was felt to be contributing to agitation as a source of annoyance.

Later that day, a catheter was reinserted, as Patient B had not passed urine and remained agitated. It was anticipated at the time of re-insertion that the urinary catheter would remain in place until it was clinically appropriate to remove. A few days later Patient B pulled their urinary catheter out. At the time, the catheter was disposed of and not fully inspected by any of the staff on duty. Over the course of Patient B's inpatient stay, they intermittently reported dysuria, urinary frequency and microscopic haematuria. Patient was treated with antibiotics for a urinary tract infection; these were discontinued three days later following a negative Mid-Stream Sample of Urine (MSSU). Following discharge, Patient B contacted the ward to advise that they had passed a clear plastic tube when attempting to pass urine. A post incident review of inpatient imaging was then undertaken. An x-ray of the lumbar and sacral spine showed a foreign body, consistent with the shape of a urinary catheter measuring approximately 11 centimetres, visualised in the urinary bladder. The foreign body did not track down the urethra. This was not present on a whole-body CT scan carried out on admission.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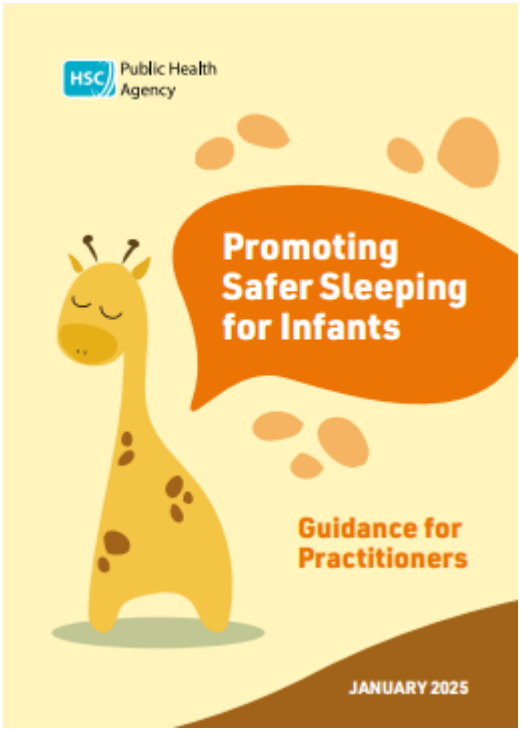
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Promoting Safer Sleeping for Infants
Guidance for Practitioners
JANUARY 2025

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