LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

The purpose of this Learning from Falls Newsletter, is to share information and key learning from inpatient falls across Health and Social Care (HSC) Trusts', which are classified as Adverse Incidents identified from post fall reviews.

HSC Public Health Agency

Any inpatient fall that has resulted in moderate, major or catastrophic harm (see table 1 below) is reported to the Public Health Agency using the Shared Learning Form (SLF) following a post fall review.

Grading the severity of harm to a person from a fall incident can be challenging for reporters. The aim of the Falls Severity Grading Document is to provide additional guidance for staff when using the HSC regional risk matrix. Examples provided are not exhaustive nor should be substituted for clinical decisions and **each case should be dealt with on an individual basis.**

KEY FACT

The consequences of fractures are significant, with a 1-year mortality rate of 31% after a hip fracture. NICE 2025

Table 1: FALLS Severity Grading of Injury: Moderate, Major and Catastrophic are reported using Shared Learning Forms1

DOMAIN	MODERATE	MAJOR	CATASTROPHIC
PEOPLE **(Impact on the Health/ Safety/ Welfare of any person affected: e.g. Patient/ Service User, Staff, Visitor, Contractor)**	The fall has resulted in • Injuries causing ***semi-permanent harm/ disability***. (Consider physical/emotional injuries/trauma). • A full recovery is expected within one year. • Injuries have resulted in harm that requires a moderate increase in treatment and follow up • The person may require a prolonged length of hospital stay or care provision (between 5 and 14 days).	The fall has resulted in • long-term permanent harm/ permanent disability, i.e. the person is unlikely to regain their former level of independence. • The person may require an increased length of hospital stay/care provision (>14 days).	The fall has resulted in death • Falls resulting in death must be discussed with the coroner by the relevant medical practitioner. **OR** • The fall results in permanent harm/disability. This could be physical/emotional trauma which impacts on more than the person injured. If the fall resulted in death, details recorded on death certificate should be recorded on the Datix system, including coroner ref number, date and time of discussion and by whom.
EXAMPLES OF POSSIBLE INJURIES	Fracture to wrist/fingers/toes; facial fractures. Surgery may or may not be required where falls result in moderate harm.	Intracranial bleed, fracture of long bones, fractured neck of femur (intracapsular/ extracapsular), pelvis and ankle.	Spinal cord injuries, Catastrophic Brain Injuries. The person requires long term care/admission to a care facility beyond 1 year because of the fall.

1 Guidance regarding the grading of inpatient falls was updated and agreed by the Inpatient Regional Falls Group, which is chaired by the PHA and has representatives from the 5 HSC Trusts, this can be accessed at FALLS SEVERITY GRADING OF INJURY. APRIL 2024.pdf (hscni.net).

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Encompass - The Adult Inpatient Falls Audit Tool

The Regional Nursing Midwifery Quality and Assurance Network (NMQAN) has led a review of the previous falls audit and refreshed its content to improve how quality of care is measured. This work included a review of workflows related to falls.

As part of the regional digital transformation programme the falls audit tool has now been standardised and fully digitised within Encompass.

This enables the use of real - time data to support continuous improvement in a learning environment, strengthening assurance across the system.

Compliance guides have also been finalised by NMQAN and agreed and these will now be integrated into current training.

The Audit tool will be used by every adult in-patient setting in Northern Ireland to measure compliance against each Falls element.

The previous 2024 'Learning from Falls Newsletter' can be accessed at PHA Learning From Falls (September 2023) (hscni.net))

A fall is defined as an event, which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO, 2021).

Patient falls have both human and financial costs. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and occasionally death. The costs to NHS organisations include additional treatment, increased lengths of stay, complaints and, in some cases, litigation. In addition, falls frequently bring about a fear of falling which increases risk and reduces independence. Staff may experience feelings of responsibility, guilt, and a loss of confidence, potentially impacting their job satisfaction and mental well-being.

LEARNING FROM FALLS

SEPTEMBER 2025

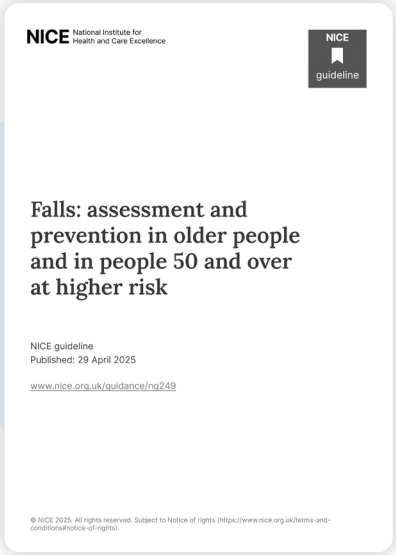
IN THIS EDITION

Falls Assessment and Prevention Guidelines from NICE

New NICE guidelines were published on the 29th April 2025 regarding Falls: assessment and prevention in older people and people 50 and over at risk. These guidelines can be found at: https://www.nice.org.uk/guidance/ng249; it covers assessing risk of falling and interventions to prevent falls in all people aged 65 and over, and people aged 50 to 64 who are at higher risk of falls.

KEY FACT

Around a third of people aged 65 and over, and around a half of people aged 80 and over, fall at least once a year. NICE 2025



Risk Assessments and Plans of Care

Risk assessments and plans of care relating to falls prevention must be **updated by nursing staff:**

- When a patient has a fall or near miss.
- When a patient is found and a fall is suspected (unwitnessed fall).
- When a patient's risk factors or medical condition changes.
- On transfer to another care setting.

KEY FACT

Over 3 million people in the UK have osteoporosis and they are at much greater risk of fragility fractures.

LEARNING FROM FALLS

SEPTEMBER 2025

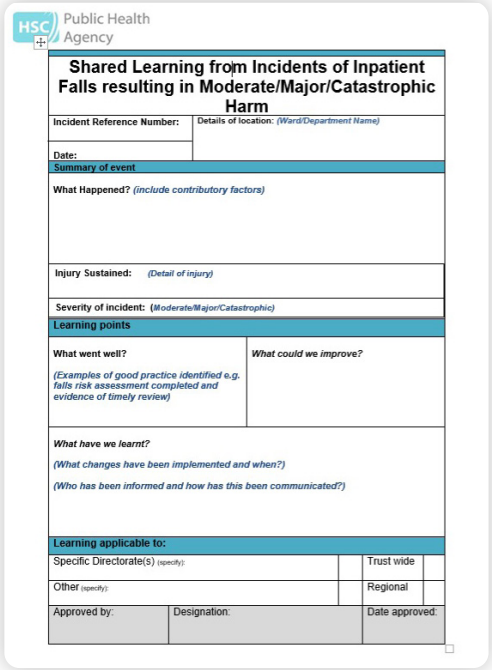
IN THIS EDITION

The Shared Learning Form

A Post Fall Review is only carried out on fall incidents that result in moderate or above levels of patient harm and not all falls. A **Shared Learning Form** is completed following a Post Fall Review to allow for **local learning** resulting in a change in practice and to reduce the incidence of future falls. For patients who fall in hospital, this form is then submitted to the PHA falls inbox falls.learning@hscni.net. This allows for a regional analysis of inpatient hospital falls which informs the annual Learning from Falls Newsletter produced by PHA.

The information that follows is an analysis of the PHA Falls Shared Learning Inbox for the period 1st April 2024 to 31st March 2025, reported by the 29th May 2025, and includes inpatients and patients who have fallen in Emergency Departments.

The Public Health Agency chairs a multidisciplinary Regional Inpatient Falls Prevention Group, which incorporates staff from all Trusts and was formed to set direction on falls prevention for adult inpatients. The Group provide advice, support and share regional learning as well as lead on the development of regional tools/pathways when appropriate, regarding falls prevention.

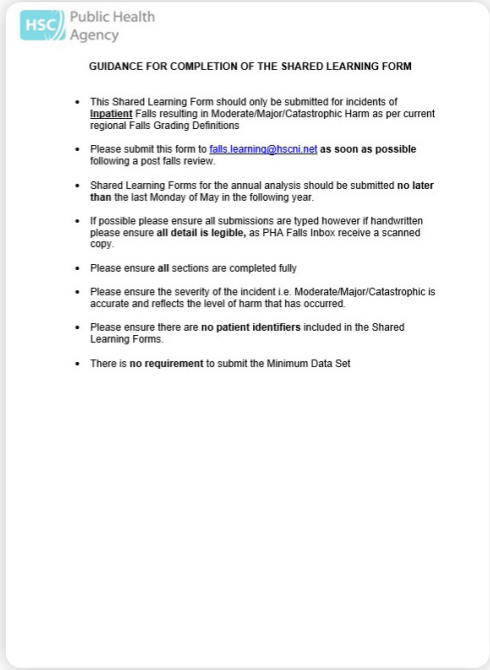


Public Health Agency

Shared Learning from Incidents of Inpatient Falls resulting in Moderate/Major/Catastrophic Harm

Incident Reference Number:	**Details of location:** *(Ward/Department Name)*
Date:	
Summary of event	
What Happened? *(include contributory factors)*	
Injury Sustained: *(Detail of injury)*	
Severity of incident: *(Moderate/Major/Catastrophic)*	
Learning points	
What went well? *(Examples of good practice identified e.g. falls risk assessment completed and evidence of timely review)*	***What could we improve?***
What have we learnt? *(What changes have been implemented and when?)* *(Who has been informed and how has this been communicated?)*	
Learning applicable to:	
Specific Directorate(s) (specify):	Trust wide
Other (specify):	Regional
Approved by: / Designation:	Date approved:

The Inpatient Falls Shared Learning Form (SLF): Version 6, dated July 2023



Public Health Agency

GUIDANCE FOR COMPLETION OF THE SHARED LEARNING FORM

- This Shared Learning Form should only be submitted for incidents of **Inpatient** Falls resulting in Moderate/Major/Catastrophic Harm as per current regional Falls Grading Definitions
- Please submit this form to falls.learning@hscni.net **as soon as possible** following a post falls review.
- Shared Learning Forms for the annual analysis should be submitted **no later than** the last Monday of May in the following year.
- If possible please ensure all submissions are typed however if handwritten please ensure **all detail is legible,** as PHA Falls Inbox receive a scanned copy.
- Please ensure **all** sections are completed fully
- Please ensure the severity of the incident i.e. Moderate/Major/Catastrophic is accurate and reflects the level of harm that has occurred.
- Please ensure there are **no patient identifiers** included in the Shared Learning Forms.
- There is **no requirement** to submit the Minimum Data Set

The Inpatient Falls Shared Learning Form (SLF): Version 6, guidance documentation

KEY FACT

Falls are the leading cause of accidental death in Northern Ireland.

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Key Findings

A thematic analysis was undertaken of all Shared Learning Forms submitted to and processed by the PHA between 1st April 2024 and 31st March 2025, received by the closing date of the 29th May 2025. This newsletter is developed and published during Falls Awareness Week in September 2025, therefore it is not possible to include Shared Learning Forms submitted after this date.

- 181 Shared Learning Forms were submitted to and processed by PHA this year (1st April 2024 to 31st March 2025) by the 29th May 2025.
- Of the 181 submitted, 94 were analysed.
- Analysis was carried out under 5 key themes
  - **What happened?**
  - **What went well before the fall?**
  - **What went well after the fall?**
  - **What we could improve?**
  - **What we have learned?**
- The Safety, Quality and Innovation Team, PHA quality assured all forms submitted during the year on a weekly basis and returned any incomplete forms to the sender, for amendments and resubmission.

Reasons why forms were returned for resubmission included:

- A query regarding grading of the Fall.
- The form was not signed.
- Information was omitted.

- **Classification of incidents:**
  - 7 catastrophic harm
  - 49 major harm
  - 38 moderate harm

Approximate Financial Cost of a Fall with a Hip Fracture

Activity	Cost
Ambulance transport	£460
ED attendance	£380
Hip Replacement	£10,000
Rehabilitation	£14,000
Community Physio 4	£344
Community OT 1	£140
Total	**£25,324**

Table 2: Quality Improvement Plan (QIP) Indicator Reporting 2024-2025 and number of completed Shared Learning Forms submitted to the PHA by the 29th May 2025: Falls

Trust	Total Number of falls	Number of Moderate, Major and Catastrophic Falls reported on QIP	% of Total falls that were Moderate, Major or Catastrophic	Number of submitted Shared Learning Forms (SLF)	% of Moderate, Major and Catastrophic Falls that had a SLF submitted by 29th May 2025
SHSCT	1517	35	2.3%	35	100%
WHSCT	1783	31	1.7%	25	81%
SEHSCT	2554	57	2.2%	27	47%
NHSCT	1725	37	2.1%	36	95%
BHSCT	2346	69	2.9%	58	84%
Total	**9925**	**229**	**Ave %: 2.3%**	**181**	**Ave %: 81%**

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Theme 1: What Happened?

Based on a sample of 94 of the 181 Shared Learning Forms (SLFs) submitted:

- **78 falls (83%) were unwitnessed.**
- **16 falls (17%) were witnessed.**

Of the patients who fell:

- 65% had a documented history of dementia, delirium or confusion.
- 61% had a documented history of falls.
- 41% were found on the floor.
- 57% got up without the required assistance with a further 15% declining assistance.
- 23% felt dizzy when standing and fell, this was often when they tried to mobilise without assistance to use the bathroom or after being assisted to the bathroom and left alone to respect their dignity, the patient then tried to mobilise independently to leave the bathroom.
- 10% had sedation recorded as a contributing factor.
- 9% slipped and fell, often because of inappropriate footwear or no footwear.
- 7% mentioned falling out of a chair.

Table 3: What Happened April 2024 to March 2025?

What Happened?	Number of Patients
Unwitnessed Fall.	78
Witnessed Fall.	16
Delirium, confusion, history of Dementia.	61
History of Falls.	57
Patient got up without asking for assistance.	54
Found on floor.	39
Lost balance/dizzy usually when toileting alone.	22
Fell out of bed/climbed out of end of bed.	19
Declined assistance.	14
Patient on new/sedation/pain relief.	9
Incident RIDDOR reported by H&S.	9
Patient slipped and Fell/relied on unstable support.	8
Patient wearing TED stockings/no shoes/ inappropriate shoes.	8
Fell out of chair.	7
Patient had a virus.	3
Controlled fall assisted by staff.	3

KEY FACT

Fragility fractures are most common in bones of the spine, wrists and hips. Falls: applying All Our Health - GOV.UK (www.gov.uk

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Theme 2: Learning Points - What went well?

These are examples of good practice as stated in the Shared Learning Forms submitted, it is recognised additional good practice may have occurred but was not captured on these forms.

'What went well before the Fall' – Pareto Analysis Summary

Within the 94 Shared Learning Forms analysed, **536 examples of good practice** were identified in relation to falls prevention. These were grouped under three key themes.

The Pareto Principle

The Pareto Principle or 80/20 rule, suggests that approximately 80% of outcomes result from 20% of causes. It highlights how a small number of key factors often drive the majority of results, allowing us to focus improvement efforts where they will have the greatest impact. By identifying the areas that account for most improvement opportunities, we can target actions that are more likely to reduce harm and improve patient safety.

A Pareto chart is a simple bar chart that displays the frequency of problems or causes in descending order.

Why it matters

- Helps prioritise effort on the most impactful areas
- Promotes efficiency by focusing on the few factors that make the biggest difference.
- Supports decision - making when resources (time, money, people) are limited

The Pareto Chart highlights that;

- **Risk Assessment & Care Planning (444; 83%)** accounted for the vast majority of reported good practice. This shows a consistent focus on structured risk assessment, care planning, and proactive clinical actions taken to mitigate falls risks.
- **Communication, Learning & Patient Engagement (59; 11%)** contributed significantly to positive practice, reflecting the importance of patient education, family involvement, and shared learning among staff.
- **Environment, Staffing & Systems (33; 6%)** represented a smaller proportion but included essential system-level measures such as environmental safety checks, staffing adjustments, and system prompts.

What this tells us:

- The data confirms that teams are consistently implementing risk assessment and care planning measures before a fall occurs.
- Communication and Patient Engagement remain important contributors to safe care and should be reinforced in practice.
- While Environment and Systems were less frequently noted, they remain a critical underpinning to overall falls prevention strategies.

The Pareto principle suggests that continuing to strengthen these three areas – particularly Risk Assessment and Care Planning – will sustain and further enhance falls prevention efforts.

LEARNING FROM FALLS

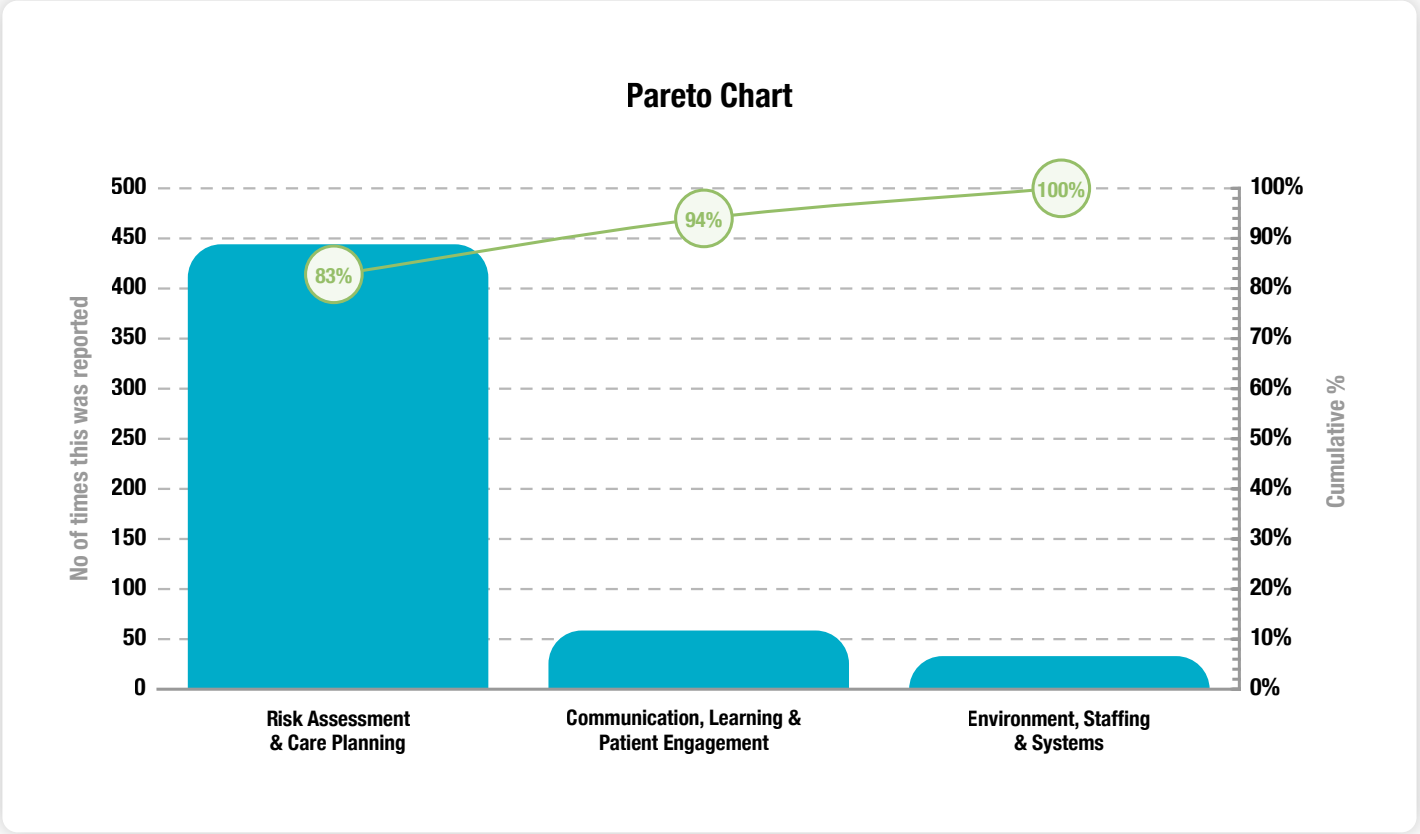
SEPTEMBER 2025

IN THIS EDITION

Table 4: Assigned themes **'What went well before the Fall'**

Assigned Theme	No of times this was reported	Cumulative %	Cumulative Count
Risk Assessment & Care Planning	444	83%	444
Communication, Learning & Patient Engagement	59	94%	503
Environment, Staffing & Systems	33	100%	536

Chart 1: Assigned themes **'What went well before the Fall'**



LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

What went well after the fall: Pareto Analysis Summary

Within the 94 Shared Learning Forms analysed, a total of **636 positive practice examples** were identified and themed from post – fall care reviews. These reflect how staff responded following a patient fall.

The Pareto Chart highlights:

- **Risk Assessment & Care Planning (355; 56%)** dominates the data set. This demonstrates that post – fall actions overwhelmingly focused on reassessment, risk management, clinical observation, and structured care planning.
- **Leadership Roles & Responsibilities (106; 17%)** reflects proactive leadership involvement, timely-decision making, and professional oversight in post – fall management.
- **Communication, Learning & Patient Engagement (105; 17%)** highlights the value placed on family and patient communication, incident reporting, and shared learning.
- **Environment, Staffing & Systems (70; 11%)** included practical measures taken at ward level, such as increased supervision and environmental adjustments.

What this tells us:

- The largest area of good practice relates directly to risk management and care planning following a fall, reflecting a clinical vigilance and responsive care.
- Leadership actions and communication with patients, families, and teams were both well-represented, showing a balanced multi – disciplinary response.
- Practical environmental adjustments supported safety but featured less frequently.
- The Pareto analysis suggests strengthening practice within these top three areas will continue to enhance post-fall care and improve outcomes for patients.

KEY FACT

Older people may remain in hospital for a number of weeks as a result of a fall, and at any one time older people recovering from hip fracture require over 3,600 hospital beds in England, Wales and Northern Ireland.

KEY FACT

Around 50% of falls are preventable.

LEARNING FROM FALLS

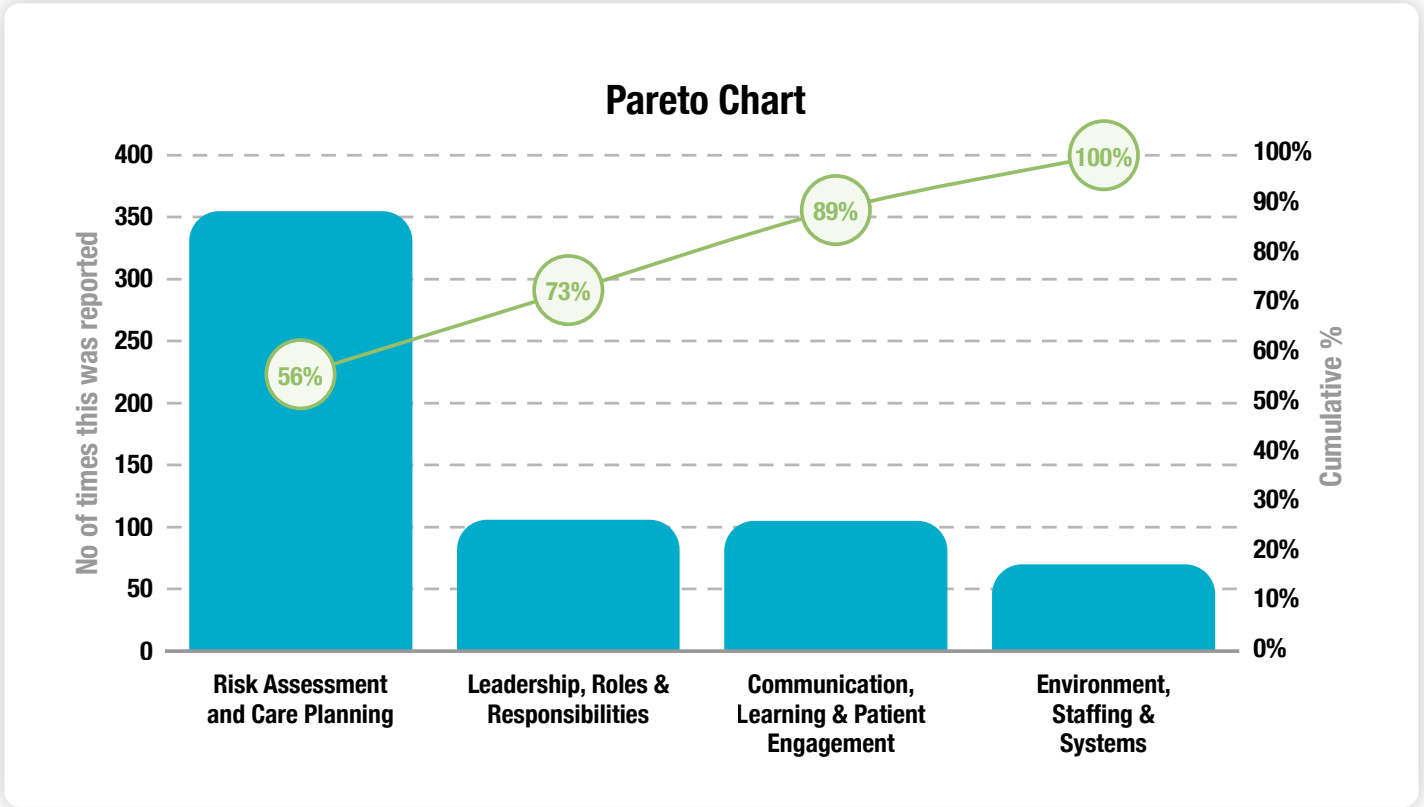
SEPTEMBER 2025

IN THIS EDITION

Table 5: Assigned themes **'What went well after the Fall'**

Assigned Theme	No of times this was reported	Cumulative %	Cumulative Count
Risk Assessment and Care Planning	355	56%	355
Leadership, Roles & Responsibilities	106	73%	461
Communication, Learning & Patient Engagement	105	89%	566
Environment, Staffing & Systems	70	100%	636

Chart 2: Assigned themes **'What went well after the Fall'**



LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Theme 3: What we could improve

Based on the information provided with the Shared Learning Forms (SLFs), of the patients who fell:

As part of this analysis of the 94 Shared Learning Forms, **650 improvement points** were identified in relation to injurious falls. Using a Pareto approach, we categorised these into 8 themes to highlight where focused improvement efforts could have maximum impact. This analysis helps us move beyond individual incidents to understand recurring patterns and system-wide opportunities. By identifying the areas that account for the majority of improvement opportunities, we can prioritise actions that are most likely to reduce harm and improve patient safety.

The following section explains how this analysis highlights our biggest risks and guides us to where targeted action will yield the greatest benefit.

How to think about the Cumulative Total (Orange Line):

- The **orange line shows the running total of impact** as you add each theme – starting from the biggest contributor down to the smallest.
- It helps you visualise **how much of the total problem you can address by tackling the biggest issues first.**

Example from the Pareto chart:

- **Documentation & communication = 30%** of all issues
- Add **Risk Assessment = 53% cumulative** (30% + 23%)
- Add **Post-Fall Actions & Reviews = 73%** cumulative
- Add **Medical Management & Clinical Interventions = 80%** cumulative

By focusing on just these **top 4 themes**, you are addressing **80% of all issues** reported. That's the power of the cumulative line – it guides your priorities for maximum impact.

Simply put, the cumulative line shows us that by focusing on the first four themes – Documentation & communication, Risk Assessment, Post Fall Actions & Review and Medical Management & Clinical Interventions – we are addressing around 80% of all improvement opportunities.

LEARNING FROM FALLS

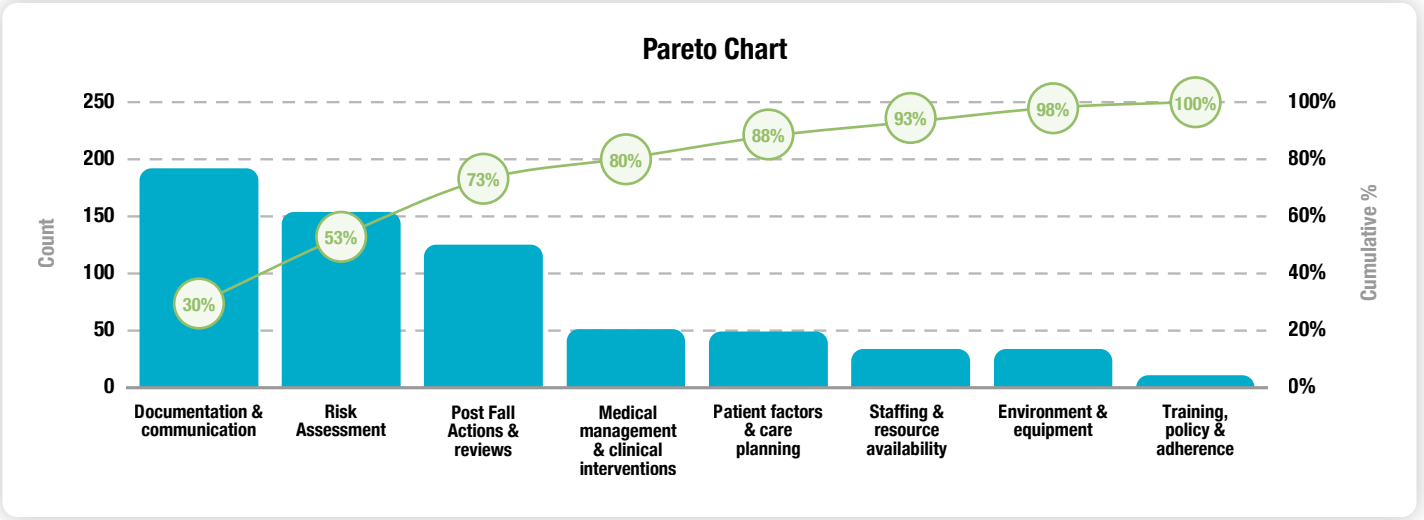
SEPTEMBER 2025

IN THIS EDITION

Table 6: Assigned themes **'What we could improve'**

Assigned Theme	No of times this was reported	Cumulative %	Total %
Documentation & communication	192	30%	31%
Risk Assessment	154	53%	23%
Post Fall Actions & reviews	125	73%	19%
Medical management & clinical interventions	51	80%	8%
Patient factors & care planning	49	88%	7%
Staffing & resource availability	34	93%	5%
Environment & equipment	34	98%	5%
Training, policy & adherence	11	100%	2%

Chart 3: Assigned themes **'What we could improve'**



KEY FACT

Falls are a regional Key Performance Indicator for quality and safety across HSC.

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Theme 4: What we have learned

Within the 94 Shared Learning Forms analysed, **378 learning points** were identified. Using a Pareto approach, we examined which areas accounted for the majority of identified issues. The Pareto Chart shows:

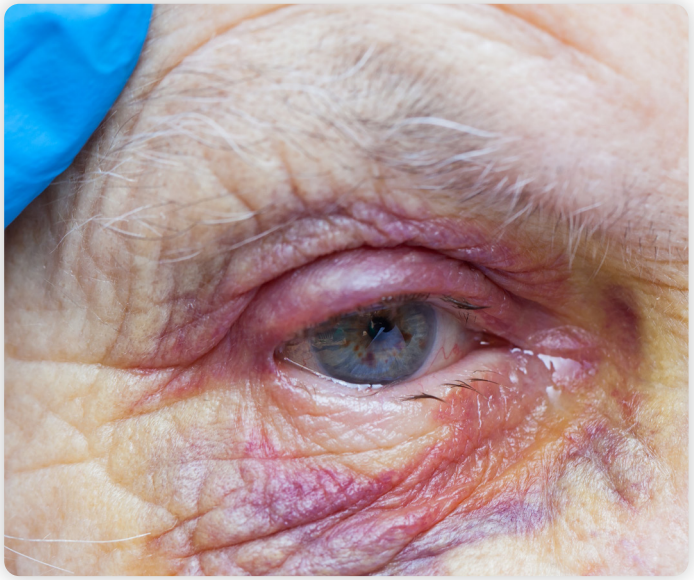
- **Communication, Learning & Dissemination (181; 48%)** emerged as the most frequent theme highlighting a significant opportunity to improve how learning is shared, acted upon, and communicated at all levels.
- **Leadership, Roles & Responsibilities (85, 22%)** and **Training & Competency (64, 17%)** followed closely. Together these areas account for **87%** of all identified learning points
- **Risk Assessment & Care Planning (34; 9%)** and **Environment, Staffing & Systems (14; 4%)** were identified less frequently but remain important contributors.

What this means:

- Focusing improvement efforts on the top three themes- Communication, Leadership, and Training – is likely to yield the greatest impact on reducing harm from injurious falls. **Most learning points relate to how we communicate, share learning, lead teams, and define roles.**
- The Pareto approach confirms that addressing these priority areas can drive meaningful change while continuing to monitor and address risks in other categories. In other words, the Pareto approach helps us prioritise - we don't ignore the other areas, but we focus initial improvement efforts where the greatest benefit is likely.

KEY FACT

90% of hip fractures are caused by a fall.



LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Specific training areas were identified these include:

- Falls Clinical Setting Regional Awareness Targeted Module eLearning.
- Falls - Universal Module Regional Awareness eLearning.
- Frailty module eLearning.
- Bite size learning to include: admission documentation around falls (inc LSBP QR code/PowToon) & post fall documentation; including CNS obs and flat lifting equipment, Trust Falls policy, pin falls flowsheet.

QR Code to a Lying/ Standing Blood Pressure Animation

- Ensure moving and handling up to date, specifically, flat lifting equipment and organise face to face refresher where appropriate.

A variety of additional actions have been taken at Trust level to help reduce falls which include:

- Use safety brief to remind staff regarding training.
- The falls Prevention in Hospital; Information for Patients and Visitors Leaflet to be provided to all patients.
- Display the Call Bell Poster and encourage patients to use it prior to mobilising.
- 15% identified the benefit of taking learning forward to other wards in their directorate, where applicable.
- Ensure moving and handling up to date, specifically, flat lifting equipment and organise face to face refresher where appropriate.
- Include areas of good practice highlighted in review.
- All patients above the age of 65 should have a Lying standing blood pressure recorded at the time of admission and if not then reason why noted.
- Moving a patient with fluctuating cognitive state can cause an increase in length of stay and increase the risk of falls.
- Ensure patients are appropriate to transfer to a rehabilitation setting with clear rehab goals.
- When care assistants are assigned 1:1, there is a need to ensure cover/precautions are available when they take a break.
- Patient deemed to be high risk of falls require a discharge pathway to safest ongoing care/ capacity issues in community to discharge.

For the full list of areas, 'What we have learned' please see Table 7.

The Emergency Department

Key learning points:

- Overcrowding increases the risk of falls.
- If a patient is confused consider support from the family.
- The need for 1:1 staffing in Emergency Departments for high risk patients.

KEY FACT

Falls are among the top 5 most frequent Adverse Incidents reported across Health and Social Care Trusts.

LEARNING FROM FALLS

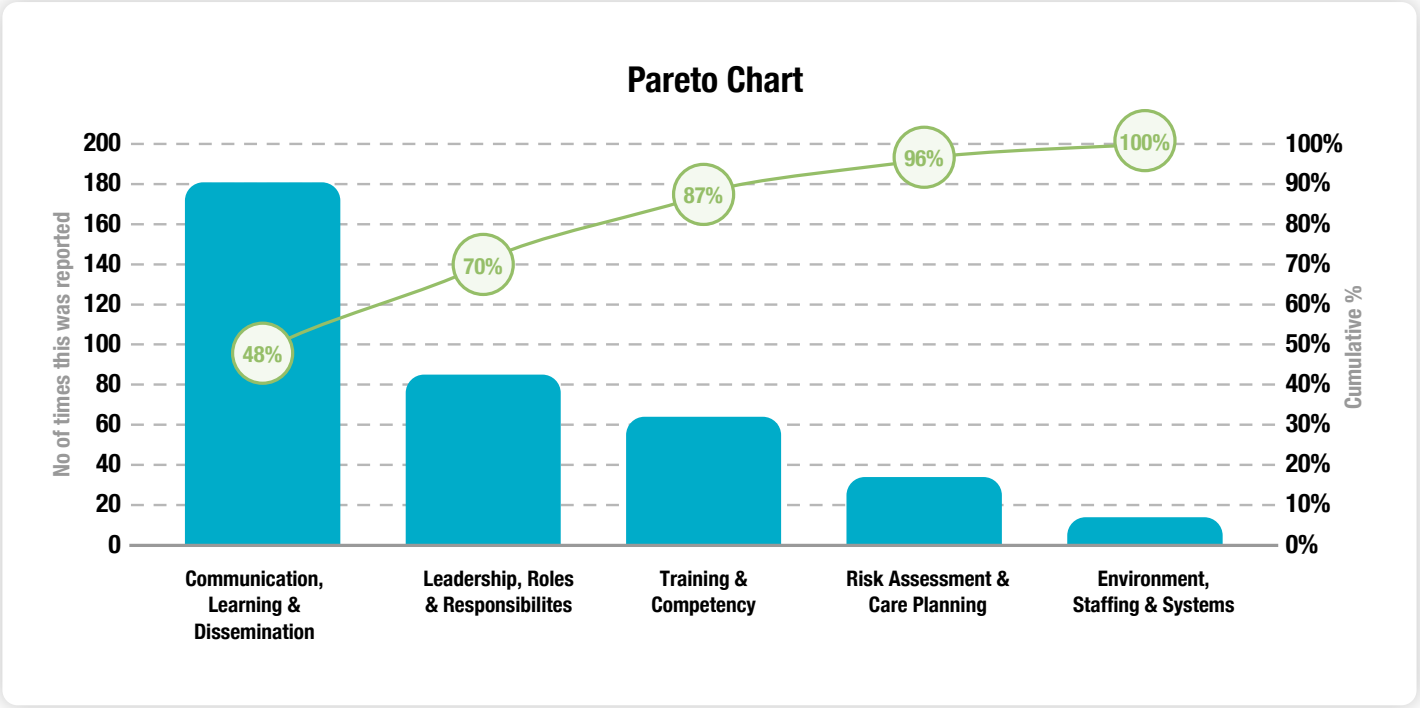
SEPTEMBER 2025

IN THIS EDITION

Table 7: Assigned themes **'What we have learned'**

Assigned Theme	No of times this was reported	Cumulative %	Cumulative Count
Communication, Learning & Dissemination	181	48%	181
Leadership, Roles & Responsibility	85	70%	266
Training & Competency	64	87%	330
Risk Assessment & Care Planning	34	96%	364
Environment, Staffing & Systems	14	100%	378

Chart 4: Assigned themes **'What we have learned'**



LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

In 2023 the Group developed a new regional **Falls Prevention in Hospital; Information for Patients and Visitors leaflet.** The purpose of this leaflet is to inform patients and their visitors of the steps they can take to reduce the incidence of falls. This leaflet works in tandem with the previously produced **Falls Poster,** which promotes the use of the Call Button, to reduce the incidence of patients inappropriately attempting to mobilise, without the required assistance of hospital staff.

Scan the QR code to visit the National Audit of Inpatient Falls (NAIF) website for further resources

Falls Prevention in Hospital; Information for Patients and Visitors leaflet

Falls Poster

LEARNING FROM FALLS

SEPTEMBER 2025

IN THIS EDITION

Conclusion

This Falls Newsletter 2024-2025 is launched to coincide with national Falls Awareness Week: Reduce Falls Together, from **Monday 15th September 2025 to Friday 19th September 2025**. This Newsletter provides an overview of the key themes identified from inpatient falls, which were classified as Adverse Incidents, in the period April 2024 to March 2025.

The analysis of 94 of the 181 Shared Learning Forms submitted by the 29th May 2025, highlights clear priorities for reducing harm from falls and enhancing care delivery. The greatest opportunities for improvement lie in strengthening communication, leadership, and training – areas that account for the majority of identified learning points from falls incidents.

At the same time, good practice consistently demonstrated the importance of robust risk assessment, care planning, and a responsive, multidisciplinary approach both before and after a fall.

To build on these insights, a regional workshop will be held on **18th Sept 2025** as part of **Falls Awareness Week**.

This event, led by the Regional Adult Inpatient Falls Prevention Group, will bring together colleagues from nursing, allied health, safer mobility, and frailty services to reflect on these findings, share experiences, and agree a collaborative workplan for the year ahead.

If you have any comments or questions related to Learning From Falls please get in contact by email at falls.learning@hscni.net

References

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- AGE UK
- RCN
- RCN Falls
- https://www.nice.org.uk/guidance/ng249

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