



ADVERSE EVENT AND ERROR REPORTING PROCEDURE

How harm, near misses and errors are reported, investigated and prevented from happening again

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1. Purpose

This procedure makes sure that anything that harms a patient, or could have done so, is reported at once, investigated fairly and used to improve the service. Consult Your Doctor follows a non-punitive approach: the aim is to learn, not to blame, and nobody is penalised for reporting in good faith.

2. What must be reported

- **Adverse event:** harm to a patient connected with a consultation, prescription, test or platform use, including a suspected adverse reaction to a medicine.
- **Near miss:** an error or hazard that was caught before it reached the patient.
- **Medication error:** a wrong medicine, dose, frequency, duration or patient, or a missed allergy or interaction.
- **Report error:** a wrong, misplaced or delayed diagnostic result.
- **Technology event:** a failure of the platform, or of Zebroid AI, that could affect care, such as a missed alert.
- **Privacy event:** any loss or exposure of patient data, which is also handled under the Breach Response Plan (CYD-DP-05).

3. Who reports and how

Any doctor, staff member, diagnostic centre or partner who becomes aware of an event must report it. Patients may report through the app, by email or by telephone to the operational office. The reporter completes the incident form set out at the end of this document or its online version. Serious events are reported by telephone to the medical lead immediately, and the form follows within twenty-four hours.

4. Severity and response times

Level	Meaning	Report	Investigation
1 - Critical	Death, life-threatening harm or permanent injury	Immediately	Starts at once; report to leadership within 24 hours; closed within 30 days
2 - Serious	Harm needing treatment or hospital care	Within 24 hours	Started within 48 hours; closed within 30 days
3 - Moderate	Temporary harm, or an error that reached the patient	Within 48 hours	Closed within 21 days
4 - Near miss	No harm; caught in time	Within 5 days	Reviewed at the monthly meeting

5. Investigation and action

1. The medical lead appoints an investigator who is not involved in the event.
2. The investigator gathers the record, interviews those involved and establishes what happened and why, looking at systems and processes before individuals.
3. A written report sets out the cause, the harm, and corrective and preventive actions, with an owner and a date for each.



4. The patient is told honestly what happened, what is being done, and whom to contact. The patient's doctor takes part in that conversation.
5. The medical lead checks that each action has been completed and effective.

6. Notification to authorities

Where the law requires an event to be notified, for example a suspected adverse drug reaction to the national pharmacovigilance system of the country concerned, a serious incident involving a medical device, or a personal data breach, the legal team makes the notification within the legal time limit and keeps a copy.

7. Records and trends

All reports are kept in an incident register. The medical lead presents a summary of events, causes and actions to the directors every quarter, and the register is used to update training, this procedure and the platform.

8. Incident report form

Field	Entry
Date, time and place of event	
Reported by (name, role)	
Patient (name or ID)	
Doctor, centre or system involved	
What happened	
Harm to the patient, if any	
Immediate action taken	
Severity level (1 to 4)	
Investigator and closing date	

9. Suspected adverse drug reactions

Where a patient or doctor reports a suspected reaction to a medicine, the medical lead records the medicine, dose, start date, reaction, outcome and any other medicines used, and checks whether the reaction is known, serious or unexpected. Serious or unexpected reactions are reported to the pharmacovigilance system of the country concerned within the time that the law sets, and the prescribing doctor is told. The patient is advised on any change that the doctor considers necessary.

10. Open communication with patients

When something goes wrong, the patient is entitled to a prompt, honest and compassionate explanation. The doctor or medical lead tells the patient what happened, apologises where care fell short, explains what is being done to put it right and what is being done to prevent a repeat, and gives a named contact. The conversation and any follow-up are recorded. An apology is not an admission of legal liability and is not to be withheld for that reason.

11. Culture and training

All doctors and staff receive training on this procedure when they join and each year. The training explains what to report, how to report it, why reporting matters and how the company protects those who report in good faith.



Managers are trained to respond to reports with support and curiosity. Deliberate harm, falsification and repeated reckless conduct are not protected by the non-punitive approach and are dealt with under the Code of Conduct (CYD-HR-01).

12. Learning and sharing

Each quarter the medical lead prepares a short learning bulletin that describes the main events and the lessons, without names, and shares it with all doctors and partner centres. Where a lesson applies to a particular medicine, test or step, the platform is changed, for example by adding a new safety check, and the change is recorded in the change log.

13. Escalation to the directors

The medical lead informs a director at once of any critical event, of any event that may become public, of any event that involves a regulator, and of any pattern of events of the same type. The directors decide on any public statement, on notifications to regulators and insurers, and on the suspension of a doctor, a centre or a platform function.

14. Measures

Measure	Target
Critical and serious events reported within the time limits	100%
Investigations closed within the set period	At least 90%
Corrective actions completed by the due date	At least 90%
Near misses as a share of all reports (a healthy reporting culture reports many near misses)	Rising over time

15. Reporting channels

Reports may be made through the incident form in the platform, by email to the medical lead, by telephone to the operational office or to the number shown in the doctor's handbook. Patients may use the same channels or the complaint link in the app. Reports may be made in confidence, and the reporter's identity is shared only with those who must know in order to investigate.

Approval

This document is approved by the directors of Zebrold Private Limited, the operator of Consult Your Doctor.

Hemendrah Kumar Sadamsetty

Electronically signed | November 5, 2026

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Director, Zebrold Private Limited

Date: November 5, 2026

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