**Abstract**

To address the subject of learning from medication errors, this presentation will first look at human fallibility in complex systems, touching briefly on human factors. It will then evaluate the importance of organisational culture in the way incident investigations are initiated and conducted. Experience of triangulating information from multiple sources will be summarised. The available opportunities to share the learning from incidents will be outlined and a personal reflection on how to embed the learning in practice will be covered. The opportunities presented by PSIRF and the experience of the Isle of Wight NHS Trust as an early adopter of the new framework will be presented.