

WRITTEN MINISTERIAL STATEMENT

DEPARTMENT OF HEALTH

Independent Review of the NHS Organ Donor Register

Tuesday 19 October 2010

The Secretary of State for Health (Mr Andrew Lansley): I am today publishing the report of an independent review of the NHS organ donor register (ODR) by Professor Sir Gordon Duff. The review, announced on 11 April, was prompted by an error in the recording of the donation wishes of a number of registrants.

I am extremely grateful to Sir Gordon for establishing so clearly the circumstances surrounding this serious error, for his recommendations on how to ensure it does not happen again, and for his wider review of the ODR.

Organ donation relies on the generosity of people who are willing to donate organs after their death to help change or save the lives of others. If organ donation is to help the many people in need of a transplant, it is essential that people who join the ODR have confidence that their wishes are accurately recorded. It is extremely regrettable that as a result of this error donation decisions were influenced by incorrect information in 25 cases. NHS Blood and Transplant (NHSBT) has rightly apologised to the affected families. I would like to offer my condolences to the families concerned for their loss and to express gratitude to their late relative for agreeing to be a donor.

Sir Gordon's review found that the error originated in 1999 when faulty data conversion software was used by UK Transplant (now part of NHSBT) to upload data on individuals' organ donation wishes from the Driver and Vehicle Licensing Agency, when moving to a new computer system. These individuals had elected, when completing their driving licence application form, to donate some, but not all of their organs. In 25 cases the decision by the donor's relatives to agree to the donation of a particular organ was made using inaccurate information about the donor's wishes as a result of the error. Sir Gordon concluded that the error was avoidable if systematic data verification procedures had been in place in 1999.

The report provides a detailed explanation of how the error occurred, how it came to light, and why it was not uncovered sooner. It also outlines the remedial action taken by NHSBT and the actions taken to prevent a recurrence. Sir Gordon concludes that once the error was identified and brought to the attention of NHSBT's senior managers it was handled efficiently and sensitively.

Sir Gordon has also concluded that the ODR is now expected to fulfil functions for which it was not originally designed. He believes that a new interactive ODR based on 21st century technology would help to reduce the scope for human error inherent in the current system. He recommends that a new ODR should be designed and commissioned as soon as resources allow. We will discuss this

recommendation with NHSBT, once it has completed its planned scoping and costing of a future operating model.

Sir Gordon has made a number of other recommendations addressed to NHSBT which are designed to ensure that the Register reflects more clearly the wishes of those registered, and that confidence in the system is maintained. We look to NHSBT to consider those recommendations carefully and to respond accordingly.

Sir Gordon's report has been placed in the Library and copies are available for hon Members in the Vote Office.