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3 November 2016

[redacted]

By email

[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 6 October 2016 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority, as part of integrated organisation known as NHS Improvement.

Your request

You made the following request:

"The following list are incidents taken from reports of Never Events for the 2015-16 financial year on the NHS England website. For each of these cases please provide me with a detailed summary of what medical intervention took place and how/why the procedure was performed on the wrong patient or in the wrong way, or what was left behind and how long it was in place for before being removed. Please note I do not want the name of the hospital or any identifying features of patient.

If this request is better dealt with by NHS England then I give you permission to transfer it to them.

i. 20 May 2015 – 30 June 2015 - Fallopian tube removed instead of appendix

ii. 20 May 2015 – 30 June 2015 – Wrong site angioplasty

iii. July 2015 – Part of a chisel

iv. July 2015 - Incorrect blood transfused

v. August 2015 - Removal of complex pelvic tumour, distorted anatomy and kidney removed inadvertently

vi. August 2015 - Procedure undertaken on wrong patient

vii. September 2015 - Wrong side incision for a craniotomy

viii. *November 2015 - Wrong blood transfused*

ix. *December 2015 - Incision to wrong testis*

x. *December 2015 - Ovaries removed when the plan was to conserve them*

xi. *December 2015 - Wrong procedure wrong patient had the procedure (x 2)*

xii. *December 2015 – Wrong toes*

xiii. *March 2016 - Wrong procedure - Gastroscopy rather than Colonoscopy"*

Decision

NHS Improvement holds the information that you have requested.

By way of background you may find it useful to know that the information we hold is from the Strategic Executive Information System (StEIS). StEIS is a database used for the notification of appropriate parties that Serious Incidents have occurred and to manage progress of investigations, as set out in the Serious Incident Framework 2015, please note it does not hold the full investigation report for Serious Incidents. The revised Serious Incident Framework published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. It replaces, the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013). The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again. Specifically, Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. For more information on Never Events please refer to the Never Events framework which can be accessed at the following link:
https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Please find below the additional details as requested above, "what medical intervention took place and how/why the procedure was performed on the wrong patient or in the wrong way,

or what was left behind and how long it was in place for before being removed", where this information was available within the individual STEIS records as reported by the original reporter, including abbreviations and any spelling mistakes made by the reporter. Please note that for the incident you listed as (iii) the STEIS report has been removed from STEIS. This would typically occur when the commissioning organisation with oversight has agreed that further information obtained indicates there had not been a Serious Incident. Please also note that the incidents you listed in your FOI request were taken from provisional monthly reports and as these reports note, the designation of an incident as a Never Event can be subject to change following local investigation.

(i) 20 May 2015 – 30 June 2015 - Fallopian tube removed instead of appendix

Admitted at [no. of weeks - third trimester] gestation with abdominal pain, ?appendicitis. Seen by surgeons for diagnostic laparoscopy and appendicectomy. Uneventful open surgery and presumed appendicectomy. (laparoscopy not suitable in pregnancy) Admitted [days] later with abdominal pain. On reviewing histology report it was noted "Normal fallopian tube" Patient informed of findings, symptoms resolved and discharged home. Immediate review of surgical notes and discussion with surgeon revealed an uneventful procedure. The surgeon identified what they believed to be the appendix and removed this not wanting to cause any further problems with an extended anaesthetic etc. The Trust have considered the revised Never Event policy and all the guidance within. It must be noted that no checking or site marking can be applied. The guidance does note that wrong site surgery excludes unknown, unexpected abnormality of patient anatomy. It is felt that a [third trimester] pregnant uterus could be deemed as unexpected anatomy. However, one would expect a discussion at the pre briefing with this regard. All histology samples were checked for that day and a second histologist reviewed the specimen which was confirmed as a fallopian tube.

(ii) 20 May 2015 – 30 June 2015 – Wrong site angioplasty

The patient,[patient description] attended the Radiology Department on [date] for a left iliac artery angioplasty which was requested on [date]. The request card detailed a history of critical limb ischaemia to left leg, no palpable pedal pulses and pain at rest in left foot. [Description of antegrade puncture procedure] After the procedure was abandoned, the Doctor carrying out the arteriogram realised that they had mis-read the request card and assumed that the patient with critical limb ischaemia needed an angioplasty of the SFA and popliteal artery but in fact the request was for a left iliac angioplasty. The patient was reassured and sent back to the ward with the correct procedure being organised for the

following week.

(iii) July 2015 – Part of a chisel

No longer on StEIS

(iv) July 2015 - Incorrect blood transfused

A [patient] was admitted [day] from [Hospital]. Patient has complex medical history including drug abuse, bilateral DVT/PE; possible infective endocarditis and femoral pseudoaneurysm. Unable to obtain blood from patient due to difficult access. Bloods taken on [date] and sent to lab. Sample stated group A positive and 2 units of blood were x-matched. patient was transfused 1 unit blood on [date/time]. No adverse symptoms apart from minor spike in temperature, but patient had a pyrexia pre-transfusion. Decision to transfuse second unit of blood on [date/time]. Reaction by patient 10 minutes after transfusing, chest pain and rise in temperature. less than 1/3 of unit transfused. Further sample sent for x-match which showed that patient was B positive. Second sample taken - confirmed patient is B positive. Alert received from lab that a transfusion error had occurred. Blood transfusion immediately stopped. Repeat blood samples taken. Patient has not developed any current side effects from the transfusion reaction. Root causes found to be: Incompatible red cells were transfused to a patient due to a pre-transfusion sampling error where the blood was collected by the doctor from the wrong patient because the required patient identification checks were not completed. The doctor involved had not received blood transfusion training. The laboratory did not request a second sample to be taken prior to issuing the blood which was a missed opportunity to rectify the pre-transfusion sampling error and therefore contributed to the incident.

(iv) August 2015 - Removal of complex pelvic tumour, distorted anatomy and kidney removed inadvertently.

Patient attended theatre for Insertion of JJ Stents and Laparotomy with removal of Pelvic sarcoma. When main body of the tumour was removed it was noted by the Surgeon that the tumour was removed with the left Kidney. The kidney was encapsulated within the tumour and the ureter was draining through the tumour. Surgeon requested Transplant, Vascular surgeons and Consultant Urologist be called immediately to theatre. All attended quickly. Patient stablized surgery completed and Patient transferred to [Unit]. Following investigation this was agreed by the provider and their commissioner not to be a Never

Event as the kidney was encapsulated within the tumour and was considered to be unavoidable.

(vi) August 2015 - Procedure undertaken on wrong patient

Patient was called in for laser PRP treatment by [staff], and presented when called. Patient was consented for PRP laser treatment given risks and benefits from it. Patient didn't tell the [staff] anything and proceeded to left eye PRP. After around 3/4 of the procedure, it became clear that the patient hadn't been booked for laser treatment, it was the wrong patient. The nurse who was assisting, knocked on the door and informed the [staff] about this patient and that the patient was the wrong person treated. Procedure stopped immediately.

(vii) September 2015 - Wrong side incision for a craniotomy

A patient underwent emergency craniotomy for an intracerebral bleed. The consent form and WHO sign in stated right side of the head but the left side of the head was prepared and a skin flap and three burr holes performed. A consultant neurosurgeon joined the operating team and identified the error. The surgery was stopped and the incision closed (prior to removal of the cranium) and the correct procedure was done on the right side. The procedure was completed and the patient taken to [Unit]

(viii) November 2015 - Wrong blood transfused

The baby was admitted to [Hospital/Unit] with clinical details of 'bleeding' and 'severely unwell baby'. • An emergency O negative paediatric unit was requested • A call was made to blood bank to request a unit of paediatric fresh frozen plasma (FFP) • No group and save sample available in the laboratory • Group O FFP issued instead of AB FFP • The unit was transfused. • The babies group and save sample received by the laboratory • The sample grouped as BRhD positive. • On entering the group on patient record it was discovered that the baby had been given group O FFP. Root cause: Lone working [staff] erroneously issued FFP group O in error for FFP group AB. This was not a selection error or an error of basic knowledge but a mistake made in the heat of an on-going emergency

(ix) December 2015 - Incision to wrong testis

The patient was due to undergo a procedure to remove a cyst from the left testis. The surgeon mistakenly started preparing the right testis to the extent of making an incision before realising this was the wrong testis. The surgeon sewed up the incision and proceeded to operate on the correct site with full normal outcome.

(x) December 2015 - Ovaries removed when the plan was to conserve them

Patient consented for Total laparoscopic hysterectomy, with removal of ovaries if abnormal. Partway through the Total Laparoscopic Hysterectomy, whilst ligating the second ovary, the assisting registrar alerted the operating consultant that the patient was not having her ovaries removed, the ovaries were normal. WHO surgical checklist had been performed.

(xi) December 2015 - Wrong procedure wrong patient had the procedure (x 2)

1. On [date] the [specialist job title] nurse telephoned [ward] to inform them that the patient due to have an ascitic drain inserted could be taken to the [Unit]. The ward clerk passed the message to a nurse. The patient was prone to confusion so they were accompanied by the ward nursing assistant to the [Unit]. The consent form was completed and signed by the patient. The ascitic drain procedure was carried out and afterwards the patient returned to the ward. On completion of the procedure the [specialist job title] nurse was informed that another patient had arrived from [ward] for an ascetic drain insertion. Root cause was identified as Failure to follow the Trust Patient Identification Policy.

2. A patient with cancer was consented for an Oesophago-Gastro Duodenoscopy (OGD). On [date] an OGD was performed as per a request made on [electronic system]. It was then noted during a clinical review of the results that the patient had undergone the OGD in error. The patient's endoscopy report and [electronic system] record has been reviewed; both confirm that biopsies were not taken. Root causes identified as 1) The referring doctor did not select the correct patient on [electronic system] when ordering the OGD investigation.
2) Decision made to proceed with the [procedure] based on a clinical indication identified in consultation with the patient rather than that indicated on the referral, but without consultation with the referring clinician.

(xii) December 2015 – Wrong toes

Patient required a bilateral flexor tenotomy on third toes, but this was done on second toes instead. The [form] identified the operation site as second toes, so this was incorrect. The surgeon who did the operation was a locum who had not assessed the patient themselves in clinic. The locum surgeon has reported that the patient was very difficult to assess on the day and so they did the operation as listed. The root causes identified were: At the time that the surgeon decided to operate the surgeon expected to be doing the operation and did not have any doubt about which toes would be operated on. The rapid through put required in this clinic does not allow for routine checking of TCI cards. Patients are only offered a second outpatient assessment if there are known complicating patient or procedural factors. The need for a further assessment was not prioritised based on the perceived need to reassess the patient, the confidence that the initial assessment would be accurate and the other operational needs on the day.
While the patient received the operation on the incorrect site, this investigation has confirmed that this is not due to a failure in the WHO checking process as such, but rather that the failure occurred at an earlier stage and that the information that was being used to confirm the operation site was not accurate and so these checks could not highlight that the incorrect operation site had been identified.

(xiii) March 2016 - Wrong procedure - Gastroscopy rather than Colonoscopy

The patient was admitted as a day case patient to undergo a Colonoscopy. The patient was consented for and underwent an OGD. The root cause was identified as follows: the team were focused on the procedure they believed they were due to carry out and did not complete further checks because they assumed that the notes they were referring to was for patient[a]. The consultant did not go back to basics and check the information thoroughly; the consultant assumed the notes were correct and focused on the clinical details and indications only.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement Patient Safety Team