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8 November 2017

[redacted]

By email

[redacted]

Dear Mr [redacted]

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

I refer to your email of **13th October 2017** 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 the 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 2016-17 financial year on the NHS England website, as well as a similar list of provisional Never Events for April 2017 to 31 August 2017. For each of these cases listed below 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.

From the 2016-17 list:
i. Cervical biopsy rather than rectal biopsy x 2
ii. Ovary removed when plan was to conserve
iii. Patient had a procedure intended for another patient
iv. Wrong patient - received a subcutanous device to monitor heart rhythm that was intended for another patient
v. Wrong side of brain
vi. Retained foreign object - Part of surgical forceps
vii. Wrong blood transfused

From the 2017 (April to August) list:
i. Ovaries removed in error during a hysterectomy when plan was to conserve them x3
ii. Retained foreign object – surgical instrument

Yours Sincerely,
Matthew Davis"

Decision

NHS Improvement holds the information that you have requested and has decided to release most of the information that it holds.

As you have specifically requested Never Events please note that the revised 2015 Never Events Policy and Framework requires commissioners and providers to agree and report Never Events via the Strategic Executive Information System (StEIS). Where a Serious Incident is logged as a Never Event but does not appear to fit any definition on the Never Events List 2015/16, commissioners are asked to discuss this with the provider organisation and either add extra detail to StEIS to confirm it is a Never Event or remove its Never Event designation from the StEIS system.
Further information on Never Events can be found in the following link:
https://improvement.nhs.uk/resources/never-events-data/

It is also important to note that we can only provide the incident descriptions as they are recorded where these were relevant to your request, therefore some of the information you requested such as how long before an object left behind in the patient was removed will not always be included. The incident descriptions provided are verbatim but have been redacted to remove personal data further to the exemption in section 40 of the FOI Act. Redactions are indicated by square brackets.

Section 40 - personal information

NHS Improvement considers that some information is exempt from disclosure under section 40(2) of the FOI Act on the grounds that it amounts to personal data and the first condition under section 40(3)(a)(i) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data should be processed fairly and lawfully) as the individuals concerned would have a reasonable expectation that their information would not be disclosed into the public domain. Section 40 is an absolute exemption and consideration of the public interest test in disclosure is not required.

Please see in Table 1 the descriptions for the list of Never Events that you provided:

Table 1

Never Event	Description of incident
cervical biopsy rather than rectal biopsy	The patient attended for a flexible sigmoidoscopy and had consented to this. The [initials] report stated that there was an unusal circumferential narrowing. The images were reviewed by Senior Nursing staff and the Colorectal surgeon and confirmed the images were of the cervix. The patient also had a biopsy and therefore a biopsy of the cervix was taken.

	Images reviewed by Colorectal surgeon and Senior nursing staff - identified images were of the cervix. Datix completed. Patient contacted by The Clincal Lead. [date] Clinical lead and Head of Patient Flow made aware. [date] Senior manager and Executive on call contacted as out of normal working hours. Alternative cover provided for the individual practitioner's endoscopy list until an initial investigation complete. [date] Patient attended for flexible sigmoidoscopy, support given by Senior Nursing staff during procedure. The patient was also reviewed by the gynaecology doctor.
cervical biopsy rather than rectal biopsy	The patient attended for flexible sigmoidoscopy for rectal bleeding. Following discussion with the patient and her mother and confirmation of her consent, [initials]performed a Digital Rectal Examination which was normal and inserted the scope. There was what looked like an abnormality at 15cm which looked like a stricture. I have received an email from Dr [initials] consultant histopathologist to inform me that biopsies showed benign endocervical tissue.
Ovary removed when plan was to conserve	[initials] was listed for a Robotically Assisted Total Laparoscopic Hysterectomy with Conservation of Ovaries, as part of treatment for cervical cancer. However, in error the blood supply to the Right Ovary was ligated (suture tied around anatomical structure to stop blood supply) causing the tissue to become necrotic and had to be removed. Therefore, [initials] had a Robotically Assisted Total Laparoscopic Hysterectomy and Right Salpingo-Oophorectomy. There has been a delay in making a NE decision as not all information was clear as to how the removal of the ovary came about. i.e. clinical reason or in error. This information as reviewed today. [date] Operating surgeon informed [initials] of the incident on [date]. Operating surgeon advised [initials] that they had damaged the blood supply to the right ovary and therefore, had to be removed. Advised [initials] that unlikely to have any severe consequences as a result due to left ovary remaining.
patient had procedure intended for another patient	The patient underwent a Loop Biopsy procedure that was planned for another patient. The wrong patient records were found in the patients records and this patient required a loop biopsy. The patients both had the same surnames. Both patients underwent a loop biopsy Incident was reported on the [date] and following a 72 hour review now identified as a Never Event and so Steised. Duty of Candour underway
wrong patient received a subcutaneous device to monitor heart rhythm	Communication error in referral process, meant wrong patient attended for implantation of lin Q. This is a sub cut device that monitors heart rhythmns. The correct patient has recieved his implant today. Patient contacted and informed of error. Device wil be removed [date].
wrong side of brain	Wrong side surgery. Patient consented for right sided diagnostic brain biopsy but procedure carried out on left side. No harm came to the patients as this was a diagnostic biopsy and therefore could have been performed on either side of the brain Scoping meeting held. RCA commenced. CCG informed
part of surgical forceps	The Trust has declared a Never Event in relation to an incident identified on the [date] as a result of a retained piece of a surgical instrument. The patient underwent a laparoscopic gynaecological abdominal surgery following which it was identified that a piece from a surgical instrument (forceps) had become detached and had been left within the abdominal cavity.

	Records indicate that a count/check of the forceps was undertaken both pre- and post-surgery, but that this did not identify that part of the instrument was missing. The failure of the equipment was identified when it was returned to the Sterile Services Department[On the same date]. An X-ray then confirmed the presence of the foreign body in the patient's abdominal cavity, further surgery was then undertaken and the foreign body was retrieved. The patient is fully aware of the events that have occurred and is currently recovering from their surgical procedure. A full investigation is in progress in accordance with the Trust's incident procedures On identification of the Never Event some initial actions have been identified for immediate review and implementation: • Notify all the internal and external contacts required for a Never Event. • Arrange a staff debrief session for the staff involved in the incident. • Send the surgical equipment externally for assessment. • Update the patient on the investigation and invite them to participate
wrong blood transfused	Patient admitted was 14 week gestation due to large retro chorionic haematoma, with a history of bleeding since 7 week gestation and she had numerous admissions. [time] Surgery commenced, suctioned evacuated two-litre blood loss. Patient continued to bleed (2.5 litre blood loss was recorded). Anaesthetist requested flying squad blood. The patient's blood group is B Rh D Negative. Two units of O Rh D positive flying squad blood were administered to the patient. The patient is a [under 30] year old female who should have been transfused O Rh D Negative. [time + 42 minutes] Wrong blood given identified by Transfusion staff. On initial investigation, • Blood checked correctly against label provided • The labelling of the blood in the blood fridge was not optimum, i.e. not clearly identified in the fridge that the blood was rhesus positive. • Since [date] only one blood fridge is in use and it is not the usual layout. A new fridge is on order. The verbal duty of candour was carried out by surgeon on [date, time] and recorded in operation noted. Consultant anaesthetist [date, time] in post op recovery ward and again on the [date] when the patient returned to have repeat blood tests. summary of discussions documented on correct form in the notes. DoC letter sent to patient on [date]
ovaries removed when plan to conserve	Patient consented pre-op for bilateral salpingo-oophorectomy changed her consent on day of theatre opting to conserve the ovaries. Surgeon aware of change in consent. When operating the ovarian arteries were divided which meant the ovaries had to be removed. Operation concluded uneventfully, surgeon spoke to patient offering explanation and an apology
ovaries removed when plan to conserve	NEVER EVENT: Consented for total hysterectomy and bilateral salpingectomy in clinic for heavy bleeding. Consent confirmed on morning of procedure by registrar at [time]. Patient called to theatre at [time + 6 hours]. At WHO checklist scrub nurse confirmed procedure "total abdominal hysterectomy and removal of both fallopian tubes".

	Procedure started and both tubes and ovaries removed. Reported today following Divisional approval. Escalated to Band [number] in theatre.
ovaries removed when plan to conserve	The patient originally consented to a bilateral salipingo-oophorectomy and subsequently requested that ovaries be preserved. A bilateral salipingo-oophorectomy was then undertaken during a total laparoscopic hysterectomy for fibroids. The patient should not suffer any physical long term health implications as a result. The Gynaecology Risk Management Team were informed immediately.
surgical instrument	A [age 60 plus] year old woman underwent major abdominal surgery for cancer on [date], including a total abdominal hysterectomy, bilateral salpingo-oophorectomy, splenectomy and left pelvic lymphadenopathy. The procedure took five hours and was complicated by higher than expected intraoperative bleeding. The patient was transferred to Overnight Intensive Recovery and then to [name] HDU before being transferred to the Gynaecology Ward on [date] (five days post-op). Her recovery was complicated by acute kidney injury, high drain output and abdominal pain. Investigations were undertaken to understand the cause of the patient's slow recovery. The patient underwent a CT scan, on [date + 15 days], which revealed a retained 22cm Roberts clamp. The patient returned to theatre on [date + 16 days] for laparotomy and removal of the clamp, and has now returned to the Gynaecology Ward. The patient is currently making a good recovery from her second surgery. • The patient and her husband have received an apology and been made aware that an investigation is underway. They will receive ongoing support from the Gynaecology [role] Nurse who will be their main point of contact. • The staff involved have been offered support and the opportunity to have a full debrief.

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