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Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Serious Incident Investigations: mid-year report		
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Meeting	Public Trust Board	**Date**	7th November 2019

1. Suggested discussion points *[two or three issues you consider the Board should focus on]*

The Board is presented with a summary of the serious incidents reported in 2019/20 to date, highlighting the fundamental reason for the occurrence of a problem, other factors that were partly responsible and the changes that have resulted following investigation to prevent a repeat issue. The report also provides an update on those incidents which were still being investigated at the time of the last report in May 2019.

A number of the investigations have been completed but the final reports are awaiting sign-off from the Group or Medical Director. Positively, in two cases Unity, our new electronic patient record, will provide a solution to the problem identified.

A further Maternal death has occurred, which is being investigated externally and as yet there is no cause of death from the post mortem.

Learning remains the key aim of investigating serious incidents although not always easy to elicit, so work continues to ensure we are able to achieve this.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	**X**	Public Health Plan		People Plan & Education Plan	**X**
Quality Plan	**X**	Research and Development		Estates Plan	
Financial Plan	**X**	Digital Plan	**X**	Other *[specify in the paper]*	**X**

3. Previous consideration *[where has this paper been previously discussed?]*

Individual SIs to EQC and Executives.

4. Recommendation(s)

Trust Board is asked to:

a.	**NOTE** the use of the IDT and to present the data within the next report.
b.	**ACCEPT** that serious incidents are being robustly investigated to ensure improvements are made and learning identified.
c.	**RECEIVE** a progress report on the **we**learn programme in January 2020.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	x	Risk Number(s):						
Board Assurance Framework		Risk Number(s):						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Private Trust Board: 7th November 2019

Serious Incident Investigations: mid-year report

1. Introduction

1.1 This report provides an update to the Board on the Serious Incidents (SIs) which were still being investigated at the time of the last report in May 2019 and SIs which have occurred since, or been reported from 1 April 2019.

1.2 Individual investigations identify changes which aim to prevent the same type of event happening again and will improve the services provided. In some of the SIs, actions identified would not have prevented or changed the outcome for the patient but may have afforded better understanding of how the incident happened.

2. Update on 2018/19 SIs

2.1 **Appendix A** provides information on the 2018/19 incidents which were still under investigation at the time of the last report.

2.2 Of the four cases presented one was a maternal death which was included in the maternal deaths learning enquiry that was presented to the Board in August. Another concluded no actions were required to prevent recurrence.

2.3 Following a stillbirth, it was identified that there was no assurance that results following ultrasound were consistently reviewed so they have introduced a flagging system to call attention that a test result is abnormal.

2.4 The final case called out the need to ensure communications are clear and who is responsible for the plan of care or portions of it are more obvious. Actions are overdue and ongoing on this incident.

3. 2019/2020 Serious Incidents

3.1 **Appendix B** gives details of the serious incidents investigated so far this year and those currently in investigation**.**

3.2 This year has seen 3 Never Events reported. One was wrong site surgery and two were retained items (a surgical swab and an instrument). All have been presented to the Board previously.

3.3 Trust Board will recall two particular trends from last year's SIs, which were head injuries (HI) and metastatic spinal cord compressions (MSCC).

3.4 There has not been the same continued trend this year for MSCC. There have been a further two patients who have sustained head injuries following a fall and have died. One case was handled in line with the Trust's guidelines which are based on NICE best practice.

The second was in an outpatient environment where we learnt that the policies and pathways we have in place are more relevant to inpatient areas. This is being resolved through the action plan.

3.5 There has been a further maternal death, which is being investigated by the Healthcare Safety Investigation Branch (HSIB). Their report and recommendations will be shared once they have completed their investigation.

3.6 Two of the incidents may be downgraded from a SI as early indications from both investigations are that the failings in care initially identified are not the case or are not causative. The investigation will continue and regardless of the conclusion, there is learning already being identified.

4. Learning from SIs

4.1 From those investigations already concluded we have learnt that the new Electronic Patient Record, Unity, will be the solution for two of the SIs, one of which is the wrong site surgery Never Event.

4.2 Assurance that staff are aware of and follow policies and guidelines is limited, which was seen from the unwitnessed fall. The introduction of a new platform early next year to support policies and guidelines will resolve this issue, whilst also amending to ensure the scope of applicability is also transparent.

5. Incident Decision Tree

5.1 The incident decision tree (IDT) was devised by the former National Patient Safety Agency (NPSA) to ensure staff were treated fairly and consistently following a SI investigation.

5.2 For those SIs it has been applied to, to date, three reviews have identified that the staff member should not be carrying out the practice without further remedial intervention. In one case this meant training and in the other two, the staff member no longer practices the intervention.

5.3 The IDT will continue to be applied to SIs and a report on all of the outcomes will be presented as part of the next SI report.

6. Conclusion

6.1 Changes to services, care and the way colleagues carry out processes are happening following incident investigations. What is less assured is that we can evidence that local change and whether the learning has been shared and adopted more widely across the organisation.

6.2 The **we**learn programme, presented to the Board in June, is the Trust's platform for putting this into practice. Some elements of the programme, such as QIHD accreditation and the Poster Contest, have moved forward but the overall delivery plan has been slow to progress. The remainder of Q3 and Q4 will focus on getting **we**learn on track

7. Recommendations

Trust Board is recommended to:

7.1 **NOTE** the use of the IDT and to present the data within the next report.
7.2 **CONFIRM** that serious incidents are being robustly investigated to ensure improvements are made and learning identified.
7.3 **RECEIVE** a progress report on the **we**learn programme in January 2020.

Allison Binns
Deputy Director of Governance

26 October 2019

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Serious Clinical Incident Summary Carried over from 2018/19

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/Solution
1.	21/12/18	199918	Women & Child Health	Maternity	Maternal Death	Woman in her first pregnancy increased Body mass Index of 51, chronic hypertension, type 2 diabetes and bipolar disorder. Collapsed at home and brought in by ambulance. Peri Mortem caesarean section performed. Death of mother and baby confirmed in ED. **Post Mortem:** Amniotic Fluid embolism	**INVESTIGATION COMPLETE** This case was managed well with no obvious areas for change. The case was one of the 5 included in the Maternal Deaths learning enquiry.
2.	23/01/2019	202452	Medicine & Emergency Care	Emergency Medicine	Unexpected patient death following a cardiac arrest	Patient attended GP 'Walk In centre" 2 days prior to admission with shortness of breath. She was diagnosed with chest infection, prescribed Ventolin inhaler and antibiotics and discharged home. **Post mortem:** Ischaemic Heart Disease (IHD) (2) Severe Coronary Artery Arteriosclerosis **Contributory factors** Chest Infection	**INVESTIGATION COMPLETE** There were no recommendations made as care was found to follow the correct pathways.

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/Solution
3.	27/02/2019	204453	Medicine & Emergency Care	Acute Medical Unit (AMU)	Failure to diagnose bowel cancer	Patient presented with iron deficiency anaemia (IDA) in September 2017. He was given iron and his IDA was thought to be caused by aspirin and warfarin. He re-presented with recurrent IDA in September 2018. An urgent oesophago-gastroduodenoscopy (OGD) and colonoscopy were requested but only an OGD was carried out. In February 2019, via the bowel cancer screening programme, he was given a colonoscopy. This identified that he has incurable bowel cancer that could have been treated if diagnosed earlier.	**ACTIONS ONGOING** - Trust guideline being developed and will be implemented (31/10/19) - Parent medical team to retain responsibility for care plan if not specified that specialty will take over care (31/08/19) **overdue** - Endoscopy procedural sheet to be amended to detail changes in procedures and why (31/08/19) **overdue** - AMU virtual clinic outcomes to have Consultant reviews (31/08/19) **overdue**
4.	26/03/2019	2019/7241	Women & Child Health	Maternity	Still birth	A 17 year old in her first pregnancy with a history of Type 1 diabetes and febrile seizures was assessed as high risk and requiring of shared antenatal care. There was some concern her diabetes was not being optimally controlled, resulting in her baby growing larger than expected, which was confirmed on ultrasound in March 2019, and that the End diastolic flow (EDF) was absent. **Contributory factors:** • Poorly controlled diabetes contributing to macrosomia. • No flagging system in place to highlight abnormal results.	**INVESTIGATION COMPLETE** A flagging system has been introduced between sonographers and obstetrics for abnormal results

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Serious Clinical Incident Summary Reported between 1 April 2019 – to date

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
1.	17/04/19	2019/11021	Medicine	Cardiology	Death following an Unwitnessed fall	The patient attended for a supervised exercise class in the cardiac rehab gym. The patient fell at approximately 2.25pm and staff within the vicinity attended to him immediately. The patient was on the floor, lying on his left side with blood beside his head. He was responsive and talking to staff at the time. An EMRT call was immediately put out although vital signs were observed and were within normal limits. The EMRT arrived and took over management. Paramedics were called and the patient was transferred QEHB for a possible spinal injury. He died 6 days later.	**INVESTIGATION COMPLETE** It has not been possible to identify what actually caused the patient to have a fractured neck. • CCTV cameras are being installed **(Oct 19)** • Head Injury Pathway being updated and will be shared widely **(Nov 19)** • Rehab team to ensure they have more than one contact number for NOK **(Oct 19)**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
2.	06/05/19	2019/11322	Medicine	Care of the Elderly	Death following an unwitnessed fall	The patient was admitted in May 2019 to Lyndon 4 ward with community acquired pneumonia and acute on chronic kidney injury. Three days later, during the early hours he had a fall and sustained a laceration over his left eye. Following a period of observation he was discharged the following day. He was readmitted 2 days later. Following a seizure, the next day, he was admitted to CCS after a CT scan showed a subdural haematoma (bleeding around the brain). He was transferred to UHB and passed away there in early June 2019.	**INVESTIGATION COMPLETED** Staff followed the HI pathway observing the patient and undertaking any necessary tests. The patient was discharged apporpiately.
3.	14/05/19	2019/11348	Surgery	General Surgery	Wrong site surgery **NEVER EVENT**	Patient booked for a planned surgical procedure but failure to document the exact location of the sinus to be operated on: – Consent form – ORMIS (operation management system) – Pre-operative checks (with patient and clinic letter) Led to the surgery being carried out on the wrong sinus.	**INVESTIGATION COMPLETED – awaiting sign off** • This will be resolved when surginet is introduced providing the correct procedure and anatomical site is entered into Unity.

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
4.	25/05/19	2019/13218	PCC&T/ S&G	Dermatology/ IT	Non-automated scheduling of an aoutpatient appointment	Patient was referred to the Dermatology Services. He had a previous history of malignant melanoma and had undergone wide local excision at Walsall in November 2017. Patient had not been attending his subsequent follow up appointments so his GP referred him to SWB to take over his care. He was reviewed in Dermatology in September 2018. He was for a further 3-month follow-up appointment but this was not completed. Patient presented to City ED in May 2019, was admitted and passed away on 6 days later, due to malignant melanoma. The lack of follow up was caused by a failure between IT systems which was not noticed by staff.	**INVESTIGATION COMPLETED** • New SOP written and shared with team who validate and check the messages between the IT systems involved. • Checklist used for the above updated and all staff trained. UNITY and Lorenzo links will prevent this from happening again.

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
5.	05/06/19	2019/ 13438	Medicine	Urology	Infection control/cross contamination	In April 2018 the IPC team was made aware of inadequate decontamination procedures being used for transrectal ultrasound probes in Interventional Radiology, Theatres and Endoscopy. A change from Clinell Universal to Tristel Trio™ wipes was recommended and this was notified to the relevant services by email. As part of routine checks in June 2019 an IPC Nurse discovered that Tristel Trio™ wipes were not being used to decontaminate the transrectal ultrasound probe in Endoscopy. **PHE involved and incident judged to be very low risk.**	**INVESTIGATION COMPLETED** Where important safety information is cascaded via email, read receipts and follow on checks need to be put into place. • Decontamination policy to be updated to include US probes **(Dec 2019)**
6.	24/06/19	2019/14182	Surgery	Theatres	Retained vaginal swab **NEVER EVENT**	Patient attended a total Laparoscopic Hysterectomy in June 2019 which was completed successfully. The following day the patient began to complain of some tenderness and discomfort in her groin and vagina. She was found to have a medium swab left within the vagina.	**INVESTIGATION COMPLETED – awaiting sign off** • Systemic refocus of the swab count process • Visual inspection of the vagina by surgeon and scrub nurse at operation conclusion

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
7.	32106/19	2019/14870	W&CH	Maternity	Neonatal death	The mother presented at 34+1 weeks gestation with reduced fetal movements. An emergency caesarean section was performed and the Baby was born in poor condition, needing prolonged resuscitation before being admitted to the Neonatal Unit. The baby D was transferred to a tertiary centre for continuing care where he passed away two days later.	**INVESTIGATION COMPLETED** CTG reading compliance to be current for all substantive and locum staff **(Nov 19)** Improve communication between triage and shift coordinator **(31 Oct 19)**
8.	10/06/19	2019/16341	Surgery	Ophthalmology	Retained instrument **NEVER EVENT**	Patient underwent a planned operative procedure in June 2019 at BMEC. Surgery was performed by a senior training fellow under the direct supervision of the consultant. The patient was discharged after the procedure on the same day and routinely reviewed in clinic a week later. The patient was discharged for further follow up by BMEC. At routine review at Shrewsbury in July 2019 it was noted there was a trocar (a surgical instrument used for draining fluid) in the upper portion of the left eye. The patient was reviewed the next day at BMEC and the retained trocar was removed under local anaesthetic.	**INVESTIGATION COMPLETED – awaiting sign off** • Swab policy to be updated **(Nov 19)** • Reinforcement of hard stop and correct instrument count procedure. (complete)

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
9.	02/07/19	2019/16365	Surgery/Medicine	T&O	Unexpected death	The patient attended ED in the afternoon in July 2019, complaining of worsening lumbar back pain from a pre-existing condition. The patient was transferred onto AMU1 very early the next morning. That same evening the patient suddenly collapsed and suffered a cardiac arrest, was transferred to CCS where she passed away four days later. **Contributory factors:** • Surgical patient on a medical assessment unit • Delay in clerking and risk assessment for VTE	**INVESTIGATION COMPLETED** **Recommendations awaiting actions:** • Consider whether VTE risk assessment should be carried out in ED at time of DTA • Develop a surgical over capacity policy with clear plan for roles, responsibilities and lines of communication for medical staff when surgical patients admitted to non-surgical beds.
10.	08/09/19	2019/19949	W&CH	Maternity	Maternal Death	Woman in her first pregnancy with spontaneous rupture of membranes in early September. Induction of labour with delivery of baby in good condition using forceps. Patient reported chest pain then became unresponsive but despite resuscitation passed away.	**INVESTIGATION BEING CARRIED OUT BY HSIB**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
11.	27/06/19	2019/19966	W&CH	Gynaecology	Delayed cancer diagnosis – SJ May be downgraded	Patient attended with irregular vaginal bleeding and foul smelling discharge following a 2ww referral in August 2018. Results of a biopsy did not show anything suspicious. The patient continued to have symptoms so was referred for a hysteroscopy procedure. Further biopsies showed nothing suspicious. She was referred back and seen in late June 2019 and has been diagnosed with cancer of the cervix.	**INVESTIGATION ON-GOING** This was initially thought to be a missed diagnosis through lack of care and treatment, however early investigation shows two admissions for biopsies, which were negative.
12.	18/09/19	2019/20853	Medicine	Care of the Elderly	Medication incident – May be downgraded	Patient was on a novel anticoagulant which he took twice a day. It was prescribed incorrectly as once a day. Once reconciliation had happened, the prescription was revised to twice daily. The patient did not receive three of the evening doses and then had a stroke. He has since died. Indications are that the stroke amy not be attributed to the medication issue.	**INVESTIGATION ON-GOING** Indications are that the stroke may not be attributed to the medication issue.
13.	01/07/19	2019/21595	Surgery	Urology	Death during a surgical procedure	The patient was a 46 year old man with diabetes admitted for a planned procedure to remove his right kidney due to renal cancer. During surgery, the patient had a massive haemorrhage and later died.	**INVESTIGATION ON-GOING**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
14.	07/10/19	2019/23073	W&CH	Maternity	Intruterine death	Woman in her fourth pregnancy. Was referred to fetal medicine as growth had fallen below 5th centile. Presented at 41+1 with decreased fetal movements. An intrauterine death was confirmed.	**INVESTIGATION ON-GOING**
15.	11/10/19	2019/23002	Surgery	Surgery	Delay in diagnosis	This patient has been diagnosed with a duodenal carcinoma. The patient was admitted in 2017 with a lesion in that area, and needed a stent sited by ERCP. Biopsies showed dysplasia. Patient was not listed for MDT discussion, neither was a clinic follow up done. The patient was left with the stent for two years until she presented recently with weight loss and vomiting, and the cancer was diagnosed.	**INVESTIGATION ON-GOING**