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 **Completed** • 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 **Completed**

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2.	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. **Completed** Improve communication between triage and shift coordinator. **Completed**
3.	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~~/Feb 2020) Overdue*** • Reinforcement of hard stop and correct instrument count procedure. **Completed** • Equipment parts count pre-close

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4.	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 and physical examination of the vagina by surgeon and scrub nurse at operation conclusion.
5.	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** • Sinus site marking for all procedures even where singular anatomy. • This will be resolved when surginet is introduced providing the correct procedure and anatomical site is entered into Unity.