Paper ref:	TB (01/21) 016

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Surgical Never Event briefing		
Sponsoring Executive	David Carruthers, Medical Director and Acting Chief Executive		
Report Author	Siten Roy, Group Director, Surgical Services		
Meeting	Trust Board (Public)	**Date**	7th January 2021

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

There has been a further Never Event involving a trocar in Ophthalmology. At the time of the incident, staff followed the correct processes to ascertain if the trocar remained in the eye but may have been falsely reassured.

Early indications show that discussion with the patient was not held or was but not documented.

The incident will now be subject to an internal investigation.

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

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

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

Individual notifications.

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** the incident and the detail so far
b.	**DISCUSS** the event
c.	**AGREE** to receive further information at February 2021 meeting

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

Trust Risk Register							
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 7th January 2021

Surgical Never Event Briefing

1. Introduction

1.1 The Trust Board will be aware of a group of incidents which are defined as 'Never Events,' essentially incidents that should never happen when systems and processes are in place and followed.

1.2 During a routine post-operative review on 21 December 2020, a patient asked the Consultant if the item that had fallen out of her eye two days prior, could be the item that had gone missing during her surgery in May 2020.

1.3 The item was identified as a trocar, which is a counted item, and thus is defined as a retained foreign object, classifying the incident as a Never Event.

2. Events on the day of Surgery

2.1 The patient attended for surgery on 22 May 2020. At the end of the operation the team identified that they had lost a trocar.

2.2 All three trocars, used during the surgery, were removed at the end, but one was lost when picked up with the forceps and not found anywhere.

2.3 The trocar was definitely not still in the original port. The lost trocar was noted on the operative record and, as is procedure, the patient had an x-ray to see if the trocar was still in the eye. The x-ray was reported as not seeing a foreign object within the eye, reassuring staff.

2.4 The loss of the trocar was documented on the operative sheet and an incident form was completed at the time.

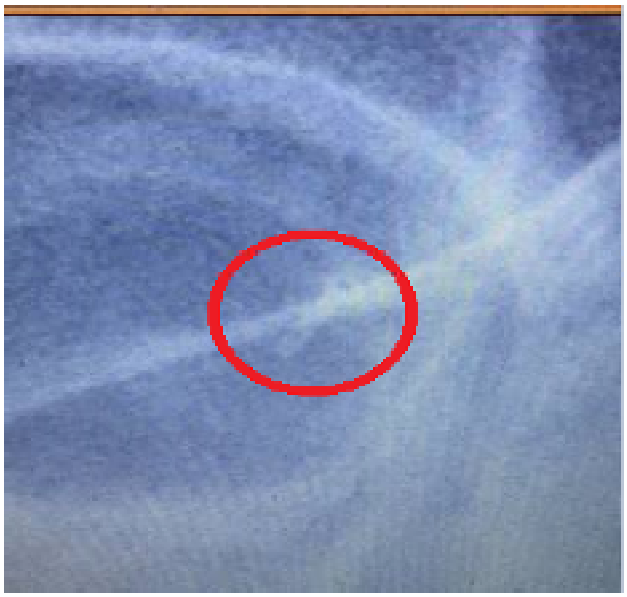
2.5 The patient remained in hospital overnight, as is normal, and was then discharged with a series of follow up appointments.

3. Post-Operative Follow Up

3.1 The patient had routine follow up appointments at 3 weeks, 3 months and 6 months, mostly with a Consultant. Her recovery was uneventful.

3.2 During the 6 month follow up, the patient showed the Consultant something that had fallen out of her eye a few days before. This was identified as a trocar used during the surgery.

3.3 It is thought that the trocar got stuck under the eyelid. Although the imaging report stated that there were no foreign bodies seen, with hindsight and a closer review, the trocar can be seen.



4. Next Steps

4.1 Investigation Lead to be assigned and commence review of processes leading up to and after the incident.

4.2 Feedback what happened and what has been learnt to the patient and across the wider organisation.

5. Recommendations

5.1 The Trust Board is asked to:

a. **NOTE** the incident and the detail so far
b. **DISCUSS** the event
c. **AGREE** to receive further information at February 2021 meeting

Siten Roy
Group Director for Surgical Services
4 January 2021