Clinical Record Review Report

Report on 31 Clinical Records Relating to General Surgery

on behalf of Wrightington, Wigan and Leigh NHS Foundation Trust

Report issued: 18 June 2020

A clinical record review on behalf of:

The Royal College of Surgeons of England

Association of Surgeons of Great Britain & Ireland

Review team:

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1. Introduction and background

On 14 November 2019, Dr Sanjay Arya, Medical Director for Wrightington, Wigan & Leigh NHS Foundation Trust ('the Trust') wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited clinical record review of a sample of general surgical cases. In particular, the request highlighted concerns that have been raised regarding the quality and safety of the care being provided. This request was considered by the Chair of the RCS IRM and a representative of Association of Surgeons of Great Britain and Ireland (ASGBI) and after further discussion with the Trust, it was agreed that an invited service review would take place.

was appointed and an invited service review was arranged to take place on 24 and 25 March. However, due to the significant challenges related to the COVID-19 pandemic, the service review visit could not proceed. Subsequently, it was agreed that there would be an invited clinical record review of 31 clinical records of patients who had undergone a general surgery procedure. This clinical record review was carried out with the purpose of meeting the terms of reference outlined in section two, and drew conclusions from the information provided in relation to the clinical record review only. It is for the Trust to consider the local situation, and determine if it would be appropriate to proceed with their request for an invited service review. The review team have included potential issues that would be important to consider in any further review(s) of the general surgical service in their conclusions outlined in section three.

A review team was appointed for the clinical record review and the Trust provided the clinical records and associated documents on 6 April 2020. The appendices to this report list the members of the review team and the documents that were provided to the review team.

The comments on the care of each patient is included in section five. The review team have highlighted areas of concern and overall conclusions in section three. The review team made six recommendations for consideration by the Trust, which are detailed in section four.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the review between the RCS and the healthcare organisation commissioning the review.

Review

The review will involve:

- A clinical record review of up to 31 cases put forward by the Trust.
- Consideration of statements provided by consultant surgeons delivering the surgical service;

Terms of Reference

In conducting the review, the review team will consider the standard of care provided by the general surgery service, including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures;
- Team-working including communication, MDT discussions and working with colleagues[1];
- Whether the care provided was what would be expected from a consultant general surgeon working in similar circumstances.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided by the general surgery service including whether there is a basis for concern in light of the findings of the review;

- Make recommendations for the consideration of the Medical Director of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the Trust and the review team on 27 March 2020.

[1] As pertained to the care of each patient and demonstrated in the information received

3. Conclusions

The following conclusions are based on the information provided in the documentation submitted and the clinical records reviewed. These are overall conclusions based on the sample of cases provided and focus on highlighted areas of concern or improvement. The review team's comments on the care of each patient are outline in section five.

Overall, the review team were of the opinion that the care provided to the patients in the sample of clinical records was of an acceptable standard. They noted that the majority of the complications experienced by patients in the sample of records were within the expected range of outcomes in providing surgical care. However, there were some areas of concern identified by the team and these are highlighted below.

In **Case 8,** the patient had a poor result following elective right hemicolectomy. It was of concern that there was no record of intervention between [redacted] and [redacted] The review team were of the opinion that re-suturing on [redacted] was never likely to be possible, and that a washout and negative-pressure wound therapy could have been applied sooner.

In **Case 9**, the post-surgery computerised tomography (CT) scan should be reviewed, as the review team's reading of the report is that a locally advanced tumour was left in place post Hartmann's procedure.

In **Case 13**, the review team were concerned that the patient went into fluid overload and considered that treatment was not prompt enough, although they did comment that the patient responded well to treatment once they received it. The review team also considered that the patient may have had a better post-operative recovery if they had remained in ICU/HDU for longer, as patients who have multiple comorbidities and have been through surgery of this magnitude generally require a higher level of care than a general ward can provide. There did not appear to be record of the operating surgeon (or any consultant surgeon) visiting the patient after surgery. With such high risk cases, the review team consider it important that there is senior specialist input to allow the best chance of a successful outcome.

The review team also considered that there should have been more consultant level involvement in the care of the patient in **Case 14**.

The review team highlighted that the retained swab incident in **Case 19** was a Never Event[2], and the review team would expect that it was investigated as such. Aside from the retained swab incident, the review team were of the opinion that the second laparotomy for this patient may not have been necessary, and that his recovery might well have been much swifter and without some of the complications (had he not undergone this surgery).

In **Case 20**, the review team were of the opinion that there seemed to be a lack of appreciation regarding the seriousness of the patient's condition on initial presentation, and certainly that xxx was septic due to an intra-abdominal catastrophe. It appeared it took nearly 48 hours for the patient to undergo surgery. The clinical record indicated that only the 24 hours immediately prior to surgery were taken up with sincere attempts at fluid resuscitation and preparation for theatre. The delay did not appear to be caused by the surgical team, but it did reflect the quality of the overall care of the patient.

In **Case 21**, the patient suffered two complications – a blown rectal stump and an ischaemic ileostomy. Neither of these complications are uncommon, but the combination raised concern about the expertise and experience of the surgeon. When the patient needed further surgery, the review team were of the view that it would have been to the patient's benefit for this to be performed by one of the established colorectal surgeons. It appeared that this approach was not

[2] As defined in the NHS Improvement Never Events policy and framework

supported. The twin complications should have triggered some concern by the specialist colorectal surgeons and prompted the decision for one of them to take over the management of the patient. The review team consider that there is an indication for the Trust to review whether team-working in the general surgical department supports the best care for patients.

In **Case 23**, there were complications including sepsis, wound infection and poor wound healing. The review team noted that nursing staff documented concerns regarding the removal of clips on day of discharge and that the wound had not healed. The patient was subsequently readmitted with dehiscence.

In **Case 24**, the records showed that the Hepato-Pancreato-Biliary (HPB) surgery team were involved in the patient's care but that this complication had persisted for a long time. The review team consider that transfer should have occurred earlier.

The review team considered that the complex ductal injury that occurred during surgery in **Case 25** was a technical error on the part of the surgeon. However, they noted that when a problem of bile leakage occurred, the error was recognised and assistance sought from a specialist HPB team.

In **Case 29**, there was a 17-hour delay between admission and review by surgical team. The patient was diagnosed with perianal necrotising fasciitis, a time critical condition which can deteriorate if treatment is delayed, resulting in worse patient outcomes.

In addition to the specific points raised above, the review team were concerned about the team-working and interpersonal dynamics that were demonstrated in the information provided. It was of concern that there was some indication that there was a potential culture of being critical of colleagues, rather than one of learning and improvement. The review team were also concerned that the team-working dynamics were not conducive to providing high quality and safe care for patients, such as was demonstrated in Case 21. The Trust should consider the most appropriate approach for providing assurance on team-working in the service, including progressing with an invited service review.

The team also noted that in some cases, it appeared that the entire patient record had not been provided for review. Where there appeared to be an absence of expected documentation, they have made a note of this in the clinical records notes in section five. This meant that there were instances where they were unable to draw conclusions on all domains of care. This was of particular concern when there were no consent forms included in the clinical record, especially given the risk profiles of the patients. The Trust should review these comments, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode. There were instances where the clinical records did not include patient outcomes, which meant that the review team could not draw conclusions on the overall quality of care.

4. Recommendations

1. The review team have formed conclusions on the care provided to this sample of patients. The Trust should consider the views of the review team, as well as the other information it holds, and on this basis provide further follow-up of any patients for which it considers this to be required. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20[3].

2. The review team were unable to determine the outcome for a number of the patients. The Trust should review the care of the patients to ensure they are aware of the outcomes and have met their ethical and legal obligations, including those outlined in recommendation one.

3. The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode.

4. In addition to recommendation three, the Trust should review this sample of records and ensure that there was appropriate informed consent obtained for each procedure or operation[4].

5. The Trust should review the interpersonal and team-working dynamics in the general surgery team, and whether team-working supports high quality and safe care for patients. The RCS are able to support the Trust to seek assurance on these matters through an invited service review, if it the Trust considers this the most appropriate course of action.

6. The Trust should ensure that the retained object incident that occurred during the care of the patient in Case 19 has been investigated in line with the NHS Improvement Never Events policy and framework[5].

[3] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

[4] The review team acknowledged that the Trust may hold a signed copy of the consent form which was not included in the documentation provided. There was indication in many of the clinical records that consent was obtained, with associated risks quoted.

[5] https://improvement.nhs.uk/resources/never-events-policy-and-framework/

5. Clinical record review notes

The following notes were made by the clinical reviewers with regard to the cases put forward for review.

Case One - [redacted]

Description

Emergency surgery for small bowel perforation. Planned return to theatre.

Co-morbid, obese patient with previous surgeries for incisional hernia with mesh (details unclear from records).

[redacted] – difficult procedure with small bowel perforation. Extensive resection with anastomoses. Planned for re-look at 48 hours.

[redacted] – at re-look, possible ischaemia at one of anastomoses, planned to look again at 48 hours.

[redacted] – re-look and excision of mesh. Resection of further 'ischaemic-looking' small intestine. Vicryl mesh closure following formation of end stoma – 85cm of small intestine from duodenojejunal flexure (DJ) to stoma, 40cm distal to ileocecal valve (ICV).

Protracted ICU stay. TPN dependent. Referred to Salford. Eventual disposition and outcome not clear from the medical records.

Comments

The review team noted that this was clearly a surgical challenge, however they considered that perhaps an emphasis on preserving bowel length and no anastomoses at the first laparotomy may have led to a better outcome. To have ended up with intestinal failure with a small bowel perforation would be unusual and must have been the result of iatrogenic injury in a very hostile abdomen. Although the note made in the surgeon's statement clearly stated that the small bowel was welded into the mesh, so that extensive loss of small bowel length was likely inevitable.

The details of assessment are not clear from the records. There was no evidence of other teams being involved but all management following the initial laparotomy appeared appropriate. The review team could not comment on the standard of consent-taking from the documentation provided.

The outcome is not clear from the records. The review team consider it important that the Trust ensures this patient has had the appropriate follow-up and care following their surgical care.

Case Two – [redacted]

Description

Palliative bypass for relapsed colon cancer

[redacted] year old [redacted] – documentation indicated a relapsed colorectal cancer after anterior resection (no details of the original surgery in the records provided).

[redacted] – laparoscopy and ileo-ileal bypass for small bowel obstruction resulting from recurrent cancer in pelvis.

[redacted] – readmitted with Acute Kidney Injury (AKI), hyperkalaemia and high stoma output. Palliative care. Outcome not clear from records.

Comments

Impressive technical procedure. Most surgeons would not have the skill or confidence to have undertaken a laparoscopic small bowel bypass in an obstructed patient with metastatic cancer.

The review team could not find details of treatment planning or MDT discussion or the consent process, but it appeared the entire patient record had not been provided.

Case Three – [redacted]

Description

Death following emergency surgery

[redacted] - admitted to Medical Admission Unit (MAU). Brought in by ambulance, with symptoms of shortness of breath and confusion - thought to have a urinary tract infection (UTI). Past history of ileostomy after surgery for perforated bowel 2012 in Bolton. History included hypertension and anxiety.

[redacted] – low sodium, infective exacerbation of Chronic obstructive pulmonary disease (COPD). Started doxycycline.

[redacted] – referred to surgical team and assessed – refusing nasogastric tube (NGT).

[redacted] – Seen by Surgical team. Small Bowel Obstruction (SBO), no clear transition on CT. For contrast study. Seen by nutrition team. Vomiting – awaiting contrast study thought to be obstructed. Seen by surgeons – conservative management. Seen by medical consultant. Hospital-acquired pneumonia (HAP) not improving. Surgical input noted.

[redacted] – still not possible to place NGT (sliding hiatus hernia).

[redacted] – seen by surgical team (Consultant) – not resolving SBO. Advised surgery.

[redacted] – laparotomy for adhesional obstruction. 360 degree twist at ileostomy. Gross proximal distension. Untwisted, decompressed. Fixed at abdominal wall.

[redacted] – return to ward from HDU

[redacted] – agitated and confused post-operatively. Modified Early Warning Score (MEWS) score 3-8. Productive cough, low saturations. Lots of input from Critical Care Outreach Team (CCOT). Antibiotics, nebulisers, oxygen, physiotherapy.

[redacted] – continuing to vomit, poor chest. NGT refused again (fell out post-surgery).

[redacted] – increasingly unwell MEWS 4-7. DNA CPR. Ward based care. Medical team registrar reviewed and advised.

[redacted] – patient passed away – reported to

coroner.

Comments

Frail patient with potential delay in referral to surgical team. No issues with surgical management. Outcome at point of referral always likely to have been poor.

The review team considered that this patient's care appeared appropriate. They were not able to comment on consent-taking based on the documentation provided.

Case Four – [redacted]

Description

Return to theatre

[redacted]year old [redacted]

[redacted] – admitted with abdominal pain

[redacted] – extended right hemicolectomy, splenectomy, and distal pancreatectomy.

[redacted] – discharged but re-admitted same night for anastomotic leak proven on urgent CT. Take down of anastomosis and formation of ileostomy. Pancreatic fistula, probable leak from pancreatic duct.

[redacted] – radiological drainage of 7cm collection splenic bed/pancreatic tail. Treated with broad spectrum antibiotics and antifungals.

[redacted] – repeat CT, collection resolved.

[redacted] – mobile, self-caring stoma active, bag over fistula. Hot clinic on Friday dressing over fistula of minimal output. Discharged. Follow-up with surgeon and Oncology. Splenectomy vaccines prior to discharge.

Comments

Difficult problem of locally advanced transverse colon cancer in a young [redacted] Extensive surgery appropriate. Appeared to have had good oncological procedure. Overall good aftercare. The treating clinician was concerned regarding his discharge, with high inflammatory markers only to be re-admitted same night. Re-imaged when deteriorated and re-operated in timely fashion. Overall, the review team did not identify any concerns.

The review team considered that this patient's care appeared appropriate. They were not able to comment on consent-taking based on the documentation provided.

Case Five – [redacted]

Description

Return to theatre

[redacted] year old [redacted]

[redacted] – 8 day history abdominal pain, vomiting followed by loose

stools. [redacted] – CT consistent with appendicitis. For open

appendectomy.

[redacted]- Retro caecal appendix, tip in abscess cavity, localised pus. Appendix base viable. On putting in transfixion suture at base cut through. Wider purse string of caecum and drain left in. Elevated MEWS post-operatively but eventually settled.

[redacted] – discharged with plan to complete PO antibiotics

[redacted] – presented to the Emergency Department with wound infection. Foul discharge from wound. Impression: stump blow out. MEWS 2 (heart rate) afebrile. Wound started oozing in morning with fever. Soft non-tender abdomen apart from around wound. Staples taken out – approx. 250mls feculent discharge.

[redacted] – CT scan caecal/appendicular stump blow out with localised peritonitis and faecal matter being discharged onto the skin.

[redacted] – Indication: stump blow out after appendectomy. Incision: reopening and extension of previous Lanz incision. Findings: stump blow out, minimal contamination, faecal fistula. Ileo-caecectomy as caecal pole looked unhealthy. Standard stapled anastomosis. Partial skin closure only due to likelihood of infection.

Ileo-caecectomy as appendix stump unhealthy.

[redacted] – discharged home.

Comments

This was an unusual complication that may have arisen from a technical issue with the stump closure at appendectomy. There were signs of sepsis before the patient left but these appeared to have settled.

When [redacted] presented with a faecal fistula, the review team were of the opinion that many surgeons would have managed non-operatively as it may well have closed. However operative management ultimately gave a very good result.

The review team considered that this patient's care appeared appropriate. They were not able to comment on consent-taking based on the documentation provided.

Case Six – [redacted]

Description

Wound infection post umbilical hernia repair

[redacted] – umbilical hernia repair with mesh

[redacted] – discharged after umbilical hernia repair

[redacted] – presented with leaking wound and

cellulitis

[redacted] – washout of wound with mesh left in-situ

Comments

Recognised complication of surgery, dealt with in a timely and standard manner.

The review team considered that this patient's care appeared appropriate. They were not able to comment on consent-taking based on the documentation provided.

Case Seven – [redacted]

Description

Death following emergency surgery

[redacted] year old [redacted] – atrial fibrillation, on warfarin. Peripheral vascular disease (PVD) with amputation, heart failure, ejection fraction 40%, and wheelchair bound.

[redacted] – two days of abdominal pain. CT scan: perforated viscus.

p-Possum - 64% mortality.

[redacted] - Laparotomy after correction of INR with Beriplex, full consent and ICU assessment - perforation of sigmoid exteriorised as a loop colostomy. Probably a stercoral perforation.

Stepped down from ICU care – not for re-escalation.

[redacted] – placed on end of life pathway after documented discussion with family.

[redacted] – passed away - reported to Coroner.

Comments

High risk emergency resection. The records indicated appropriate work up, risk scoring and consent. The review team also noted that there was good liaison pre-operatively with Haematology and ICU. Appropriate plans regarding levels of care and end of life care all documented.

Case Eight – [redacted]

Description

[redacted]year old [redacted]

[redacted] – laparotomy and right hemicolectomy and omental

biopsy

[redacted] – discharged

[redacted] – re-admitted with wound problems – gaping foul smelling

wound

[redacted] – listed for re-suturing but cancelled as too late at night

[redacted] – wound very sloughy with small bowel loops visible

[redacted] - returned to theatre for burst abdomen, Vicryl mesh and wound

VAC

[redacted] – VAC stopped – regular dressings

[redacted] – open abdomen with mesh – healing well. Subsequently

discharged.

Comments

No records of the index admission and primary surgery.

Poor result from elective right hemi. No real evidence of progress/intervention between [redacted]. Re-suturing on [redacted] was never likely to be possible. The washout and VAC could have been applied sooner.
The review team were not able to comment on consent-taking based on the documentation provided.

Case Nine – [redacted]

Description

Post-operative death

[redacted] year old [redacted]

[redacted] – admitted via ambulance – 24 hrs abdominal pain and left-sided weakness detected by crew. No apparent co-morbidity. Systolic blood pressure 80 on arrival.

[redacted] – CT – sigmoid colon perforation, source unclear.

[redacted] - Hartmann's for stercoral perforation, predicted mortality 40% - lots of faecal contamination. Probable rectal tumour (dissection said to have gone below this – so no residual disease).

Multiple organ failure on ICU.

[redacted] – extubated, off filter

[redacted] – On ICU combination of chest and intra-abdominal sepsis with possible small bowel obstruction in pelvis on CT. Not fit for reoperation. Non-operative management – explained to family. (CT suggested locally advanced rectal/sigmoid tumour still in place)

Pathology – stercoral perforation – diverticulosis – no malignancy.

[redacted] CT pulmonary angiogram (CTPA) – extensive bilateral consolidation. No pulmonary embolism.

Hypoxic arrest during change of vascath. Intubated, resuscitated, however increasing inotropes and decision made to limit care.

[redacted] – Passed away – report to Coroner – no outcome in

records.

Comments

A very high risk case with outcome as anticipated. The post-surgery CT scan should be reviewed, as the review team's reading of the report is that a locally advanced tumour was left in place post Hartmann's procedure. Although this may not have altered the outcome, the review team consider that it should be reviewed to identify learning and to ensure that the Trust have met Duty of Candour obligations to the patient's family.

Case Ten – [redacted]

Description

[redacted] year old [redacted] – diabetes, hyperparathyroidism, chronic kidney disease, hypothyroidism.

Two week wait (2ww) referral – declined endoscopic investigations. CT colonoscopy cancelled by patient.

[redacted] – 2130hrs - Presented as emergency with 5 days symptoms of bowel obstruction. CT on emergency admission 2300hrs [redacted]: obstructing sigmoid tumour with localised perforation and caecal dilatation 9.5cm.

[redacted] – laparotomy and Hartmann's. Perforated sigmoid unclear whether diverticulitis or tumour. Advanced disease with psoas abscess. Residual disease if tumour. 0330hrs finished 0530hrs (Consultant surgeon assisting an ST5 as primary surgeon).

Post-operative ICU care developed acute coronary syndrome (ACS). Echo poor LVSD, poor prognosis. Multiple organ failure, ceiling of care.

[redacted] - DNA CPR after full discussion with patient and family.

[redacted] – patient passed away, reported to Coroner.

Comments

High risk emergency case with advanced disease – outcome as anticipated. The review team considered that this patient's care appeared appropriate.

Case Eleven – [redacted]

Description

Laparotomy for Bowel Obstruction / Perforation

Admitted to the surgical assessment unit [redacted] with abdominal pain. Significant co-morbidity (including Parkinson's disease with morphine syringe driver, Mitral valve replacement (MVR), Atrial Fibrillation, Thrombocytopenia). Previous abdominal rectopexy six months before. SBO on x-ray, so planned for surgery.

Laparotomy revealed multiple adhesions and obstructed closed loops with non-viable bowel, perforations and peritonitis. Second Consultant (who had performed the rectopexy seven months before) called in to help operating Consultant. Loop Jejunostomy, small bowel resection and double-barrelled ileostomy, washout and drains.

Cared for on HDU but inexorably deteriorated and, with DNR policy in place (agreed with patient pre-operatively and supported by family) allowed to slip away, dying on day three.

Comments

Very high-risk surgery and result was expected. Due thought and care was evident throughout. Excellent involvement of family in all decisions.

There seems to be some friction between the operating surgeon and their colleague. It appears there is an allegation of the colleague raising issues about patients they had not seen or had involvement with.

From what was demonstrated from the documentation provided for this case, there would be no cause for concern for the way the patient was managed. The review team considered that this patient's care appeared appropriate.

Case Twelve – [redacted]

Description

Multiple Small Bowel Resections for Ischaemia

This [redacted] year old [redacted] was admitted as an emergency with abdominal pain. [redacted] was known to have a large parastomal hernia having had a Hartmann's procedure some years before. The hernia was large and "inoperable".

A CT examination showed small bowel obstruction with part of the stomach, colon and small bowel in the large parastomal hernia. [redacted] was very poorly and despite the recognised significant risks of surgery, which were discussed with the patient and their family, it was decided to proceed henceforth to a laparotomy.

At laparotomy there was a long segment of small bowel that was completely ischaemic and other areas which were dusky and of dubious viability. The Clinical Director for surgery was asked for an opinion about management and a decision was made to resect the small bowel from a point

about 50cm distal to the DJ flexure and then leave a further 135cm of small bowel proximal to the ileo-caecal valve. The plan was to perform a further laparotomy at 48 hours and when this was done a further segment of non-viable bowel was found in the jejunum which was resected. At this point it was estimated that [redacted] had 60cm of proximal jejunum and 60cmof distal ileum. A further laparotomy was planned for 48 hours later. At [redacted] third laparotomy there were, unfortunately, further patches of full thickness necrosis in the proximal jejunum. The situation was discussed with the upper gastrointestinal surgeons at Salford who suggested further resection of the affected bowel and another look at 24 hours. If there was further unviable bowel at this point [redacted] was to be palliated only. Therefore, a further 20cm more of proximal bowel was resected.

After the third operation there were further honest and open discussions with the family. A fourth laparotomy resulted in another 10 centimetres of dubious bowel being resected. [redacted] was left with a double-barrelled ileostomy as well as the original colostomy with its encompassing parastomal hernia.

The Intestinal Failure Unit in Salford was contacted and throughout the next two to three months regular conversations with them took place to gain advice, prior to their agreement to taking the patient over. There were ongoing difficulties with fluid management, respiratory failure and a small cerebro-vascular accident (CVA), all of which complicated [redacted] recovery. [redacted] spent nearly four months in hospital being managed for all these issues before [redacted] was finally able to be transferred to Salford for further management.

Comments

This was an extremely challenging case. The review team did not identify any issues with any of the decisions made regarding the management of [redacted] bowel at surgery where attempts were made to conserve as much as possible, whilst also having an aggressive approach to removing any segments which were not viable. Repeated laparotomies to check on bowel viability is the standard approach in these testing situations.

The patient was in hospital for four months being managed with a very short residual bowel length and for issues with fluid balance, chest infections, renal failure and a small CVA. Multiple clinicians were involved in [redacted] care and there seemed to have been excellent communication between all of them, as they attempted to care for this patient through this difficult time. The review team considered that this patient's care appeared appropriate.

Case Thirteen – [redacted]

Description

Recto-Sigmoid Perforation with Hartmann's

This [redacted] year old [redacted] was admitted as an emergency in the early hours of the morning with abdominal pain. In the past [redacted] was known to suffer from Crohn's disease was hypothyroid and atrial fibrillation, for which [redacted] was on warfarin. A CT revealed a perforation and a probable collection in the right lower quadrant. The surgeon discussed risks with the patient, who agreed to surgery which was performed a few hours later.

At laparotomy, the abdomen was very hostile and dissection was difficult. [redacted] had a perforated rectosigmoid with faecal peritonitis. A difficult Hartman's procedure was performed and the rectal stump was noted to be very thick from Crohn's disease.

Initial progress on the intensive care unit was good, but after two or three days [redacted] began to get quite confused. It was noted that [redacted] respiratory rate was increasing and it was discovered that [redacted] had a positive fluid balance of over 2 1/4 L. A successful diuresis was achieved and initially [redacted] slightly improved, although remained very confused. The clinical record showed that [redacted] was not strong enough to make good progress and [redacted] deteriorated inexorably. A DNR order was discussed with the patient and the family. [redacted] passed away 17 days after surgery.

Comments

This was another high risk case where the outcome was never likely to be very good. There was one mention of her having had a colonoscopy as part of [redacted] Crohn's disease management a week before the emergency admission, but nobody seemed to refer to this possibility again in the notes. If this is correct, the perforation might have been related to this.

The fact [redacted] was allowed to become so fluid overloaded on ICU was unfortunate and could be criticised, although [redacted] did respond well to treatment. The surgery was clearly difficult and of a fairly heroic nature. The review team considered that [redacted] may have done better if [redacted] had remained in ICU/HDU for longer, as patients who have multiple comorbidities and have been through surgery of this magnitude really need more intensive care than a general ward can provide.

There appeared to be little evidence of the operating surgeon (or any surgeon of Consultant status) visiting the patient after surgery, although the record indicated that they were consulted over the phone on a few occasions. With such high risk cases, senior specialist input is required if the outcome is going to be successful. It may not have made any difference here, but the review team would have expected more consultant surgeon involvement.

Case Fourteen – [redacted]

Description

Diverticular Abscess

This [redacted] year old [redacted] was an emergency admission with an abscess in the left lower quadrant of the abdominal wall on the background of chronic diverticular disease.

[redacted] had been known to have diverticular disease for some time but the records indicated that [redacted] had not agreed to any surgical intervention. The CT scan confirmed a peri-colic abscess but with no apparent connection to the bowel itself. The abscess was drained under general anaesthetic and 500 ml of pus was obtained. The wound was left open and packed.

Initial improvement was good but a couple of days later there were concerns raised about [redacted] respiratory rate and oxygen saturations. [redacted] was noted to have a significant positive fluid balance, although later in the day [redacted] subsequent urinary output had still not been properly documented. The following day [redacted] had nausea and vomiting and was noted to be confused. There is a record of nursing staff attempting to contact the junior medical staff but they either got no response or the doctors reported being “too busy to attend”.

Six days after the operation (at a weekend) [redacted] was noted to have a MEWS score of 6, was breathless and wheezing and only had 92% saturation on 8L of oxygen. [redacted] heart rate was 127. The following day [redacted] MEWS score had risen to 9 and it was noted that it had been eight hours since [redacted] had last passed urine. Urinary catheterization produced only a small volume of urine. The critical care outreach team were contacted in the early hours and noted that [redacted] was in respiratory distress and heart failure. [redacted] had a 4L positive fluid balance over the previous two days and arterial blood gases revealed a metabolic acidosis with a base excess of 12. [redacted] was given intravenous diuretics and responded well. However, a few hours later [redacted] was noticed to be in acute fast AF and to be tender in the abdomen which was swollen. A chest x-ray revealed a dilated stomach and small bowel, so a Ryles tube was passed with over 3L of aspirate in the first 2 hours thereafter.

After discussion with the family, the clinical record stated that it was decided [redacted] should not be for aggressive resuscitation and certainly not for a further trip to theatre. [redacted] continued to deteriorate and the patient (supported by [redacted] family) asked for active treatment to stop. XXX was put on an

Integrated Care Pathway and lived a further 10 days before passing away three weeks after [redacted] surgery.

Comments

The patient's predicted morbidity and mortality was high, but [redacted] would have had a reasonable chance of survival after the 'minor' surgery to drain [redacted] abdominal wall abscess. [redacted] initially developed problems with [redacted] respiration and then was noticed to have a very positive fluid balance.

It was of concern, based on the attempts to deal with these medical issues, that they did not appear proportionate or timely enough. In particular, stringent recording of [redacted] fluid input and output were not found in the medical records provided, and there did not appear to be a record of a clear plan for how aggressive [redacted] management should be. Even though [redacted] did not have major surgery, the review team were of the opinion that the best chance for survival and progress was by intense medical management involving a multidisciplinary team. It was of concern, from reviewing the clinical records, that medical management was not as enthusiastically pursued as it could have been, prior to the point where a decision was made to withdraw it.

However, after reviewing a statement provided by the operating surgeon, the review team were provided further information on the extent of the underlying disease from the notes and concluded on balance that the post-operative care was appropriate. This patient's problems evidently began some months before the segment of [redacted] notes that was provided to the review team. [redacted] was known to have had significant diverticular disease on the background of considerable frailty, a deep vein thrombosis (DVT) (for which [redacted] was on Warfarin) and chronic lymphocytic leukaemia. [redacted] had been extensively investigated in the months before [redacted] eventual admission, and many MDT discussions had taken place regarding the management of [redacted] colonic issues (peri-colic abscesses) – with a decision made to manage [redacted] conservatively with antibiotics. The clinical record clearly showed that the patient was very much against a surgical approach. When admitted with a subcutaneous extension of one of [redacted] abscesses, [redacted] once again declined major surgery but was persuaded to agree to minimal intervention in the form of drainage. [redacted] succumbed three weeks after the procedure. The review team were of the opinion that the surgery (which was just drainage of a superficial abscess) was reasonable.

Overall, the review team were of the opinion that on balance, the care of this patient seemed appropriate. However, they considered there should have been record of daily decision making regarding [redacted] management, being made at a consultant level – medical input seemed to be mostly at a non-consultant level (at least until [redacted] deterioration was well established).

Case Fifteen – [redacted]

Description

Right Hemicolectomy

[redacted] year old man admitted for Right Hemicolectomy for a non-endoscopically resectable polyp in region of hepatic flexure on [redacted]

The patient's history included Rivaroxaban (stopped [redacted]) and other cardiac drugs + inhalers. BMI>>35. Some Chronic renal failure (CRF) pre-existing.

Difficult procedure in view of obesity, thickened mesocolon and poor access. Tattooed polyp marker not seen. End to end ileo-colic anastomosis.

Deteriorated first post-op night with bleeding. Inotropic support and blood transfusion and returned to theatre in early hours of [redacted] where, after induction, he had a cardiac arrest for 26-7 mins before circulation restored. No specific bleeder, but general ooze (>2L blood loss) from RUQ which was packed. Laparostomy.

Re-explored [redacted] for removal of packs and abdominal closure.

Returned to theatre [redacted] because of faecal fluid in drain – 'small localised anastomotic leak', whence he had washout, end-ileostomy with mucous fistula and mesh closure of abdomen.

Recovery complicated by AKI (requiring haemofiltration) chronic anaemia and infection.

Returned to ward from HDU/ICU on [redacted].

Difficult ward recovery owing to difficulties with fluid balance, managing inflammatory markers/infection, anaemia, stoma and wounds, as well as poor mobility.

Comments

The type of complications this [redacted] suffered are within the normal range for the circumstances and as a single case there were no concerns identified The review team were of the opinion that the fact he survived was extraordinary, and a tribute to the medical and nursing care he received.

The review team were of the opinion that the patient's care was well managed and documented. Decisions made to return to theatre were swiftly made and properly executed. His post-operative care was ultimately successful in getting [redacted] out of hospital, which was a real achievement under the circumstances. The initial operation was clearly difficult and complications of post-operative bleeding were recognised events.

The review team did note that there was not documentation available to the review team prior to the admission (and the review team could not find a clerking note from the doctors either), which made it difficult to know if the risks of surgery had all been carefully enough considered.

Case Sixteen – [redacted]

Description

Defunctioning Colostomy

[redacted] year old [redacted] admitted as an emergency with sepsis, an acutely obstructing sigmoid mass on the background of over two months of slow deterioration at home. Investigations revealed bilateral pneumonia, large and small bowel obstruction and liver metastases. It was recorded that [redacted] was considered too unwell for any major interventions other than a defunctioning colostomy, following which [redacted] survived for a few hours only.

Comments

Surgery was very high risk and an alternative strategy might have been to palliate only, but the review team noted that after careful discussions with anaesthetists, surgeons and the family it was decided to at least defunction [redacted] so [redacted] could be made more comfortable. The review team considered that this patient's care appeared appropriate.

Case Seventeen – [redacted]

Description

Emergency Laparotomy for Perforated Peptic Ulcer

This [redacted] year old [redacted] was admitted as an emergency with abdominal pain. Investigations showed that [redacted] had a prepyloric perforation and [redacted] went to theatre the same day for a laparotomy. The perforation was confirmed with one litre of purulent peritonitis. The abdomen was washed out and an omental patch was placed over the perforation.

Initial progress was good with the patient requiring no inotropic support and within two days [redacted] was transferred to the ward from HDU. Over the next few days there was concern documented about confusion, abdominal distension, and general lack of progress. A gastrograffin swallow was performed which showed that there was no passage of contrast beyond the O-G junction. A subsequent CT scan showed an ileus but no evidence of leakage of the gastrograffin contrast. Attempts were made to reintroduce fluid and food but a few days later [redacted] deteriorated with raised inflammatory markers and loose stools. Clostridium difficile infection was confirmed on microbiological analysis of [redacted] stools. Despite intravenous vancomycin treatment [redacted] failed to progress and inexorably deteriorated. Discussions with the family resulted in a decision not to be more aggressive in treatment and [redacted] died two and a half weeks following [redacted] operation.

Comments

A [redacted]year old (albeit quite a fit one) with a gastric perforation is considered a high-risk patient and so it proved in this case. However, it was of concern that as the days went on and [redacted] failed to progress (and then regressed as the C. Diff infection worsened) there appeared to be an attitude of inevitability about the patient's outcome and the review team were not convinced that the efforts to do all that was possible were undertaken. Failed attempts at intravenous cannulation seemed to be accepted rather than escalated[6]. The review team found the oral intake reports and instructions confusing – on some occasions [redacted] seemed to be nil by mouth (NBM) for no documented reason, especially in light of the patient being reported as previously tolerating a light diet.

The review team acknowledge that the increased efforts post-operatively may not have changed the patient's outcome but were of the opinion that a more aggressive approach might have allowed [redacted] to get home. They commented that if surgeons opt to perform surgery with these associated risk factors such as in this case, there is a duty to follow it up with full-on after care.

The review team considered that the patient was provided with prompt, correct and effective emergency surgery.

Case Eighteen – [redacted]

Description

Ischaemic Large Bowel from Mesenteric Embolus – Subtotal Colectomy and Ileostomy

This [redacted] year old [redacted] was found collapsed at home where [redacted]lived alone. [redacted] had had diarrhoea and vomiting and was complaining of abdominal pain. Initially, the diagnosis was thought to be gastroenteritis and [redacted] was admitted under the physicians - septic, hypovolemic and with an acute kidney injury. It was noted that he had had a CVA in the past and was in atrial fibrillation. The surgeons were asked to see [redacted] and they felt that ischemic bowel needed to be excluded. A CT examination showed small bowel obstruction with a transition point in the region of the pelvis where a band or adhesion was thought to be possible. There was also evidence of aspiration pneumonitis. Surgery was considered but the risks were recognised as being extremely high. After discussions with the family it was decided that [redacted] should be given a chance at surgery. On induction, the patient suffered a cardiac arrest but was resuscitated with adrenaline and the laparotomy proceeded. A gangrenous colon was found from the transverse colon all the way round to the upper rectum. The gangrenous bowel was resected and an end ileostomy fashioned.

[6] The was a note in the patient record stating that an FY2 had teaching to go to and wouldn't be able to try siting a cannula for at least another three hours.

Following surgery, the patient was transferred to the ICU[7]. Five days after the surgery, attempts were made to wean the patient off his ventilator and the following day [redacted] was successfully extubated. [redacted] was being treated for a hospital acquired pneumonia with apparent good response. Three days later, it was noted that he had a possible septic arthritis of one of [redacted] fingers and the orthopaedic surgeons performed open exploration and drainage under local anaesthetic in theatre. The following day, for reasons which are not well recorded, the patient was re-intubated, although, five days later extubated again with success. [redacted] was on non-invasive ventilation and the DNR status was agreed. Two days later [redacted] passed away, but the notes did not clearly document the circumstances leading to [redacted] death. Renal function was normal at this point and there are no indications as to why [redacted] cardio-respiratory function might have been compromised leading to death.

Comments

This was a very high risk case and the patient's death was within the expected range of outcomes. There appeared to have been reasonably prompt action in recognising the seriousness of [redacted] condition and the need for urgent surgery. The patient suffered a cardiac arrest on induction which is a very bad prognostic sign. The surgery appeared to have been conducted successfully but the review team were not able to assess post-operative care due to a lack of documentation. The patient's overall chance of surviving was very low and indeed [redacted] sadly did not make it, however, the Trust should ensure that the patient's death has been appropriately reviewed.

Case Nineteen – [redacted]

Description

Left Hemicolectomy for Ca Splenic flexure (elective)

BMI 31.5

Admitted for elective hemicolectomy for left sided colonic carcinoma tattooed at colonoscopy.

Operation [redacted]

The operation was documented as being difficult due to the patient's obesity and the fact that the tattooing had infiltrated out of the colon into the surrounding fat. The tumour was in the splenic flexure, mobilization of which was reportedly challenging. A primary anastomosis was constructed, and the patient returned to the recovery ward. An hour or so later the operating surgeon realised that a swab had been placed in the region of the bed of the spleen and had not been removed before the conclusion of the operation. The patient then went back to the operating theatre where this swab was removed.

[redacted] received care for two days on the high dependency unit and then returned to the main ward. Whilst there [redacted] had significant problems with analgesic control and an ileus. One week after surgery [redacted] had a persistent unexplained tachycardia and this was thought to be due to a right basal effusion.

The patient had some additional post-operative difficulties with pain control and nausea as well as a minor wound infection which was opened and packed. Although, 10 days after the operation [redacted] was still tachycardic and had developed an anaemia requiring a two-unit blood transfusion. However all of these issues settled and [redacted] was discharged to home 13 days after the initial surgery.

[7] The ICU notes were not as comprehensive as expected, which raised the question if there were records which were not provided, as it would be very unusual for a patient to be managed on the ICU without entries in the records from the anaesthetists who were managing XXX

Comments

Clearly the retained swab was a Never Event, and review team would expect that it was investigated as such. The review team note that there was a reflective apology from the operating surgeon who appeared to have learned from the error. The never event was very unfortunate, but was documented as being addressed promptly and effectively dealt with.

The review team were of the opinion that while the second laparotomy may not have been necessary and without the second surgery his recovery might well have been much swifter and without some of the complications.

Case Twenty – [redacted]

Description

Laparotomy, Washout, Hartmann's, Hysterectomy

Emergency admission to MAU [redacted] at ~22:00 with drowsiness, sepsis and distended abdomen. Assessed by junior doctor and then at 09:44 by medical specialty registrar (SpR). The first blood cultures appeared not to have been done until 11:56 on [redacted].

Surgical review requested at 19:59 on [redacted]. A non-consultant grade surgeon saw the patient at 00:07 on [redacted]. Consultant Surgeon then saw patient at 09:30 on [redacted] (patient had not seen a Medical Consultant by that stage). Surgery thought necessary and wise, but needed a Medical and Anaesthetic review first. Medical Consultant review at 10.39, Anaesthetic review at 11:44. And decision made to resuscitate with further fluids before surgery the following day. It appeared that a Locum Surgical Consultant advocated for same day surgery but was dissuaded.

At laparotomy the next day a necrotic perforated recto-sigmoid was found and a Hartmann's performed, with concomitant resection of uterus and tubes by Gynaecologist. Developed cardiac arrythmia at end of surgery and attempts at resuscitation abandoned in the patient's best interest and [redacted] passed way in the Recovery unit.

Comments

There seemed to be a lack of appreciation regarding the seriousness of the patient's condition on initial presentation, and certainly that [redacted] was septic due to an intra-abdominal catastrophe. It took nearly 48 hours for [redacted] to get [redacted] to theatre, only the last 24 hours of which were taken up with sincere attempts at fluid resuscitation and preparation for theatre. The delay did not appear to be caused by the surgical team, so the review team could not fault their approach. The review team were of the opinion that the decision to abandon attempts at further resuscitation once [redacted] had developed a significant arrhythmia in theatre was the correct one.

Case Twenty One – [redacted]

Description

Total Colectomy and Ileostomy for Acute on Chronic Ulcerative Colitis (UC)

[redacted] year old [redacted] with chronic UC managed for more than 20 years medically.

Admitted from Medical Outpatient Department with increasing abdominal pain and bowel frequency with blood. The patient's history included a previous laparoscopic cholecystectomy and subsequent umbilical port hernia, repaired with mesh.

Surgeons were notified the following day and reviewed patient, the recorded decision was there was no need for urgent surgery at present. Stomatherapist involved at early stage.

The patients deteriorated two days later but it was documented that the surgeons still did not feel this was a toxic megacolon.

One week later there had been some further clinical deterioration and surgeons felt that surgery was now required. A total colectomy (preserving rectal stump) was performed with an end ileostomy. In the first couple of days there were concerns about the ileostomy being a bit dusky. Two days later there was a marked deterioration with signs of sepsis and the stoma looked ischaemic. The patient moved into toxic shock and so a further laparotomy was performed.

At laparotomy the rectal stump was found to have blown and there was a large pelvic abscess. The ileostomy was ischaemic in the terminal 2 cm. After a wash out a catheter was placed in the open rectal stump and the stoma was refashioned.

Five days later the wound was noted to be infected with lower abdominal cellulitis and pus oozing from the wound. The wound was reopened in the lower segment and left open to drain and the patient treated with intravenous antibiotics.

Although there were some further concerns about the stoma and issues around the stomal wound leaking and bags not fitting properly, eventually the patient made a satisfactory enough recovery to be discharged five weeks after initial admission.

Comments

A total colectomy, preserving the rectal stump, is a major procedure, especially in a patient with acute colitis on steroids. There were two regrettable complications – a blown rectal stump and an ischaemic ileostomy. Neither are uncommon, but the combination raises concern about the expertise and experience of the surgeon. Exteriorisation of the rectal stump is favoured by many surgeons, as if there is a blow-out (breakdown of the closure) it will not result in peritonitis. However, this is not always technically feasible. Forming an end-ileostomy in these patients should be straightforward (especially as the abdominal walls of these patients are usually relatively thin) and although complications with the stoma are common, ischaemia of the bowel is usually a technical error.

The review team were concerned about the two major complications following the surgery, which raised questions regarding the technical competence of the surgeon. However, the surgeon appeared to have carefully consulted with more senior colleagues about the plan and they seemed happy for [redacted] to proceed. In their statement, they reported that the operation was difficult due to the inflamed tissue, which would not be surprising. It appeared that they correctly closed the stump of the rectum both by linear staples and then by over-sewing, leaving a drain in case of a blowout, which the review team considered acceptable. The surgeon noted that the ileum was very inflamed and that they revised the ileostomy twice in order to get it to appear healthier and less ischaemic.

When, three days later, the patient needed further surgery, the review team were of the view that it would have been to the patient's benefit for this to be performed by one of the established colorectal surgeons. They were aware of the case, and – the original surgeon argues – should have taken over the patient's care according to the departmental protocols. The operating surgeon remains critical of the fact that they were left to manage the patient without the help of more specialist colleagues, despite systems being in place for such patients to be looked after by specialists rather than generalists. The twin complications should have raised concern among the specialist colorectal surgeons, triggering one of them to take over the management of the case. The review team consider that there is sufficient indication for the Trust to review whether team-working in the general surgical department supports the best care for patients.

Case Twenty Two – [redacted]
Description

Displaced PEG. Liver Cirrhosis. SCC Piriform fossa

[redacted] year old [redacted] Previous history of liver cirrhosis due to previous alcohol excess.

Diagnosed [redacted] with SCC Piriform Fossa T2N0 - treated with radiotherapy.

Admitted: [redacted]. Discharged: XXXXXXXXX 17. Readmitted: [redacted]

[redacted]. Died [redacted].

[redacted]- Admitted with acute airway and poor oral intake requiring emergency tracheostomy, re-biopsy and NG feeding.

[redacted] - Failed RIG, therefore referred for surgically

placed PEG CT showed local disease progression

[redacted]: Laparoscopically placed insertion of balloon

gastrostomy Discharged [redacted] after gastrostomy feed

established

[redacted] 8pm: Readmitted with abdominal pain, distension and tenderness

[redacted]: CT showed PEG tube dislodged in abdominal wall with gas and fluid in upper abdomen and PE

Consented with family for laparotomy NELA 30% mortality and 95.8% morbidity

7pm: Laparotomy, washout and re-do surgical gastrostomy

Enteral feed in peritoneal cavity, misplaced tube with balloon intact, liver cirrhosis

Post-operative stay in ITU

Weaned from ventilator but developed liver and renal failure and C Diff infection

Gastrograffin confirmed PEG placement

Liver function and clotting continued to deteriorate therefore support not escalated and decision for palliative care

Patient passed away [redacted]

2017

Comments

High risk patient with liver cirrhosis, advanced cancer.

No fixation sutures used at laparoscopic placement of gastrostomy. The review team were uncertain of the rationale behind the fixation of gastrostomy tube in high risk patient.

No consent form in the notes which was concerning given the risk profile of the patient.

Case Twenty Three – [redacted]

Description

Perforated diverticular disease, peritonitis. Abdominal wound dehiscence

[redacted]year old [redacted]. History included asthma, hypertension, Ischemic Heart Disease with angina, osteoporosis.

Admitted: [redacted]. Discharged [redacted]. Readmitted [redacted]. Discharged: [redacted]

Admitted [redacted] - 5am with three days lower abdominal pain and generalised tenderness, high CRP

CT (8am, reported 11am): free intraperitoneal air esp RIF with diverticular disease. Perforation? caecal

Consented for theatre. NELA risk mortality 9.6%, morbidity 80%

[redacted] 5pm: Hartman's resection of perforated sigmoid diverticular disease. 150 mls of free pus in lower abdomen, caecum and appendix normal.
Post-op desaturated, therefore re-intubated and nursed in ITU. Acute kidney injury and sepsis. Discharged from ITU [redacted].

On ward, developed wound infection with cellulitis extending to flank, purulent discharge and pyrexia. Some clips removed. Nursing staff recorded being anxious about removing further clips day 14 as wound had not appeared to have healed.

[redacted] - rest of clips removed, no packing. Patient otherwise mobile and stoma managed therefore discharge planned.

[redacted] - patient discharged at 3pm from discharge lounge with family.

[redacted] - 6pm readmitted with full wound dehiscence with small bowel and omentum eviscerated from abdomen.

[redacted]: 8pm seen by consultant together with wife and daughter and consented for theatre. NELA risk mortality 2.5%, morbidity 40%

[redacted]: 10pm. Exploration of wound, washout, closure with Vicryl mesh and VAC dressing. Recovery in HDU with probable myocardial ischaemic event (echo showed severe ventricular dysfunction)

Discharged

[redacted]

Comments

Elderly patient with co-morbidities treated for perforated diverticular disease. Laparotomy and Hartman's procedure complicated by sepsis, wound infection and poor wound healing. The review team noted the nursing staff's concerns regarding the removal of clips on day of discharge and wound that had not healed.

The review team did not sight a consent form in the documentation provided.

Case Twenty Four - [redacted]

Description

Laparoscopic cholecystectomy complicated persistent bile leak.

[redacted]year old [redacted]

[redacted]: Laparoscopic cholecystectomy. Fibrotic gall bladder. Three accessory ducts noted and clipped bile leaking from porta hepatis post-procedure therefore drain inserted. Drain fell out but replaced by percutaneous radiological guided drain.

ERCP: [redacted]: No IHD or extravasation. Sphincterotomy and stent inserted. Continued leak, sepsis, worsening LFTS.

CT: [redacted]: Large collection and no pneumobilia - query blocked stent.

ERCP: [redacted]: No extravasation. Stent repositioned and 2nd stent inserted. Repeat CTs: [redacted] and [redacted] showed decreasing collection, well positioned drain and stent. Bile leak improving but persistent. Antibiotics for sepsis. Discussion with HPB team at Manchester Royal Infirmary, who agreed with management.

Discharged [redacted] with plan for two week review. Readmitted on [redacted]: abdominal pain, fever and change in drain output - query sepsis. Treated with antibiotics.

CT [redacted]: persistent slightly increased GB fossa collection.
MRCP: [redacted]: post cholecystectomy, collection GB fossa, and narrowing right hepatic duct
– query stricture.

Transferred on advice of Manchester Royal Infirmary HPB team

[redacted]

Comments

Fibrotic gall bladder. Clips to three accessory ducts which the review team considered to be the likely cause of the right hepatic duct injury. The review team noted that there was no further exploration performed, as this may have worsened the complication. There was an intra-operative account of the dissection, however, it did not appear that the anatomy was appreciated. The review team commented that this is a recognised injury.

The records showed that the HPB team were involved in the care provided but this complication had persisted for a long time and the review team consider that transfer should have occurred earlier.

No consent form was in the notes to assess whether the complication was discussed with the patient, prior to the operation. There were no notes available from previous admissions to assess whether this was anticipated as a difficult gall bladder dissection.

Case Twenty Five - [redacted]

Description

Laparoscopic cholecystectomy complicated by CBD injury

[redacted]year old [redacted] Previous history included hypertension, gastro-oesophageal reflux disease. Waiting list for laparoscopic cholecystectomy [redacted]

Admitted: [redacted]. 7:30 am. Transferred to Manchester Royal Infirmary: [redacted]

Laparoscopic cholecystectomy. Converted to open due to bile leak. 7-8 hour procedure. Complex duct injury with entire common hepatic duct excised with gall bladder. Attempted intra-operative cholangiogram. HPB team from Manchester Royal Infirmary called and attended theatre. Repair with high biductal hepatico-jejunostomy. Documented that the patient's [redacted] was informed by surgeon of events. Patient recorded as stable post-operatively and transferred [redacted] for further care to HPB unit.

Comments

Complex ductal injury which the review team consider was a technical error on the part of the surgeon. Surgical colleague and HPB unit called to further manage the case.

There was no consent form in the notes to assess whether the complication was discussed with the patient, prior to the operation. There were no notes available from previous admissions to assess whether this was anticipated as a difficult gall bladder dissection. There is an intra-operative account of the dissection however the review team considered that the anatomy was not appreciated. However, when a problem of bile leakage occurred, an error was realised and assistance sought. A specialised HPB team were called and an immediate hepatico-jejunostomy performed after the injury was recognised.

Case Twenty Six – [redacted]

Description

Complicated Appendicitis, abscess

[redacted] year old [redacted], Insulin dependent diabetes mellitus (IDDM). Admitted: [redacted] to [redacted]. Presented with abdominal pain for one week. CT confirmed perforated appendicitis and abscess formation. The records indicated that the patient consented for theatre laparoscopy, conversion, bowel resection. There appeared to be some delay in theatre due to ITU case and trauma.

[redacted]: Laparoscopic converted to midline laparotomy and appendectomy and drainage of abscess. Washout, drainage, post-operative antibiotics. Discharged [redacted]

The patient was readmitted [redacted] with post-operative pain, vomiting and pyrexia. CT indicated 6x3cm pelvic abscess adherent to loops of bowel. Not amenable to percutaneous drainage.

Consented for laparotomy which was performed the same day. The patient underwent a laparotomy, mobilisation of adhesions and drainage of large pelvic abscess. Discharged [redacted]

Comments

Patient with IDDM with late presentation of established appendicitis and intra-abdominal abscess. The review team were of the opinion that the patient received the appropriate treatment surgically with attempted laparoscopic appendectomy which necessitated conversion to laparotomy. Despite surgical management, intra-abdominal lavage, drainage and antibiotics, the patient re-presented two weeks later with a further intra-abdominal collection.

The review team noted that the patient had a CT scan pre-operatively to assist with diagnosis on both admissions. The clinical record indicated that the patient consented with all alternatives, although the notes do not contain the actual consent form. The review team considered that this patient's care appeared appropriate.

Case Twenty Seven – [redacted]

Description

Splenic trauma. Liver Cirrhosis.

[redacted] year old [redacted]. Previous history included liver cirrhosis due to alcohol excess.

[redacted] 2am. Admitted via Emergency Department following alleged assault with head injury, abdominal pain and hypotension. Resuscitated.

Nothing abnormal detected on a CT head scan. CT abdomen showed advanced cirrhosis, splenic injury and hemoperitoneum.

[redacted] 9am: Laparotomy, Splenectomy and packing. 7L blood loss, Cirrhotic liver with portal hypertension / splenic varices. The patient was cared for on the ITU post operatively, with recorded abdominal distension, increasing inotropic support and acidosis.

[redacted]: Re-laparotomy: Removal of pack, no evidence of ongoing bleeding. Likely decompensated liver failure. Multi organ failure and treatment withdrawn.

Patient passed away on 18/09/2018 at 1pm.

Comments

High risk patient with liver cirrhosis and severe traumatic injury. There was no consent form included in the notes provided but the review team noted that this patient had severe trauma and was unconscious upon presentation, with no family members recorded as being present pre-treatment.

The review team considered that this patient's care appeared appropriate.

Case Twenty Eight – [redacted]

Description

Appendectomy for suspected appendicitis

[redacted] year old [redacted] Previous history included five miscarriages, currently eight weeks pregnant.

Seen in the Emergency Department at 3am on [redacted] with abdominal pain and right iliac fossa (RIF) tenderness. Raised White Cell Count and CRP. Initially reviewed by gynaecology & obstetrics team. Previous scan four days ago showed intrauterine pregnancy.

Referred and seen by surgical team. Abdomen soft and tender in RIF and clinically diagnosed as uncomplicated appendicitis. Discussed with consultant and planned for appendectomy in morning. Consent recorded in the notes with discussion of miscarriage and conversion to open surgery.

[redacted]: 12pm. Diagnostic laparoscopy and appendectomy. Appendix appeared inflamed, histology was reported as normal.

The patient experienced pain and nausea post-operatively, and PV discharge. Reviewed again by gynaecology team.

Discharged [redacted].

Comments

The review team considered that this patient's care appeared appropriate. However, they noted there was not a consent form in the notes provided.

Case Twenty Nine – [redacted]

Description

Perianal necrotising fasciitis

[redacted] year old [redacted] with diabetes mellitus for which he was taking metformin. Noted to have been seen previously [redacted] with recurrent groin abscess managed on antibiotics.

[redacted] - presented with a one week history of perianal pain and lump. Examination indicated erythematous swelling with skin necrosis and crepitus diagnosed as necrotising fasciitis. Examination under Anaesthetic (EUA) performed with extensive debridement of necrotic tissue around perianal area and scrotum. Cavity washed out and packed. Tieman catheter inserted by urology registrar as Foley catheter would not pass past prostate.

Patient recorded as being consented with continence discussed as necrosis possibly involved anal sphincter, as was the possibility of stoma. Treated with Clindamycin and tazocin as antibiotic protocol.
Plan for second look and change of dressing under further general anaesthetic, however this was deemed risky as he was a difficult intubation and therefore change in dressings were done on ward.

It was noted that patient was documented as being admitted at 3pm on [redacted] but not seen by surgical team (who were reportedly not aware of admission) until 8am [redacted].

Patient discharged

[redacted]

Comments

The review team noted that the delay between admission and review by surgical team was suboptimal. This is a time critical condition which can deteriorate with worsened outcomes, in the event of delay in treatment.

The review team noted that the urology team was involved in care, which was good practice.

Case Thirty – [redacted]

Description

Small bowel obstruction

[redacted] year old [redacted]. Previous history included ulcerative colitis with total colectomy. Other history included adhesiolysis in 2000, small bowel obstruction in 2010, cholecystectomy in 1971, lung calcification and osteoarthritis.

[redacted] at 1am - Seen in admission unit by surgical team. 24hr history of faecal vomiting, abdominal pain and no stomal output for three days. Diagnosed as small bowel obstruction.

[redacted]: High MEWS score noted and became unwell leading to peri-arrest call. A CT at 10:20am indicated a proximal small bowel and jejunal dilatation but no transition point. The notes indicated that the patient was consented for laparotomy following transfer to critical care for

optimisation. NELA mortality score 5.6%

[redacted] – Laparotomy with division of dense adhesions, closure of 3x enterotomies and mesh closure of laparostomy. Post-operative care in ITU – the patient developed ventilator associated pneumonia, requiring renal and inotropic support.

[redacted] - CT showed open abdomen, no intra-abdominal collections or gas, lung consolidation. Increasingly septic, despite improving respiratory function.

[redacted] - CT showed locules of gas in upper abdomen, free fluid and dilated bowel loops. A repeat Laparotomy was performed - drainage of pus, exteriorisation of ileum, T-tube insertion of jejunum.

It was recorded that the patient became increasingly septic, acidotic and dependent on increasing inotropes with leakage from the laparostomy of enteric contents through mesh and drains.

[redacted] - Third Laparotomy performed - excision and re-siting of ileostomy in wound for perforation.

Patient further deteriorated and developed multi organ failure. Decision to withdraw support and the patient passed away on [redacted] at 5pm.

Comments

It was documented that the patients had dense adhesions, it appeared to be a complex laparotomy resulting in complications. There was a delay in admission of patient with dehydration and sepsis before he deteriorated on the ward requiring peri-arrest call. Other than this, the review team considered the care of the patient was reasonable, and noted that multiple teams and consultants had input into this difficult case.

It was noted that there was not a consent form included in the documentation provided.

Case Thirty One – [redacted]

Description

Perforated duodenal ulcer

[redacted] year old [redacted] History included COPD, Type II diabetes mellitus, Osteoporosis, previous appendectomy / hysterectomy.

Admitted 8am [redacted] to resus in the Emergency Department with acute onset severe generalised abdominal pain since 3am. Given morphine in ambulance. Abdomen assessed as soft but tender and chest x-ray as basal band atelectasis.

Due to clinical suspicion a CT scan was performed at 2pm. CT reported as perforation with free intraperitoneal fluid and air. Assessed by surgical team at 3pm, consented for laparotomy (NELA risk mortality 8-12%).

Laparotomy performed at 7pm - generalised peritonitis with perforation of anterior duodenal ulcer. Suture of perforation with omental patch, lavage and drainage.

Patient transferred to ICU. The patient continued to require ventilation and inotropic support and remained septic and acidotic. Findings, progress and prognosis documented as being discussed with son (next of kin).

The patient passed away on died [redacted] reported to

coroner.

Comments

This was an elderly patient with co-morbidities treated for perforated duodenal ulcer. It was recorded that [redacted] was seen in the Emergency Department shortly after onset of symptoms. It appeared there may have been some delays in diagnosis, CT and transfer to theatre but it was within the same day and within hours.

It was noted the maximal therapy was given with laparotomy and critical care post-operative support but the patient sadly succumbed to [redacted] illness. Other than the delay noted above, the review team considered that the care of the patient was reasonable.

It was noted that there was not a consent form included in the documentation provided.

6. Guidance for the healthcare organisation

6.1. Responsibilities in relation to this report

This report has been prepared by The Royal College of Surgeons of England and Association Of Surgeons Of Great Britain & Ireland under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[8]

6.2. Further contact with the Royal College of Surgeons

Where recommendations have been made that relate to patient safety issues, the Royal College of Surgeons will follow up with the healthcare organisation to request confirmation that timely action has been taken to address these recommendations.

If further support is required the College may be able to facilitate this. Additionally, if it is considered that a further review would help to assess improvements that have been made the College's Invited Review service may be able to undertake this.

[8] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

Appendix A – Royal College review team

[redacted] — **The Royal College of Surgeons of England**

[redacted] BSc, MB BS, MD, FRCS (Gen Surg) graduated from St. Mary's Hospital Medical School in 1990 and undertook surgical training in the St. Mary's Hospital group and the Yorkshire Hospitals. [redacted] completed surgical training in the United States as International Fellow in Surgical Oncology at Memorial Sloan Kettering Cancer Centre, New York (1999-2000) and Fellow in Colon and Rectal Surgery at the Cleveland Clinic Foundation, Cleveland, Ohio (2000-2001).

[redacted] was appointed Consultant Surgeon to the Hull and East Yorkshire Hospitals in 2002. From 2007 to 2010 he served as Specialty Tutor in Coloproctology in the Raven Department of Surgical Education at the Royal College of Surgeons of England. From 2010 to 2013 [redacted] Chaired the Education and Training Committee and sat on the National Executive of the Association of Coloproctology of Great Britain and Ireland. From 2012 to 2014 [redacted] served as Regional Specialty Adviser for General Surgery for the Yorkshire Region. [redacted] is a former Director of Professional Practice member of the National Executive of the Association of Surgeons of Great Britain and Ireland (2014-2016). During that time [redacted] represented the Association of Surgeons on the Royal College of Surgeons Invited Review Mechanism. [redacted] elective surgical practice is concerned almost exclusively with the treatment of colorectal disease.

[redacted] — **Association of Surgeons of Great Britain & Ireland**

[redacted] graduated from the University of Cambridge in 1989 and trained in oesophago-gastric cancer surgery in London, Hong Kong and Tokyo. [redacted] was appointed as oesophago-gastric surgeon in Middlesbrough in 2002, where [redacted] has held trust positions of Clinical Director and Assistant Medical Director. [redacted] is an experienced clinical assessor having worked with the National Clinical Assessment Service for ten years. [redacted] is currently the chair of the upper GI MDT as well as the chair of the Northern region upper GI tumour board. Since 2017, [redacted] has been the Northern Regional Director for the Royal College of Surgeons of England.

[redacted] — **Association of Surgeons of Great Britain & Ireland**

[redacted] qualified from St Bartholomew's Hospital London in 1977. Following surgical training in Oxford and Cambridge, [redacted] gained an MS at The Ludwig Institute of Cancer Research in Cambridge. [redacted] was appointed Lecturer in Surgery at the Royal Free Hospital London in 1988. [redacted] spent a year as Visiting Lecturer in the Department of Surgery at the Chinese University of Hong Kong in 1989/90, before being appointed Consultant Surgeon at The North Devon District Hospital in 1992.

[redacted] became heavily involved in surgical education, firstly as Royal College of Surgeons Tutor, then as Programme Director for the South West Higher Surgical Training Programme. In 2006 [redacted] was appointed as the inaugural Head of the South West Peninsula School of Surgery, a post [redacted] held until 2011.

[redacted] was on the Executive Board and Director of Informatics at the Association of Surgeons of Great Britain and Ireland (ASGBI) from 2005 to 2015. [redacted] was elected to the Council of the Royal College of Surgeons of England, representing ASGBI, in June 2015, serving for four years. [redacted] was Chair of the College's Invited Review Mechanism from 2016-2017.

Appendix B - Statements provided to the review team

- Written statement by Mr Imran Alam
- Written statement by Mr Marius Paraoan
- Written statement by Ms Naomi MacKenzie
- Written statement by Mr Martin Antony
- Written statement by Mr Petre Ichim
- Written statement by Mr Rabindra Nath
- Written statement by Mr Mazyar Fani