Introduction

In this edition of Nevermore we look at a Serious Incident which refers to delayed treatment where there were missed opportunities to remove a patient’s biliary stent.

We also examine a Serious Incident regarding a systems failure, during which staff missed three opportunities to refer a child, who had suffered sexual abuse.

There is also information in this issue about our Trust’s Patient Safety Conference, which is now in its third year, following two previously successful events.

Regards,

Lisa Pinkney
Patient Safety Manager
In this case study we look at a delay in treatment for a patient, who underwent stent placement for obstructed Common Bile Duct (CBD) stone. A cholecystectomy was performed in October 2012, but the biliary stent was not removed. However, the patient represented with severe sepsis and went on to have a laparotomy and removal of an infected biliary stent.

The patient was admitted under Consultant A as an emergency, with obstructive jaundice and cholangitis secondary to choledocholithiasis. An ultrasound scan confirmed a dilated common bile duct. A sphincterotomy was performed with drainage of pus under Consultant B. A stent was placed across the extrinsic stricturing into the common hepatic duct.

The patient was discharged two days later, with an Outpatient Clinic appointment with Consultant A for four weeks later. The patient was reviewed in clinic by Specialist Registrar 1, on behalf of Consultant A, who consented and listed the patient for a laparoscopic cholecystectomy clinic. However, an ultrasound scan confirmed the patient was pregnant.

After her delivery, six months later, the patient was admitted for elective laparoscopic cholecystectomy, which was uneventful. The operation was carried out by Specialist Registrar 2 and supervised by Consultant A. The surgery was technically difficult due to Mirrizzi’s syndrome, an intrahepatic component of the gallbladder. The cystic duct was stapled and a cholecystectomy completed. The biliary stent was not removed.

Ten months later, the patient presented under Consultant C with severe sepsis, epigastric pain radiating to the shoulder, with protein and bilirubin in the urine. She went on to have a laparotomy and removal of an infected biliary stent by Consultant C.

One month later the patient was admitted as a day case under Consultant D for a post-operative wound infection, with purulent discharge from the lateral end of the Kocher’s incision.

Eleven days later, the patient was admitted under Consultant E for pain. A CT scan showed intra and extra hepatic duct dilatation with evidence of a retained stone. She was treated aggressively with antibiotics. The patient underwent a further ERCP and a further CBD stone removal was performed by Consultant B. The patient was discharged, to be followed up in outpatient clinic, and has now made a good recovery.

**Investigation Findings**

- A patient having a stent inserted is not uncommon as biliary stents can be left in place or removed (there are different clinical scenarios where in a biliary stent is placed and hence this is a carefully considered decision by the Consultant).

- The discharge letter from the responsible Consultant noted the presence of the stent, but not a plan of action of when and how it would be removed. The clinic discussion four
weeks after the stent was placed did lead to listing the patient for a laparoscopic cholecystectomy but no mention is made of a plan for dealing with the biliary stent.

- The lady became pregnant which meant that there was a time gap between the two episodes of biliary pathology care.
- When the patient came in for a planned laparoscopic cholecystectomy (which was successfully performed) the issue of the retained biliary stent was not discussed.
- The patient visited the hospital both as an inpatient and outpatient after insertion of the stent. There were four missed opportunities in identifying that the stent was still in place.
- There is no system of entering biliary stents on a register in the Trust. The Urology department have a stent removal register and this has been reviewed by the lead investigator.

**Recommendations made as a result of this SI are the following;**

- Maintain a record of details of all patients who have a biliary stent inserted including details of when the stent is to be removed. Details of stent removal also need to be included on the endoscopy report following the ERCP. This record needs to capture patients who have biliary stent insertion at all sites across the Trust.
- Improve information given to patients who have biliary stent insertion.

The above actions are currently on-going.

**Case Study 2 System Failure**

A child (Patient A) attended the Emergency Department (ED) with thoughts of self-harm. The child shared their experience of previous sexual abuse with the doctor, and was then referred, seen and assessed by the Child and Adolescent Mental Health Services (CAMHS) in ED, who documented that Patient A was safe to go home under the care of their parent. No consideration was given to discussing the need for an assessment by a paediatrician specialising in Child Sexual Assault (CSA) and there was no discussion regarding accessing sexual health services at this attendance.

Patient A attended the ED a second time (one month later), having taken an overdose of Paracetamol. The patient disclosed previous experience of sexual assault but again there was no discussion with a paediatrician who specialises in CSA or a referral to sexual health services. On this occasion Patient A was admitted to the children’s ward and assessed by CAMHS, who documented that there was a safety plan in place. The patient was discharged home two days later with a follow up appointment with CAMHS for four days after discharge.

Ten days after the CAMHS outpatient review, the patient attended the Genito-Urinary Medicine (GUM) clinic without a parent. Patient A requested a chlamydia test at the
reception and disclosed to the receptionist that they had previously been sexually assaulted. The receptionist spoke to the Sexual Health Nurse who advised that an appointment be made to attend the clinic. At this stage the nurse was not aware that the patient had presented to the clinic and thought there were on the telephone. Patient A was given an appointment for later that day but did not attend.

On the following day, the Lead Nurse in the GUM clinic emailed the Sexual Assault Centre to check if Patient A was known to them. At this point they were not, therefore a further appointment was made which Patient A attended and was seen jointly by the Lead Nurse for Sexual Health and the Lead Nurse, Child Sexual Assault Assessment Centre.

**Investigation Findings**

This investigation highlighted a failure to seek advice for Patient A on three occasions from a paediatrician specialising in Childhood Sexual Abuse, or to refer to the GUM clinic to ensure all services and support were offered. These were missed opportunities to provide support.

**Recommendations following investigation:**

- Raise awareness about the sexual assault centre service and the process to escalate to a paediatrician where CSA is suspected. Review current training provision in relation to child sex exploitation.

**Lessons learnt**

*All children who present to the Emergency Department or Children’s ward who disclose sensitive information of sexual assault, whether or not a child protection plan is in place, should be referred to a paediatrician who specialises in CSA for advice.*

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**Preliminary Agenda**

**Patient Safety Conference, York Racecourse Friday, 9th June 2017**

**Knivesmire Stand 2nd Floor**

.50 - 09.40 Registration, refreshments, exhibition and poster gallery

**Voltigeur Suite 2, 3rd Floor**

.45 - 10.00 Opening address

Patrick Crowley, Chief Executive, York Teaching Hospital NHS Foundation Trust

11:00 – 11:15 Leading to High Reliability: A Cultural Transformation
If you would like to submit an abstract for an oral or poster presentation, please register your entry on the proforma available on the Trust website: [https://www.yorkhospitals.nhs.uk/about_us/patient_safety_/patient_safety_conference_2017/](https://www.yorkhospitals.nhs.uk/about_us/patient_safety_/patient_safety_conference_2017/). Email your completed entry to charlotte.Craig@york.nhs.uk. The closing date for submissions is **Monday, 15th May**. For additional guidance and support on abstract submissions please contact lisa.pinkney@york.nhs.uk. To reserve a place, please contact Liz Jackson on ext (772)1216 or liz.jackson@york.nhs.uk.