TO: Transfusion Laboratory Manager, Transfusion Practitioner, Chair of RTC, Chair of HTC, Consultant Haematologist with Responsibility for Blood Transfusion

13 September 2022

ABO Grouping and Organ Transplantation

Dear Colleague

We are writing to inform you of a recent incident that led to a Never Event in an organ donation and transplantation and to share initial actions, relevant to the transfusion laboratory, that are required to help prevent reoccurrence.

We recognise that the activities of the transfusion laboratory are a part of a wider process and confirm that separate investigations and communications are taking part covering the rest of the process.

Summary of Incident:

A patient who underwent massive transfusion, subsequently died, and went on to become an organ donor. The massive transfusion led to the transfusion laboratory being unable to confirm the blood group of the patient and the blood was reported onto the Trusts Electronic Patient Record (EPR) as O D negative. The patient was later confirmed to be group B and the EPR was corrected. Unfortunately, the organs donated from the patient had already been transplanted into group O individuals and this resulted in the transplantation of blood group incompatible kidney and liver to recipients.

Action Points:

- Transfusion laboratory staff working in all shifts need to be aware that they may be contacted by specialist nurses in organ donation to confirm blood group in patients/organ donors. This step has been introduced as an additional safety measure to ensure safe transplantation. The donor blood group is not rechecked again prior to transplantation so it is vital to get this right at the time of retrieval/allocation

- When contacted by the specialist nurses for organ donation, Transfusion laboratory staff must clearly communicate if there are any pending investigations for defining the blood group and if any inconsistencies have been identified
• Transfusion laboratory staff must review local policies for handling, reporting and investigating indeterminate blood groups to ensure they accord with national guidance.

Further learning points from this unfortunate incident will be circulated in due course once a full investigation has been completed. The true root causes and human factors are yet to be established. The above actions should not be interpreted as “corrective actions” to the original incident.

Should you have any queries on this matter please get in contact with your Customer Service Manager.

Please cascade to laboratory and clinical staff as appropriate.

Kind regards,

Dr Farrukh Shah
Medical Director for Transfusion

Chris Philips
Head of Hospital Customer Service

Save a life
Give blood