NHS BLOOD AND TRANSPLANT

LIVER ADVISORY GROUP

Clinical Governance Report

In the six months to the end of March 2015, there were 47 Incidents reported to NHSBT which included the Liver as a key-word. This number is largely in line with previous similar periods.compared with the previous numbers of lung-related incidents. Many did not involve the liver at all, but it is mentioned in the setting of a multi-organ donor

17 involved the liver alone, and the remaining 30 at least one other organ

Of the 47, a breakdown into the various stages of transplantation was:

Retrieval	23
Donation	11
Support Services	10
Transplantation	3

The same breakdown for the liver-only Incidents again shows a predominance of retrieval problems:

Retrieval	10
Donation	3
Support Services	3
Transplantation	1

Within those classed as retrieval, there were 4 reports of **hepatic artery damage** – this was a trend noted in a previous Governance Report to LAG. One injury was reported as mild, with no effect on outcome. Another was more severe, but the liver was successfully used for a super-urgent recipient with a good result. One liver was regarded as unusable on arrival at the recipient centre, and in another, the recipient returned to theatre for persistent bleeding and had areas of poor perfusion.

An additional incident concerned poor communication about vascular anatomy, and a mistaken vessel ligation in a liver destined for splitting. Liver eventually transplanted whole and splitting abandoned.

Other retrieval problems included delayed transport, delays to retrieval because of cardiothoracic decision-making problems. The latter incidents have already been raised as an important trend at CTAG.

There were two problems related to organ perfusion. In one, non-adherence to protocol by the lung team resulted in massive blood loss during NRP. The liver was cold-flushed and used successfully, but the pancreas was not used. This problem was raised at NRG and again at CTAG, and the NRP/Lung retrieval protocol is being adjusted. There was an apparent failure of perfusion on an Organox machine, and after flushing, the liver, which was also fatty, was not used because of appearance and apparent poor perfusion.

One recipient developed a bile leak related to QUOD biopsies, and had recurrent biliary peritonitis. This has been extensively investigated and is an isolated problem.

The donation incidents affecting the liver alone surrounded non-used livers being sent for research.

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The single incident in transplantation revolved around non-reporting of a liver biopsy result (in fact benign) to centres transplanting other organs.

Other incidents were carried and in general trivial – examples include wrong donor DOB recorded on EOS and transcription errors for toxoplasma serology.

The support service incidents were in general mild, although in one instance a patient listed for liver-kidney transplant was disadvantaged because the kidneys had been allocated to another recipient. This issue has also been raised elsewhere, and is a difficulty running through allocation for multi-organ recipients.

Late change of mind by centres, usually around marginal DCD livers, reported as a trend at a previous LAG, was not seen in the past six months.

Details of key incidents will be presented

Members of LAG are reminded that reporting incidents serves a valuable purpose for the whole transplant community, allowing recurrent concerns to be identified at an early stage, and providing a means of learning from others.

April 2015