

**NHS BLOOD AND TRANSPLANT  
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE**

**BOWEL ADVISORY GROUP**

Clinical Governance Report - October 2015

In very few reported Incidents does “Bowel” or “Multi-visceral” appear in a keyword search of the database used to record reports.

In a six-month period up to the end of August 2015, there were x such incidents.

One incident is perhaps of direct interest to the Bowel Advisory Group (BAG). The right and left kidneys were confused, and sent to the wrong implant centres. It was noted that the retrieval was very complex, with the standard NORS cardiothoracic and abdominal teams, as well as an additional team retrieving small bowel. All organs were eventually successfully used.

There were two other, very tangential incidents:

- 1) With a simultaneous bowel retrieval, the liver was reported as badly packed, in the wrong sized box. This had no impact on the small bowel retrieval.
- 2) Before a liver and kidney retrieval, abdominal scars had not been noticed by the SNOD. A history of bowel surgery some 20 years previously had been forgotten by the daughter of the donor, and it was not in the GP or hospital records. At laparotomy, he was found to have had a hemicolectomy and appendicectomy.

It is suggested that in future, this report details the number of incidents and any of direct relevance to BAG.

John Dark  
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