Queen Mary Hospital announces sentinel event

The following is issued on behalf of the Hospital Authority.

The spokesperson for Queen Mary Hospital (QMH) announced a sentinel event today (May 18):

A six-year-old female patient with biliary atresia received splenic artery embolisation in QMH this year on April 27 due to coagulopathy and hypersplenism. On the day of the operation, the patient's platelet count was assessed to be low. In order to reduce the risk of bleeding and complications at femoral vascular access, the doctor planned to use a vessel closure device instead of manual compression for haemostasis upon completion of the interventional procedures.

During the operation, a vascular sheath was inserted at the common femoral artery and the splenic artery embolisation procedure was uneventful. The vessel closure device was subsequently used, however, without success in haemostasis. The doctor thus removed the device and achieved haemostasis by manual compression. The patient was then transferred to a general ward for medical surveillance, and was discharged on May 1 upon satisfactory recovery.

On May 14, the patient attended follow-up as scheduled. It was noted that the patient encountered right lower limb claudication. A clinical examination and computed tomography arteriogram were arranged and the pulses of the patient's right lower limb were found to be weak. An emergency vascular operation was immediately arranged. A tiny fragment of the vessel closure device was discovered and removed in the vessel lumen. The patient was subsequently transferred to the Paediatric Intensive Care Unit. She is currently in stable condition with satisfactory blood circulation.

The hospital is very concerned about the incident. The Department has contacted the device supplier yesterday to follow up and obtain more information to facilitate further investigation.

The hospital expresses its apology to the patient concerned. A meeting was arranged last evening with the parents to explain the incident in detail. The case has been reported to the Hospital Authority Head Office via the Advance Incident Reporting System. A root cause analysis panel will be set up to look into the incident. The investigation report will be submitted in eight weeks. The hospital will continue to provide appropriate treatment to the patient and to keep close contact with the relatives to render necessary support.