

Freedom of Information Request	FOI 21-502	13 <sup>th</sup> December 2021
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- 1. The number of reported incidents of instruments unaccounted for following a surgical procedure, broken down by hospital in your Local Health Board area in the financial years 2018-19, 2019-20 and 2020-21, along with monthly figures up to November 2021;**
- 2. Out of these reported incidents, how many patients were x-rayed to determine if the instrument had been inadvertently retained in the patient broken down by hospital in the years and months above;**
- 3. In each instance where an X-ray was undertaken which confirmed the instrument was inadvertently retained within the patient, can you confirm that a Duty of Candour had been evidenced by documenting the reason for X-ray within the patient record; and**
- 4. A list of the root causes of these incidents**

Date	Hospital	Adverse Event	X-ray Undertaken	Duty of Candour	Root Cause
July 2018	Royal Gwent Hospital	Retained needle/swab/ instrument	<b>Yes</b>	Yes	Not Known
Dec 2018	Nevill Hall Hospital	Missing needle/swab/ instrument	<b>Yes</b>	Yes	Equipment checklist updated to include plastic protective sheaths.
June 2019	Nevill Hall Hospital	Retained needle/swab/ instrument	<b>No</b>	No xray performed.	Cannot be ascertained.
April 2019	Royal Gwent Hospital	Missing needle/swab/ instrument	<b>Yes</b>	Yes	Swab recording error.
Feb 2020	Nevill Hall Hospital	Missing needle/swab/ instrument	<b>Yes</b>	Unable to review T&O X-ray report to confirm, but logged on incidents record.	Practice of using clips to hold drapes insitu revised.
Feb 2020	St Woolos	Missing needle/swab/ instrument	<b>Yes</b>	Yes	Not known.