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Case Report

Retained needle in surgery *

Vyse v. The Sisters of St. Joseph & Sweeney, Dist. Ct. of Ont., File No. 4939/86, July 11, 1990

The facts

Mark Vyse underwent hernia surgery in July, 1981 at St. Joseph's Hospital in London, Ontario. During surgery, a needle count indicated that one eyed needle was short and/or missing. A search for the missing needle proved unsuccessful. An X-ray was taken. The needle could not be found and the operation continued.

The patient was not informed that a needle had been lost.

In 1985, following a fall, Mr. Vyse underwent a series of X-rays. An eyed needle was discovered in the lower left lobe of the lung. A decision was made not to remove it unless trouble arose.

A lawsuit was commenced against the hospital and Dr. Sweeney. Prior to trial, the action against the hospital was dismissed.

The decision

The court was faced with disturbing evidence regarding the intra-operative X-ray. The radiologist's report dated July 11, 1981 indicated that a chest X-ray had been taken during the operation. On February 17, 1987, this was amended by the radiologist to read "abdomen". The record was changed after Mr. Vyse had launched his lawsuit. The X-ray was not produced at trial since it had been disposed of by the hospital. Hospital policy only required X-rays to be retained for six years.

The surgeon testified at trial that he did not use an eyed needle. However, during a pre-trial discovery examination, he had stated that he probably had used one. The court found that Dr. Sweeney had used an eyed needle and that this was the lost needle which had travelled from the site of the abdominal surgery to the patient's lung. Expert evidence was accepted that if reasonable care and attention were exercised, it is unlikely that a needle would be lost without anyone knowing it. The court found that if a thorough, appropriate and accurate search had been carried out, including the taking of an X-ray in the proper area, the needle would

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have been found. Therefore, the court concluded that the defendant was guilty of negligence.

Lessons for risk management

1. Develop and implement a checklist to ensure searches for lost needles or instruments are completed during surgical procedures.
2. Document the type of X-ray requested, date and time of completion and the radiologist's report, ensuring that the *requested* X-rays were completed.
3. Prohibit late entries in any record following the commencement of legal proceedings. Separate documentation should be used for this purpose.
4. Take appropriate measures once a claim is filed. Make certain relevant documentation on missing needles or instruments, including X-rays and radiology reports, are transferred to the person responsible for claims management.
5. Develop an appropriate retention period for documentation relating to missing needles or instruments.
6. Develop and implement a policy for informing patients of missing needles or instruments.