Sent via email
[redacted]

Information Governance
Christopher Ward, West Pavilion
St Charles Centre for Health & Wellbeing
Exmoor Street
London
W10 6DZ

www.clch.nhs.uk
foi.request@clch.nhs.uk

FOI 2016/080

20 June 2016

Dear [redacted]

Freedom of Information Act 2000 request:

With reference to your request for information, dated 27th May 2016, made under section 1(1) of the Freedom of Information Act, I am writing to inform you of the outcome of your information request.

You asked the following:

> *'I would like to see a copy of the STEIS incident report, reference number: W35440. It is referenced on page 110 of this http://www.clch.nhs.uk/media/212387/clch_agenda_and_papers_26.05.16.pdf.'*

Our response:

> *The STEIS incident report is confidential and therefore we are unable to release this. However we can advise that the incident relates to the administration of vacinations that had been subject to a cold chain break. Expert advice was sought and it was considered that the break did not result in any harm to those who received the vaccination.*

This completes our response to your request for information. If you are unhappy with our response, please write to us giving your reasons and we will address them. If you remain dissatisfied you are entitled to appeal to the Information Commissioner:

Customer Contact
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow SK9 5AF
Tel: 0303 123 1113
http://ico.org.uk/concerns/getting/report_concern_foi

Yours sincerely,

Jonathan Walmsley
Information Governance Facilitator
Central London Community Healthcare NHS Trust

Serious Incident Reporting Document

Created by URYX on 12/05/2016 at 13:40:39

Exit

Organisation reporting SI on STEIS:	Central London Community Healthcare NHS Trust	Log No:	2016/12922
Region (Geography):	London	Status:	Ongoing
CCG/CSU: Select from list	Barnet Local Authority	Commissioner leading oversight of investigation:	
BF/wd Date:	04/08/2016	Organisation leading investigation	Central London Community Healthcare NHS Trust

When, Where & Your Details

Date of Incident:	31/05/2016	Reporter Name:	[redacted]
Time of Incident:	14:00	Reporter Job Title:	Serious Incident Coordinator
Site of Incident:	Vale Drive Clinic	Reporter Tel. No.:	0[redacted]
Location of Incident:	Healthcare premises	Reporter Email:	[redacted]
Date Incident Identified:	11/05/2016		

Who

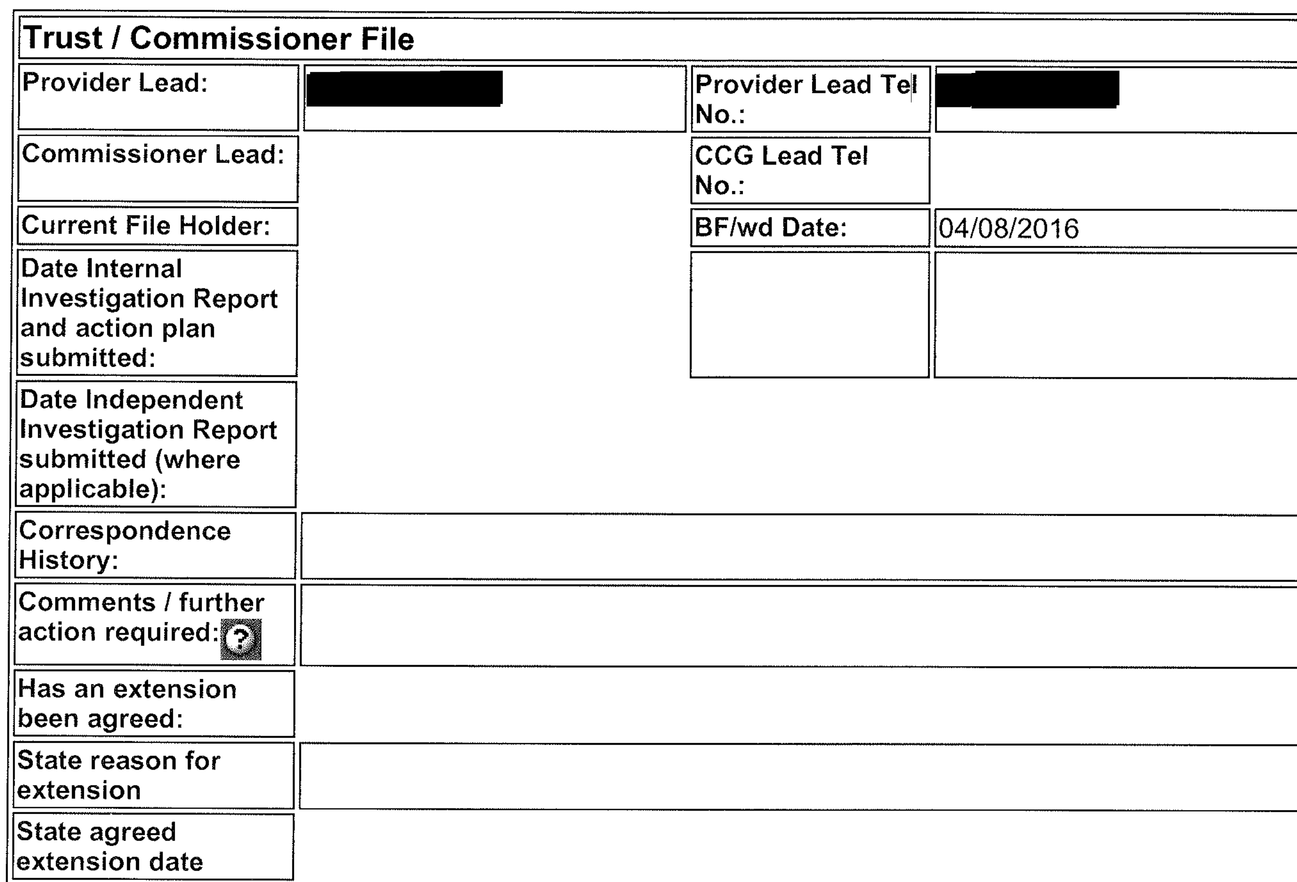
Care Sector:	Other Please provide more info :Community Healthcare	Type of Patient at time of incident:	Receiving (or awaiting) community or outpatient care from MH services
Clinical Area:	Medicine	Gender:	Not applicable (not patient SI)
Date of Birth (dd/mm/yyyy, N/A or Not Known):	not known	Ethnic Group:	Not Stated
Patient's GP Practice:		Legal Status of patient at time of incident:	Not applicable - not patient SI

What Happened?

Reason for	Unexpected / potentially avoidable injury causing serious harm

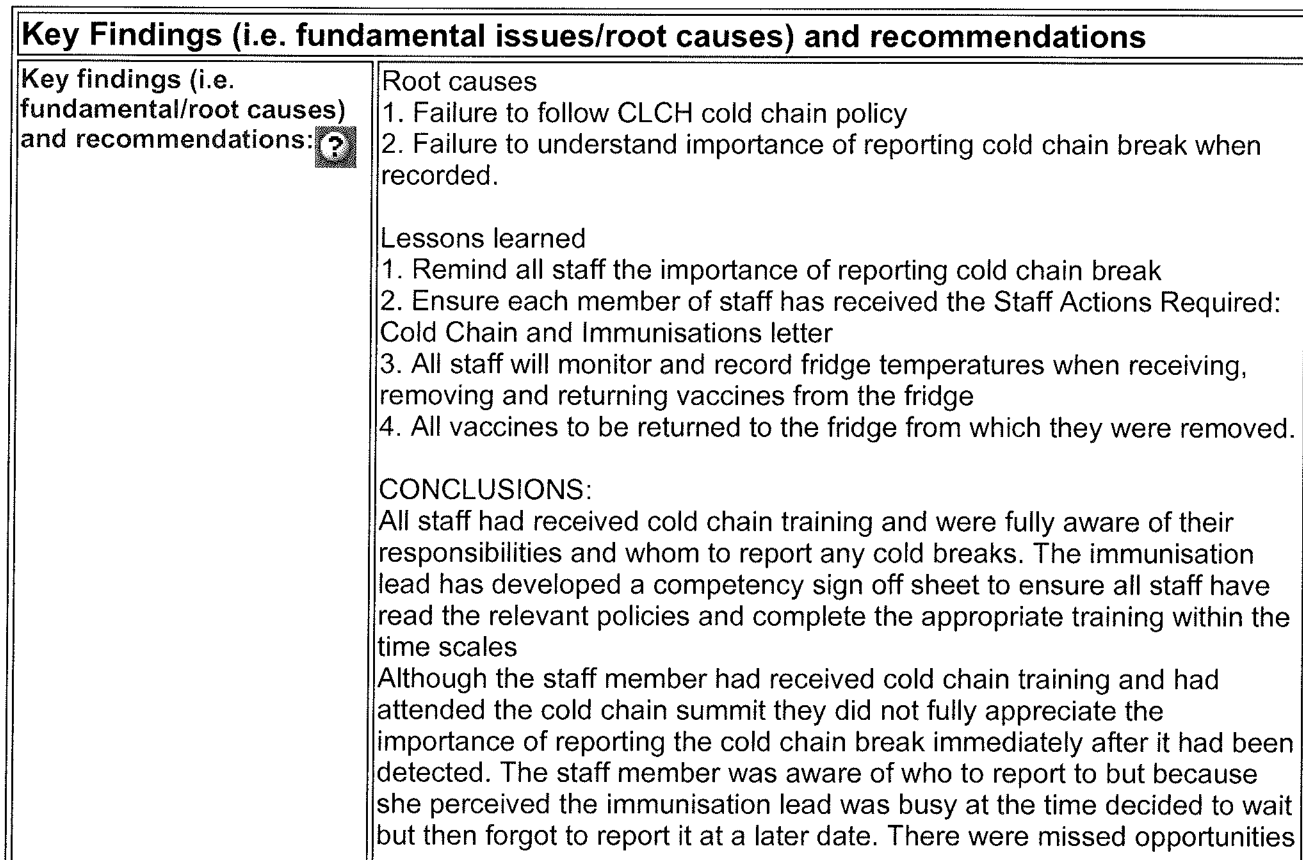
Reporting:			
Type of Incident:	Medication incident meeting SI criteria		
Where is patient at time of reporting:	Unable to say - multiple patients	Never Event:	Not a Never Event
Internal Investigation Required:	internal comprehensive	Expected investigation Completion date (excluding externally led investigations) :	05/08/2016 Read Only This will be calculated 60 days from date report submitted
Independent Required:	No	Expected date of Completion	
Non-health led investigation required	Not applicable	Expected date of Completion	
Description of what happened:	Administration of vacinations that have been subject to a cold chain break. 100 Revaxis administered on 29th March after first break. 113 Revaxis administered on 30th March after first break 191 Menveo administered on 30th March after first break		
Immediate action taken:	Resident of Barnet. The stock in the fridge was quarantined and medicines management team was informed. Reason for delay in reporting on StEIS: 48 hour meeting was held on 14th April 2016. The outcome of the meeting was to investigate further, establish facts for discussion with Public Health England. 2nd Follow up meeting held on 3rd May 2016 with PHE in attendance. Outcome of the meeting to investigate as an internal serious incident. Further communication from NHSI and Barnet CCG outcome to report on to StEIS.		
Patient family / victims family informed?	No		
Patient(s) informed?	No		
Duty of Candour comments - include Steps taken to involve and support those affected (including patient(s), victims, families, staff):	It was not communicated to parents as the initial meeting concluded there was no harm to students. It was considered during the meeting on 03/05/2016 that communicating cold chain breach could cause more harm and distress..		
Media Interest:	No	Line being taken by Trust/CCG:	Cold chain break.
Externally reportable:	Yes	Externally reportable to:	National Reporting and Learning System (NRLS), Public Health England

Have relevant organisations been notified:	Yes		



Trust / Commissioner File

Provider Lead:	[redacted]	Provider Lead Tel No.:	[redacted]
Commissioner Lead:		CCG Lead Tel No.:	
Current File Holder:		BF/wd Date:	04/08/2016
Date Internal Investigation Report and action plan submitted:			
Date Independent Investigation Report submitted (where applicable):			
Correspondence History:			
Comments / further action required:			
Has an extension been agreed:			
State reason for extension			
State agreed extension date			



Key Findings (i.e. fundamental issues/root causes) and recommendations

Key findings (i.e. fundamental/root causes) and recommendations:

Root causes
1. Failure to follow CLCH cold chain policy
2. Failure to understand importance of reporting cold chain break when recorded.

Lessons learned
1. Remind all staff the importance of reporting cold chain break
2. Ensure each member of staff has received the Staff Actions Required: Cold Chain and Immunisations letter
3. All staff will monitor and record fridge temperatures when receiving, removing and returning vaccines from the fridge
4. All vaccines to be returned to the fridge from which they were removed.

CONCLUSIONS:
All staff had received cold chain training and were fully aware of their responsibilities and whom to report any cold breaks. The immunisation lead has developed a competency sign off sheet to ensure all staff have read the relevant policies and complete the appropriate training within the time scales
Although the staff member had received cold chain training and had attended the cold chain summit they did not fully appreciate the importance of reporting the cold chain break immediately after it had been detected. The staff member was aware of who to report to but because she perceived the immunisation lead was busy at the time decided to wait but then forgot to report it at a later date. There were missed opportunities

	to review the fridge temperature when staff were removing or returning vaccines which may have detected the cold chain break earlier and prevented vaccines being administered that had been stored at sub-optimal temperatures. Recommendations 1. Remind all staff of their responsibilities under the cold chain policy 2. Record fridge temperatures on the vaccine log when removing and returning vaccines from the fridge 3. Dedicated immunisation team member to check fridge daily and ensure deputy in place 4. Return vaccine stock to the same fridge it had been removed from 5. Meet with individual staff member to stress the importance of reporting any issues to senior responsible staff to ensure actions can be carried out in a timely manner. 6. Individual will receive a letter which will include her roles and responsibility for cold chain process and the possibility of taking action within Human Resources Policies if this should happen in the future.
How will lessons be disseminated to interested parties:	Arrangements for Shared Learning Divisional Team Meetings Immunisation team meeting Bi Monthly Children's Quality Meeting Monthly Integrated Quality & Performance Meeting
Plan for monitoring action plan in place:	Yes
Date Closed by commissioner:	

Exit

Modified Date and Time	By
12/05/2016 13:21 12/05/2016 13:40 30/06/2016 11:31	URYX URYX URYX