

Date Received: 22/02/07

Date Completed: 16/03/07

Detail of request:

I am requesting the following information as it pertains to Queen's Hospital.

Anonymous details of all adverse incidents involving radiotherapy treatment from 1996 until present date, including details on:

- Date when the incident occurred.
- Details of how the treatment received differed from the intended treatment: Overdose, under dose, administered to wrong part of the patient etc. Including degree of overdose or underdose i.e. how many times over or under intended dose.
- Details of any follow up treatment or other action taken (g independent reports/enquires).
- The cause of the incident (human error, mechanical failure etc).

Highlighted to the applicant that Queen's Hospital had only opened to the public in December 2006, confirmed would like information Trustwide.

Details of response:

Internal investigation of all incidents occurred. Reports were written with improvement to the systems of work, which were carried out.

19/01/1996	Anterior field treated instead of posterior field. This resulted in an under dose of 19% from the single fraction. The effect was corrected. Overall delivered dose was neither an overdose or under dose to the prescription point. However, an error of 2.4% over dose occurred in a small area.	Report written and compensation calculated.	Human error.
30/11/2001	Dose prescription was delivered as intended to the prescription point. No under dose or over dose to the prescription point.	Error compensated by the phase II plan resulting in a dose distribution that did not cause significant clinical effect. Transfer of information between planning system and	Human Error. Manual process of transferring information from planning system to treatment machines.

	Different dose distribution compared to intended - hot and cold spots in the wedged directions. Compensated plan received 110% instead of 105% planned.	linear accelerators were automated. Department of Health was notified.	
10/01/2002	Small size ovoids were used for one fraction (1/5) resulting in an overdose. After compensation, No under dose or overdose.	It was compensated during the remaining fractions. Department of Health was notified.	Human error.
13/01/2006	Wrong area was treated. Sequence of events: Meningioma patient. Two fractions were delivered to the wrong nearby area. The clinician drew the volume anteriorly based upon a visible abnormality from an old infarct. The error was picked up in simulator during the treatment.	Correct Area and dose delivered. No harm done to the patient due to the low dose involved. Department of Health was notified.	Human error since the notes was not scrutinised enough by the second clinician who drew the volume.
13/02/2006	Wrong area was treated. Sequence of events: Bed was moved for film check. Bed was not moved back to the treatment position. Patient was irradiated for one field (0.96Gy) to the abdominal region instead of chest. Wrong dose was delivered to 23.6 cm inferior area.	Automatic Imaging (Electronic Portal Imaging) system now exists, which prevents the above types of error. Department of Health was notified.	Human error.