

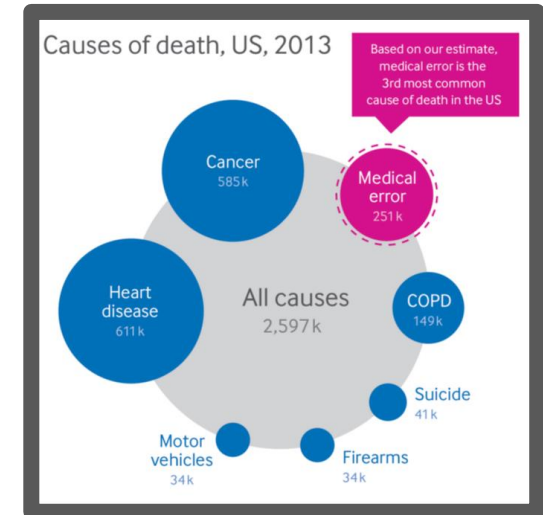
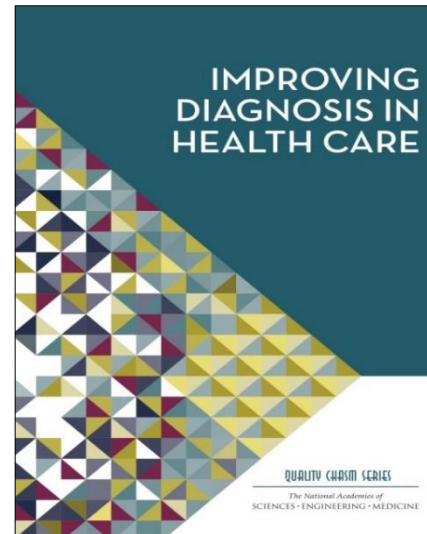
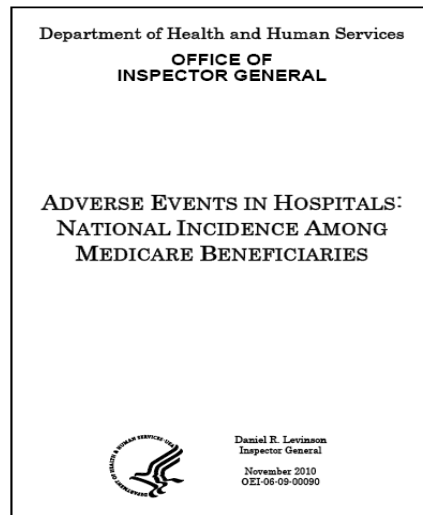
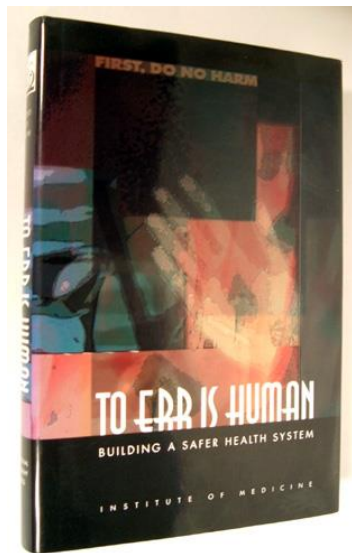


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# Safety 1999 - 2016



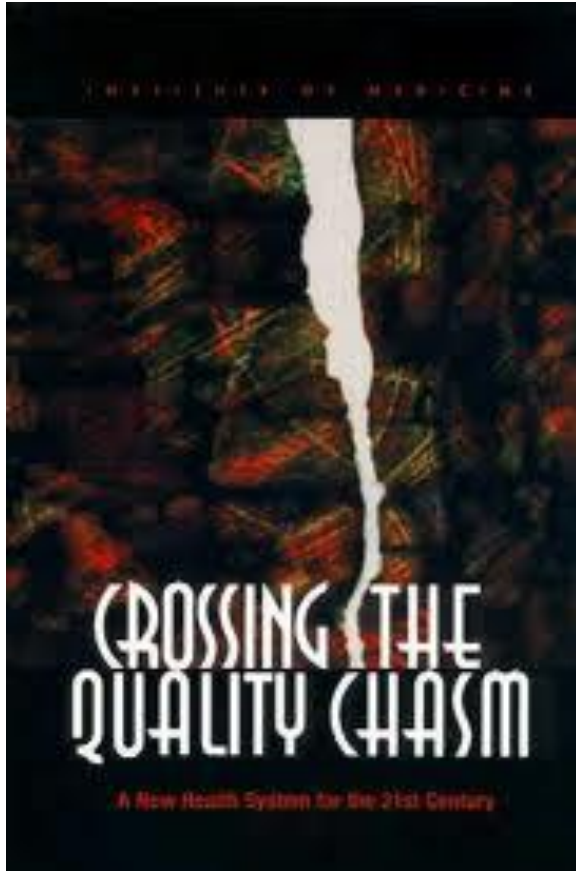
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# Crossing the quality chasm (IOM 2001)



HR4Safety

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# HR4Safety

## THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Chaired by Robert Francis QC

### Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary

OF



BMJ 2017;357:j2359 doi: 10.1136/bmj.j2359 (Published 2017 May 15)

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## NEWS

### Surgeon is struck off after three “never events”

Clare Dyer

The BMJ

A senior surgeon has been struck off the UK medical register for his role in three surgical “never events” in a two year period. “A never event is something that should never, ever happen,” Michael Zeigerman, an expert witness for the General Medical Council, told a medical practitioners’ tribunal in Manchester. “It’s so serious that [England’s health secretary] Jeremy Hunt himself has every single one of them written in his office—and we have three of them here.”

The three botched operations were the work of Lawal Haruna, 59, a specialty doctor in general surgery at Sheffield Teaching Hospitals NHS Trust. In September 2013, while doing an emergency laparoscopic appendicectomy, he failed to identify the appendix and removed a fat pad instead.

In March 2015, during an open appendicectomy, Haruna removed a patient’s ovary and fallopian tube instead of the appendix. Six months after that, he failed to review a woman with a cyst on her perineum to locate the lesion before she was anaesthetised. Although he realised that he did not know the location of the cyst, he “recklessly” went ahead with the surgery, the tribunal found, and removed a skin tag instead.

Haruna, who qualified in Nigeria and had held the Sheffield post since 2001, represented himself at the hearing. He admitted most of the factual charges against him at the outset, denying only two: that he had failed to call for help when he ran into trouble operating on the first patient, and that he had failed to adequately review the third case preoperatively.

In the first case, he argued that because he had believed himself to be excising the correct organ, he did not know that he was in trouble and therefore could not be expected to request help, an argument the tribunal accepted.

He was able to prove that he had seen the third patient preoperatively and had obtained consent, but his review was still found to be inadequate, because he had failed to locate the lesion due for removal.

Haruna also told the tribunal that he had experienced vision problems at times during the operations. But Zeigerman countered, “If you feel you are not capable for any reason then you should not perform the procedure.”

Claire Sharp, chairing the tribunal, said that even “never events” were not automatically grounds for erasure given sufficient insight and remediation. But Haruna had not shown enough of either, she added.

His only evidence of an attempt to improve his clinical knowledge was a certificate of completion of a BMJ module on appendicitis equivalent to one hour of continuing professional development, she noted.

“Whilst you have apologised to the patients in question, the tribunal considered that you showed a lack of empathy for them, as well as for the serious consequences of your failings. Patient A was in pain for a month after your operation and had to undergo a further operation to remove his appendix.”

“Had Patient B been of child bearing age,” continued Sharp, “your removal of a fallopian tube and ovary could have been incredibly serious and potentially life changing for her, but you showed no recognition of these potential consequences.”

Noting that he had referred to these mistakes as “trifling errors” in evidence, Sharp told Haruna that his insight was “superficial at best” and that “a continuing risk to patients” could be removed only by erasing him from the register.

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# Programma

- Menselijk falen en systeemaanpak: modellen en inzichten  
(Prof. Dr. Walter Sermeus)
- Recent beleidsrelevant onderzoek m.b.t. HR4Safety  
(dr. Luk Bruyneel)