Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 8369

Please reply to:
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31 July 2023

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Metallic implants in MRI scans - 2022/23.

You asked: All questions are shown as received by the Trust.
Please tell me with respect to the financial year 2022/23:
1) How many incidents were reported by your Trust on the Datix incident reporting system under the category 'MRI safety'?
2) How many of these MRI safety Datix incident reports were listed under the division, 'MRI Non Declared Internal Passive Metallic Implant'?
3) How many of these MRI safety Datix incident reports were under the division 'MRI Non Declared Internal Active Metallic Implant'?

For all of the incidents captured under 2 and 3 above in 2022/23, can you please provide a verbatim copy of the description of the adverse event? Please do a search based on relevant words and then review to ensure they meet the criteria outlined above of non-declared passive and active metal implant incidents in MRI scans.

Another alternative, if your Trust lacks the Datix system, could be to search for safety incidents logged under the location 'MRI'.

Trust response:
The Trust reporting system does not have any of the categories mentioned in the request. We have searched our reporting system for incidents logged under the location of MRI.

May 2022. Lifting or moving a patient or other person. Patient went down to MRI mobile scanner. They were taken in a wheelchair as they can transfer but were unaware that once in the scanner they would need to

mobilise and walk to the bed. Patient is immobile and this was very difficult for them to do. Patient later complained of pain in their shoulders and said it was due to being pulled around.
July 2022. Equipment - lack/unavailability of device Imaging Magnetic Resonance Imaging (MRI). MRI brain performed on ventilated patient without monitoring during MRI
July 2022. Transfer - delay/failure. Patient had MRI C-Spine and L-Spine. Job released at 11:27. Only to be dispatched at 12:52 and in progress at 12:55. Patient in a lot of pain
July 2022. Diagnostic images or laboratory tests not available when required. Patient could not have MRI scan on appointed time due to Porters delay. Job released @ 09:29. 10:20 on assist and cancelled by MRI at 10:40 due to Outpatients List.
July 2022. Slip - or trip on level ground. Slipped on newly cleaned floor by Nuclear Medicine TW reception desk. The floor was being cleaned.
August 2022. Unsafe environment - personal safety. This causes issues as machine detector temperatures are not regulated causing failure in switching on in the AM or during patient studies.
September 2022 Patient incorrectly identified. Another Patient was here to be scanned for CT. Both very similar sounding names. CT Porters collected the wrong Patient waiting for Scan and brought them to AMU. Causing Delay in bringing back correct patient to AMU
September 2022. Transfer - delay/failure. Patient released at 14.39 to come for MRI appointment for 3pm. Patient still not arrived and pending on PorterTrack system at 15.45. Patient scan cancelled as staff home time at 4pm.
October 2022. Security - verbal abuse (swearing or other discriminatory language). Patient came in for their scan appointment front reception front reception staff member explained they will need an X-ray orbit before having the MRI patient got angry and started to shout saying they had had the scan done in Maidstone team check the system and we could not see anything for Maidstone and explained that to the patient. Patient got paperwork out and it said another hospital name. Patient was still not happy and shouted why teams do not communicate. I then heard the altercation and approached my team asking what issues was. I then explained to the patient the MRI will not go ahead without the X-ray
November 2022. Collision with an object. During a patient transfer the door closed faster than expected and hit the porter on elbow cutting his elbow.
December 2022. Equipment - failure of a device or equipment. Room breakdown of Fl2 Rm27 X-Ray dept Tunbridge Wells Hospital. PC error of machine
January 2023. Treatment/procedure - inappropriate/wrong. Patient went down to MRI with chest drain insitu- drain NOT clamped.
March 2023. Delay or failure to monitor. The patient arrived in MRI in a wheelchair.