Craniotomy in wrong location
16HDC01498, 28 June 2019

Neurosurgeon ~ District health board ~ Craniotomy ~ Wrong site ~ Follow-up consultation ~ Right 4(1)

A man underwent neurosurgery for the removal of a metastatic carcinoma.

The neurosurgeon determined the positioning of the surgery using a stereotactic guidance machine (stereotaxy), and he and the registrar marked on the skin where the incision would be. Once the initial incision was made, however, it became apparent that the stereotaxy was inaccurate. The neurosurgeon extended the bone opening into what he thought was the correct area. However, it became apparent that the opening had been made in the wrong place of the skull. The operation was then discontinued.

Further attempts to remove the tumour were considered to be too risky.

Findings

Once the neurosurgeon realised that the craniotomy was in the wrong location, he should have undertaken further checks prior to deciding to proceed. It was held that the neurosurgeon did not provide services with reasonable care and skill and, accordingly, breached Right 4(1). The neurosurgeon was criticised for omitting to arrange a follow-up consultation after the surgery.

It was considered that the district health board did not breach the Code.

Recommendations

It was recommended that the district health board shared services group use this report as part of a case study to educate the neurosurgery community on the risk of incorrect craniotomy placement, and to assess further ways to prevent such an event occurring again.

It was also recommended that the neurosurgeon provide a written apology.