**Surgery on wrong end of bowel**
**16HDC01466, 14 February 2019**

*General surgeon ~ District health board ~ Bowel motility ~ Laparoscopic end colostomy ~ Stoma revision ~Right 4(1)*

Following a long history of bowel motility issues, a woman underwent a laparoscopic end colostomy. Before completing the surgery, the surgeon conducted a visual check to ensure that the correct end of the bowel had been opened.

There was no stoma output in the first five days following the operation, and the woman complained of increasing pain. Two enemas were administered via the stoma, without notable effect. A further enema was administered the following day.

The general surgeon went on annual leave for four days, during which time another surgeon was responsible for the woman's care. There continued to be no stoma output over this period. A Gastrografin X-ray showed was indicative of a bowel obstruction. An attempt to pass a Foley catheter down the stoma for decompression was abandoned when resistance was felt 10cm in. Further Gastrografin was injected, and it was evident that the contrast was not passing into the proximal small bowel. This led to the conclusion that there was a technical or mechanical problem.

The woman was returned to theatre for a stoma revision. It was discovered at this point that the colon was not able to empty, as the wrong end of the bowel had been used to form the stoma.

**Findings**
It was held that the general surgeon failed to identify in her visual check that she had used the wrong end of the bowel to form the stoma. The incorrect formation of the stoma was a significant departure from the normal accepted standard of practice. Accordingly, it was found that the general surgeon breached Right 4(1).

It was also held that staff did not respond adequately to the woman's non-resolving clinical symptoms postoperatively. The wrong end stoma formation and poor postoperative care were service failures that significantly departed from the standard of care expected of a surgical service. Accordingly, it was found that the district health board breached Right 4(1).

Adverse comment was made about the district health board's failure to conduct a morbidity and mortality process or a sentinel event review of the woman's care.