

# Sentinel Event Report

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**Event Name:** Sentinel Event Analysis – Unexpected Patient Death

**Date of Event:** September 30, 2025

**Date of Report:** October 10, 2025

**Location:** City Hospital, Department of Surgery

## Executive Summary:

This report details the investigation into the unexpected death of a patient, Mr. John Doe, following a routine surgical procedure on September 30, 2025, at City Hospital. The aim is to provide a comprehensive analysis of the event, identify contributing factors, and outline corrective actions to prevent recurrence.

## Background of the Event:

Mr. John Doe, a 57-year-old male, underwent a scheduled laparoscopic cholecystectomy. The procedure was initially reported as uneventful. However, post-operation, the patient developed complications that were not promptly identified or treated, leading to cardiac arrest and subsequent death.

## Methodology of the Investigation:

The investigation included interviews with staff, review of medical records, examination of the surgical equipment and environment, and consultations with external experts.

## Findings:

- **Immediate Cause:** Acute hemorrhage due to a missed surgical laceration of a small artery.

- **Systemic Issues:** Delay in response time from the surgical team, inadequate post-operative monitoring, and failure of communication between the surgical and nursing teams.
- **Environmental Factors:** High caseload at the time, contributing to rushed procedures and oversight.

#### **Action Plan and Recommendations:**

- **Training:** Enhanced training on post-operative care for surgical teams.
- **Policies:** Revision of communication protocols between surgery and nursing departments.
- **Monitoring:** Implementation of more rigorous post-operative monitoring protocols.
- **Review:** Regular equipment checks and maintenance schedules.

#### **Timeline for Implementation:**

Detailed timeline starting from November 2025 to implement training programs, policy revisions, and equipment reviews, with follow-up assessments every three months.

#### **Accountability Measures:**

Assigning responsibilities to department heads to ensure the completion of training and policy updates. Establishing a compliance committee to oversee the implementation of recommendations and report progress.

#### **Conclusion:**

This sentinel event highlighted significant flaws in procedural and communication protocols at City Hospital. The recommendations provided aim to rectify these shortcomings and improve patient safety significantly. The hospital is committed to

transparency and accountability in addressing this event and preventing future incidents.

**Appendices:**

- Appendix A: Detailed timeline and responsibilities for implementation of recommendations.
- Appendix B: External expert analysis and second opinions
- Appendix C: Summary of staff interviews and personnel actions.