Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4134
Kathleen.Smitheram@cdhb.health.nz;

14 October 2021

[redacted]

[redacted]

Dear [redacted]

RE Official Information Act request CDHB 10694

I refer to your email dated 25 August 2021 requesting the following information under the Official Information Act from Canterbury DHB **in relation to a vaccine error incident that occurred in Wigram on 14 July 2021.** Specifically:

1. **All communications between you or your staff and the Ministry of Health regarding the incident. I would expect this to include all reports, briefings or aide memoire as well as emails, text messages, WhatsApp messages etc.**
2. **All communications between you or your staff and any Minister and or their offices regarding the incident. This should include the Prime Minister and her office.**

I am particularly interested in any information which discusses alerting those people vaccinated that there has been a vaccine error and steps taken to identify those affected (should individuals have been affected). I do not wish to receive any information which identifies any individual recipient of the vaccine.

Please refer to **Appendix 1** (attached) for communication between staff and the Ministry of Health regarding the incident that occurred in the Wigram Vaccination Centre on 14 July 2021. This includes discussions regarding alerting the affected people who received an injection of saline solution as opposed to the Covid-19 vaccination.

Note: We have removed 'double up' email trails and anything we consider to be 'out of scope' of your request. We have also redacted information pursuant to the following sections of the Official Information Act:

- Section 9(2)(a) *i.e. "….to protect the privacy of individuals involved in the incident at Wigram on 14 July 2021"*
- Section 9(2)(g)(i) *i.e. "….to maintain the effective conduct of public affairs through the free and frank expression of opinions".*

3. **A copy of all communications between you or your staff and any member of the media regarding the incident up to and including today's date (25 August 2021).**

All media requests were referred to the Ministry of Health to respond to, however there is information included in **Appendix 1** between our Communications Team and the Ministry of Health referring to content of media statements.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Tracey Maisey
Executive Director
Planning, Funding & Decision Support

Kathleen Smitheram

From: 9(2)(a) @ccn.health.nz>
Sent: Thursday, 15 July 2021 5:00 PM
To: Peter Bramley; 9(2)(a), MoH
Cc: ECC Controller (CDHB)
Subject: Fw: URGENT - Significant vaccination error at 9(2)(a) Wigram
Attachments: Covid error .docx

Importance: High

Kia ora Peter and 9(2)(a)

As discussed with you both below and attached is information on the vaccination error at 9(2)(a) Wigram yesterday that I was alerted to this afternoon. Advice is being sought from IMAC on next steps and I will keep you updated once this advice is received and a plan is developed.

John has requested that the PM's office is notified. 9(2)(a) - is this something you are able to progress?

Ngā mihi

9(2)(a)
Canterbury Covid-19 Vaccination Programme Lead
Phone: 9(2)(a)
Email 9(2)(a)

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 3:53 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Subject: FW: URGENT - Significant vaccination error at 9(2)(a) Wigram
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Acting Controller
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From: 9(2)(a) @pegasus.org.nz>
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[redacted]
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COVID-19 Vaccination Operations Lead
M: 9(2)(a)
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Importance: High

Primary Care Covid-19 Vaccination team
Pegasus House
Madras Street, Christchurch

Cellphone 9(2)(a)

From: 9(2)(a) 9(2)(a)
Sent: Thursday, 15 July 2021 2:02 pm
To: 9(2)(a) t@pegasus.org.nz>
Cc: 9(2)(a)
Subject: Covid Vaccination error

Kia Ora 9(2)(a)

Please find the attached document re Yesterday's Covid vaccine incident.
Please feel free to email back for any queries.

Kind regards,
9(2)(a)

Kathleen Smitheram

From: 9(2)(a) on behalf of ECC Controller (CDHB)
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From: 9(2)(a) on behalf of ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
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E: 9(2)(a)

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Kia Ora 9(2)(a)

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Kind regards,

9(2)(a)

Hi 9(2)(a)

Good afternoon,

Further to our phone conversation this afternoon re the vaccination error. This is a written confirmation of events that happened yesterday as per your request.

Myself 9(2)(a) and second RN- 9(2)(a) were involved in drawing vaccines. We understood we had drawn 10 vials of Covid vaccines yesterday (14/07/21), however at the end of the clinic we were left with few more extras than we expected with one extra tray of 7 vaccines without a vial. Each vials are kept with lots of vaccines drawn out from that vial.

We anticipate the problem being a Covid vaccine vial was reconstituted twice by error, which means we have potentially administered 7 doses of vaccine- that were not actual vaccine but the diluent- Normal Saline, and we are unsure which lot of vaccines these were out of the 7 vials.

We are very confident that the first three lots of vaccines (X3 vials) were reconstituted properly. We administered a total of 76 doses of vaccine yesterday. Out of those 76, 21 doses belong to the first three vials that were reconstituted correctly, so we can confidently say those 21 patients were not affected by this issue and were administered the correct vaccine dose.

We were requiring some guidance on what we need to do going forward.

Kind regards,

9(2)(a)

9(2)(a), Wigram

Kathleen Smitheram

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:06 PM
To: ECC Controller (CDHB); John Hewitt; Carol McSweeney; Ramon Pink; ECC Public Information (CDHB)
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

Just off phone to Anja Werno. She agrees with suggestion to do antibody testing at time of second [or first for some] dose in 3-4 weeks. If antibodies present we can safely assume vaccine has been given. If no antibodies then reasonable to assume no vaccine given and so proceed to give 2 more. Importantly no clinical urgency – essential to be as clear as possible about what happened. Once we know which way to proceed I can talk to microbiology some more.

Alan

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Sent: Thursday, 15 July 2021 4:12 PM
To: ECC Controller (CDHB); John Hewitt; Carol McSweeney; Ramon Pink; Alan Pithie; ECC Public Information (CDHB)
Cc: 9(2)(a) [redacted]; Karalyn van Deursen; Alex Taylor (Communications)
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) [redacted] Wigram

Hi all, here's what we're thinking comms-wise

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I'll write a call script for the clinic to use, also a pre-record for their voicemail – should I also prepare a follow-up letter?

Alex will write a media statement to send out tomorrow afternoon - We need to name the clinic – it will come out anyway so we need to front foot it.

We need to ensure the clinic knows to refer all media queries to the DHB – there will be some! Is 9(2)(a) [redacted] the best person to have this conversation with them?

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

Be a **DOER!**
KARAWHIUA
The stronger our immunity, the stronger our community

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Double Up

[redacted]

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Isn't there some uncertainty around what has happened, and whether people didn't get vaccinated? Is it not best to investigate a bit more first before sending out comms as circumstance still so murky?.
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To: ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>
Cc: 9(2)(a) [redacted]
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) [redacted] Wigram

Isn't there some uncertainty around what has happened, and whether people didn't get vaccinated? Is it not best to investigate a bit more first before sending out comms as circumstance still so murky?.
Alan

From: Haidee Scott **On Behalf Of** ECC Public Information (CDHB)
Sent: Thursday, 15 July 2021 4:12 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Cc: 9(2)(a) [redacted]
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) [redacted] Wigram

Hi all, here's what we're thinking comms-wise

Ideally the clinic will call everyone who attended the clinic yesterday, not just the 55 – this is because when it hits the media people will know they were at the clinic and will want to know if they're affected.

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Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

Be a **DOER!**
KARAWHIUA
The stronger our immunity, the stronger our community

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 3:53 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Subject: FW: URGENT - Significant vaccination error at 9(2)(a) Wigram
Importance: High

FYI - 9(2)(a) is exploring next steps with IMAC and MoH. All in hand at this point, but would be useful for comms to be ready with a letter to those affected.

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4. The site will have to report this on CIR.
5. I am discussing options with Labs re antibody testing.

Will fill in interested parties as more info comes in.

9(2)(a)
Acting Controller
9(2)(a)

From: 9(2)(a) @pegasus.org.nz>
Sent: Thursday, 15 July 2021 2:45 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; 9(2)(a) @ccn.health.nz>; 9(2)(a) @pegasus.org.nz>
Cc: 9(2)(a)

Subject: URGENT - Significant vaccination error at 9(2)(a) Wigram
Importance: High

Kia ora All,

I just spoke to 9(2) to give a heads up on a significant issue which occurred at the 9(2)(a) Wigram vaccination clinic yesterday. This was alerted to 9(2)(a) by phone this afternoon, 9(2)(a) requested the information in writing which is attached. The key information is that up to 55 individuals have been vaccinated with saline or an incorrect dose of vaccine.

9(2)(a) Clinical Lead for Primary Care is on leave this week, 9(2)(a) has been in contact with IMAC to determine next steps. 9(i will contact the ECC to advise the next steps as directed by IMAC.

Ngā mihi,
9(2)(a)

9(2)(a)
Canterbury Primary Care
COVID-19 Vaccination Operations Lead
M: 9(2)(a)
E: 9(2)(a) s@pegasus.health.nz

Canterbury
District Health Board
Te Poari Hauora o Waitaha

From: 9(2)(a) @pegasus.org.nz>
Sent: Thursday, 15 July 2021 2:06 PM
To: 9(2)(a) @pegasus.org.nz>; 9(2)(a) @pegasus.org.nz>; 9(2)(a) @pegasus.org.nz>
Subject: FW: Covid Vaccination error
Importance: High

Primary Care Covid-19 Vaccination team
Pegasus House
Madras Street, Christchurch

Cellphone 9(2)(a)

From: 9(2)(a)
Sent: Thursday, 15 July 2021 2:02 pm
To: 9(2)(a) @pegasus.org.nz>
Cc 9(2)(a)
Subject: Covid Vaccination error

Kia Ora 9(2)(a)

Please find the attached document re Yesterday's Covid vaccine incident.

Please feel free to email back for any queries.

Kind regards,

9(2)(a)

Kathleen Smitheram

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:23 PM
To: Alan Pithie; ECC Public Information (CDHB); ECC Controller (CDHB); John Hewitt; Ramon Pink
Cc: 9(2)(a))
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

I agree with Alan. Regarding media queries, its usually someone senior and medical fronting up. When there is any possibility of revaccination being required, the MOH is usually involved in the process and comms.

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a)
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs COVID-19 Vaccination Programme

Unite against COVID-19

AT

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:19 PM
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Cc: 9(2)(a) [redacted]
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Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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From: 9(2)(a) [redacted] **On Behalf Of** ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 3:53 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
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Cc: 9(2)(a)
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Kind regards,

9(2)(a)

Kathleen Smitheram

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:28 PM
To: ECC Controller (CDHB); John Hewitt; Carol McSweeney; Ramon Pink; ECC Public Information (CDHB)
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

10 vials, 7 doses per vial = 70 doses. They delivered 76 doses plus 7 unused = 83 doses [ie 13 more than expected from 10 vials]. If they had simply used 1 vial twice that would presumably equal 77 doses. Seems very unclear to me what has happened.

Is my arithmetic wrong?

Carol, could you expect consistently 7 doses/vial.

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 3:53 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Subject: FW: URGENT - Significant vaccination error at 9(2)(a) Wigram
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9(2)(a)
Acting Controller
9(2)(a)

Double Up

[redacted]

Kathleen Smitheram

From: 9(2)(a) on behalf of ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:39 PM
To: Alan Pithie; ECC Controller (CDHB); John Hewitt; Carol McSweeney; Ramon Pink; ECC Public Information (CDHB); 9(2)(a)
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

Fantastic, thanks for handling that. We await more info from 9(and the primary care team.

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:06 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

Just off phone to Anja Werno. She agrees with suggestion to do antibody testing at time of second [or first for some] dose in 3-4 weeks. If antibodies present we can safely assume vaccine has been given. If no antibodies then reasonable to assume no vaccine given and so proceed to give 2 more. Importantly no clinical urgency – essential to be as clear as possible about what happened. Once we know which way to proceed I can talk to microbiology some more.

Alan

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 3:53 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>
Subject: FW: URGENT - Significant vaccination error at 9(2)(a) Wigram
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9(2)(a)
Acting Controller
9(2)(a)

Double Up

Double Up

Kathleen Smitheram

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:43 PM
To: ECC Controller (CDHB); John Hewitt; Carol McSweeney; Ramon Pink; ECC Public Information (CDHB); 9(2)(a)
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram
Attachments: rapidity of vaccine responses.pdf

Some data on antibody responses attached. If we end up having to check antibody results 96.4% of people have detectable antibodies at 28-34 days after first dose [and 89% after 14-20 days. So testing at 4 weeks would be very reliable.

Alan

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Sent: Thursday, 15 July 2021 4:39 PM
To: Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>; 9(2)(a) @ccn.health.nz>
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

Fantastic, thanks for handling that. We await more info from 9(and the primary care team.

Double Up

[redacted]

The BMJ

Cite this as: *BMJ* 2021;373:n1274
http://dx.doi.org/10.1136/bmj.n1274
Published: 18 May 2021

Covid-19: Most UK adults had antibodies after one dose of AstraZeneca or Pfizer vaccine, data suggest

Gareth Iacobucci

More than nine in 10 UK adults have antibodies to SARS-CoV-2 following one dose of the Oxford AstraZeneca or Pfizer BioNTech vaccine, while almost everyone does after a second dose, preliminary data suggest.[1]

A study of 8517 adults in England and Wales by University College London's Virus Watch project found that 96.42% (95% confidence interval 96 to 96.79) of people who had either vaccine had developed antibodies 28 to 34 days after their first dose, rising to 99.08% (95% CI 97.8 to 99.62) within seven to 14 days of the second dose.

Seropositivity rates and spike antibody levels rose more quickly following the first dose of the Pfizer vaccine (89.27% (95% CI 83.52 to 93.25) than for AstraZeneca (66.27% (95% CI 2.56 to 69.80) at 14 to 20 days, but were equivalent for both vaccines by 4 weeks (96.17% (95% CI 94.22 to 97.50) *v* 95.21% (95% CI 93.75 to 96.35)).

"Our data indicate very high rates of seroconversion to spike following a single dose of either vaccine, with near complete seroconversion following a second dose, in people with no evidence of prior infection," said the UCL research team led by Maddie Shrotri.

The study, published as a preprint and currently undergoing peer review, examined 13 232 antibody samples taken from the 8517 study participants (8115 following AstraZeneca and 5008 following Pfizer) with an average age of 65 (interquartile range 58 to 71).

Participants provided blood samples and self-reported vaccination status. None had antibodies before receiving a first dose.

After a single dose, there was evidence to suggest a significant difference in antibody levels by age group at ≥28 days (P=0.0001), with levels lower in older people (18 to 34y, median 63.4 U/ml (IQR 34.2 to 99.34) *v* ≥80y, 26.13 (8.34 to 80.4) (P=0.0001)).

In 65 to 79 year olds who had had only one dose, lower antibody levels were observed in men (25.9 *v* 42.3 U/ml, P<0.0001), people with a chronic condition (33.0 *v* 41.2 U/ml, P<0.0001), diabetes (22.32 *v* 36.01 U/ml, P<0.0001), cardiovascular disease (32.1 *v* 36.7 U/ml, P=0.0002), or those history of cancer (30.1 *v* 35.7 U/ml, P=0.0001), particularly those with haematological rather than solid organ cancer (7.48 *v* 31.68 U/ml, P<0.0001), and those currently on immunosuppressive therapy (21.7 *v* 35.6 U/ml, P<0.0001).

But disparities did not persist after a second dose, with high antibody titres (≥250U/ml) observed for nearly all people across all ages, demographics, and clinical groups.

The authors concluded, "High seroconversion rates after the first dose lend support to the UK policy to prioritise first dose coverage across the population, however our data also suggest attenuated immune responses in some clinical groups, which warrant further investigation."

The Virus Watch study is being funded by UK Research and Innovation and the Department of Health and Social Care through the National Institute for Health Research.

1 Shrotri M, Fragaszy E, Geismar C, et al. Spike-antibody responses following first and second doses of ChAdOx1 and BNT162b2 vaccines by age, gender, and clinical factors - a prospective community cohort study (Virus Watch). *Medxiv* 2021.05.12.21257102v2 [Preprint], 2021www.medxiv.org/content/10.1101/2021.05.12.21257102v2.

Kathleen Smitheram

From: 9(2)(a) on behalf of ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 4:44 PM
To: Alan Pithie
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

That's great, thanks.

From: Alan Pithie <Alan.Pithie@cdhb.health.nz>
Sent: Thursday, 15 July 2021 4:43 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>; 9(2)(a) @ccn.health.nz>
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Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

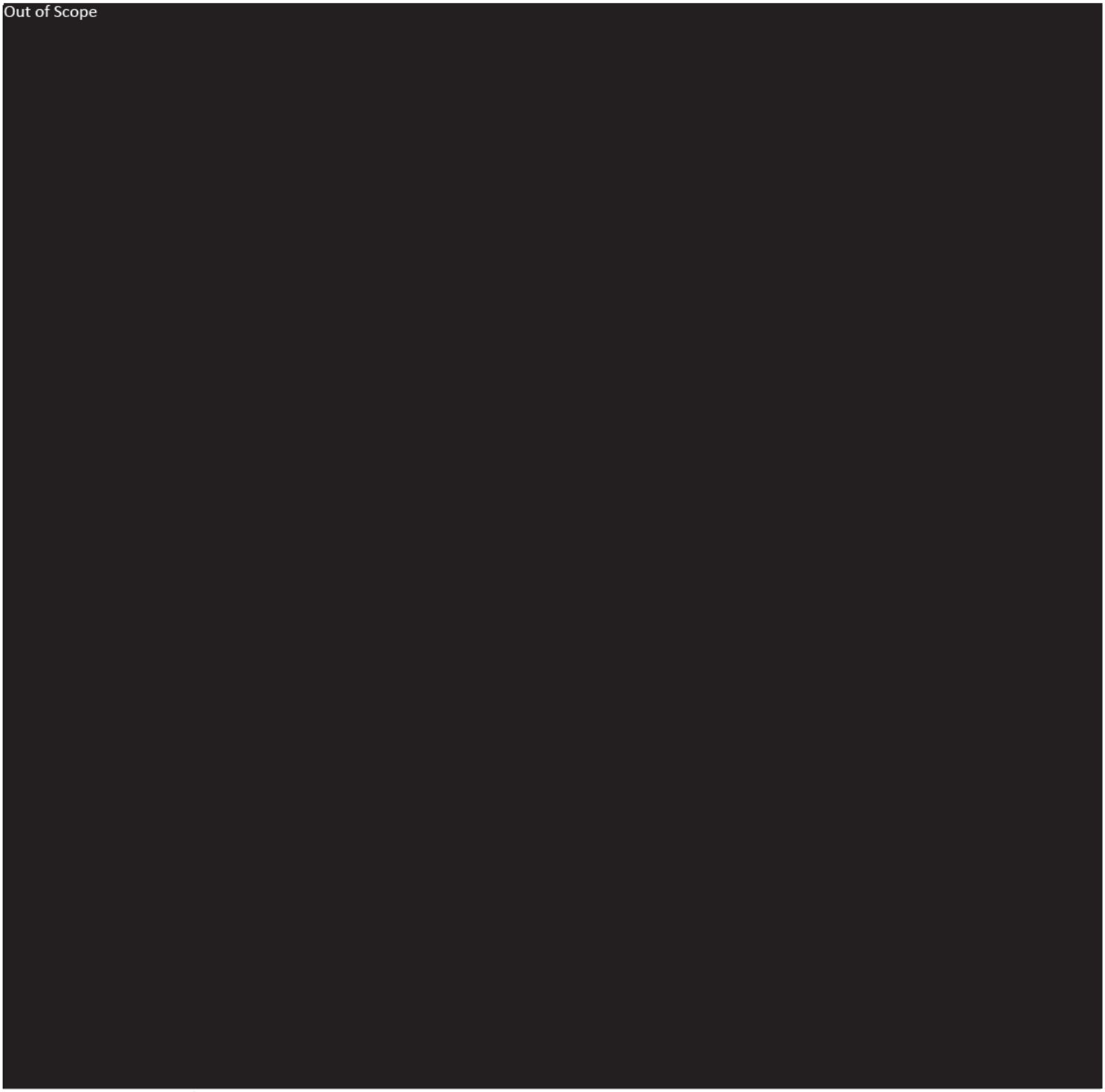
Fantastic, thanks for handling that. We await more info from [redacted] and the primary care team.

Double Up

[redacted]

Double Up

[redacted]


Out of Scope

Kathleen Smitheram

From: 9(2)(a) on behalf of ECC Controller (CDHB)
Sent: Thursday, 15 July 2021 4:49 PM
To: Cheryl Brunton
Subject: FW: URGENT - Significant vaccination error at 9(2)(a) Wigram
Attachments: Covid error .docx

In lieu of Ramon who is on leave for another week, I wanted to make sure you are aware of what's occurred. We are currently awaiting more information from 9(2)(a) Pegasus, who is contacting IMAC.

9(2)(a)
Acting Controller

From: Haidee Scott <Haidee.Scott@cdhb.health.nz> **On Behalf Of** ECC Public Information (CDHB)
Sent: Thursday, 15 July 2021 4:22 PM
To: Alan Pithie <Alan.Pithie@cdhb.health.nz>; ECC Public Information (CDHB) <ECCPubInfCDHB@cdhb.health.nz>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; Ramon Pink <Ramon.Pink@cdhb.health.nz>
Cc: 9(2)(a) @ccn.health.nz>; Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>; Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Subject: RE: URGENT - Significant vaccination error at 9(2)(a) Wigram

We won't send a statement until after all people have been spoken to.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

Be a DOER!
KARAWHIUA
The stronger our immunity, the stronger our community

Double Up

[redacted]

Kathleen Smitheram

From: 9(2)(a)@health.govt.nz>
Sent: Friday, 16 July 2021 12:52 PM
To: ECC Controller (CDHB)
Cc: 9(2)(a)
Subject: FW:
Attachments: CVIP Incident Report Template V4.docx

Follow Up Flag: Follow up
Flag Status: Flagged

To whom it may concern
The attached form is a template for you to fill out with regards to the event at 9(2)(a) Wigram
Happy to discuss
9(2)

Ngā mihi,

9(2)(a)
Regional Liaison Lead South Island
COVID-19 Vaccine and Immunisation Programme, Ministry of Health
Mobile: 9(2)(a)

MINISTRY OF HEALTH
MANATŪ HAUORA

Provider with MoH Initial serious incident & adverse event notification form

Provider (sections A & B) and MoH (sections C onwards)

Section A: Provider Notification Details

Provider or DHB to complete:	
Time and Date of Incident:	
Time and Date Reported:	
Name of person reporting the incident:	
Your contact phone number:	
Your email address:	
Ministry to complete:	
Date and time received by Ministry:	
Person Receiving notification:	

Section B: Description

Type of Incident[1] or adverse event[2] or an AEFI[3] - it's possible two of the four options apply

Incident ☐ Serious adverse event ☐ AEFI ☐ Near miss ☐

Please provide a brief description of the Incident/Adverse Event/Near miss.

[1] An incident means any unplanned event resulting in, or having a potential for injury, ill health, damage or other loss, an incident includes an accident.

[2] An adverse event is an incident resulting in harm, or with the potential to result in harm to a health consumer. Please assign an adverse event SAC rating. Refer to Appendix One. Report a SAC 1,2 or 3 SAC event, a cluster of SAC 3/ 4 events +/- near misses.

[3] Adverse event following immunisation (AEFI) - an untoward medical event which follows immunisation and does not necessarily have a causal relationship with the administration of the vaccine. The adverse event may be an unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.

- If an adverse event following immunisation, has this been reported to CARM? Yes ☐ ☐ No
- Has a preliminary investigation been undertaken? Yes ☐ ☐ No
- Has a preliminary SAC rating for an adverse event been assigned? Yes ☐ ☐ No
- Preliminary SAC rating: ☐

Provider: When the concern is an adverse event or an AEFI, please arrange for open communication with affected person/s.

Section C: Initial Assessment and actions by Ministry of Health investigation team

Actions taken by Ministry of Health investigation team

Action	Description	By whom	By when

Section D: Decision making

Based on the assessment by the Ministry of Health assessment team and information gathered outline the decisions made - add rows as required.

Date	Decision	By whom	Authorised by

Decision matrix

Type of incident	Assessment team	Decision maker
Clinical	[Clinical Lead CVIP(Lead)] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	
Operational	[GM Operations] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	
Logistics	[GM Logistics] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	

Section E: Notification Checklist

Role	Yes	Not required and why	Date/time
National Director			
Comms involved			
Minister's office			
DG of Health			
DHB/Org CEO			
DHB/Org SRO			
DHB/Org Clinical Lead			
DHB/Org Ops Lead			
GM Operations			

Section F: Other

Section G: Appendices

Appendix One: CVIP SAC

Appendix Two: Please use this section to attach material relevant to this incident report.

APPENDIX ONE

If an adverse event, either following immunisation or other cause, please arrange for open communication with the affected person/s.

COVID-19 Vaccine and Immunisation Programme Severity Assessment Code (SAC) examples

This list is for guidance only. All events should be rated on actual outcome for the consumer. To see more detailed information on SAC rating, see the SAC Rating and Triage Tool for Adverse Event Reporting

SAC 1 Death or permanent severe loss of function	SAC 2 Permanent major or temporary severe loss of function
• Medication or dose error resulting in death or causing renal failure and need for permanent renal replacement therapy • Anaphylaxis resulting in death or permanent loss of function • Wrong site of vaccine resulting in removal of healthy limb or organ • Delayed referral, treatment resulting in treatment options limited to palliation (delay direct contributor) • Delayed recognition of patient deterioration resulting in permanent disability or death	• Fall resulting in fracture • Serious adverse reaction with delayed administration of adrenaline or delayed presence of emergency services • Delayed recognition of patient deterioration resulting in unplanned transfer to intensive care or to another hospital for higher acuity care, cardiopulmonary resuscitation and/or intubation • Medication or dose error resulting in major harm (eg, requiring dialysis, intervention to sustain life, anaphylaxis) • Consumer serious assault occurring within vaccination care setting when a known safety plan in place is not upheld (eg, protection order)
SAC 3 **Permanent moderate or temporary major loss of function**	**SAC 4** **Requiring increased level of care** **OR no injury, no increased level of care; includes near misses**
• Fall resulting in laceration requiring sutures • Failure of essential service with moderate consequence to consumer • Temporary nerve damage or pain from vaccine administration • Severe injection site infection • Vasovagal event following immunisation resulting in injury	• Additional monitoring, investigations or interventions due to the event • Medication, dilution or dose error resulting in no increased level of care • Breach of confidentiality • Near miss events, such as not identifying a person is underage prior to the event

Version 1: Adapted for the COVID-19 Vaccine Programme (CVIP) from Severity Assessment Code (SAC) examples 2019–20 | Health Quality & Safety Commission 2019

APPENDIX TWO

Please use this section to attach material relevant to this incident report.

REPORT ENDS.

Kathleen Smitheram

From: 9(2)(a) [redacted] on behalf of ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Sent: Friday, 16 July 2021 1:07 PM
To: 9(2)(a) [redacted]
Cc: John Hewitt; 9(2)(a) [redacted]
Subject: FW:
Attachments: CVIP Incident Report Template V4.docx

Kia ora 9([redacted] – are you able to complete the attached form for the event at Wigram this week? Let me know if I need to direct this to someone else.

Ngā mihi,
9(2)(a) [redacted]
ECC Controller (Acting)

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

ECC Controller | COVID-19 Vaccination Programme Roll-Out | Canterbury District Health Board | Tel: 9(2)(a) [redacted] |
320 Manchester St, Christchurch

From: 9(2)(a) [redacted] @health.govt.nz>
Sent: Friday, 16 July 2021 12:52 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Cc: 9(2)(a) [redacted] @health.govt.nz>
Subject: FW:

To whom it may concern
The attached form is a template for you to fill out with regards to the event at 9(2)(a) [redacted] Wigram
Happy to discuss
9(2)(a) [redacted]

Ngā mihi,

9(2)(a) [redacted]
Regional Liaison Lead South Island
COVID-19 Vaccine and Immunisation Programme, Ministry of Health
Mobile: 9(2)(a) [redacted]

MINISTRY OF HEALTH
MANATŪ HAUORA

Kathleen Smitheram

From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 16 July 2021 4:25 PM
To: ECC Controller (CDHB); 9(2)(a) ; Alan Pithie; John Hewitt; ECC Operations (CDHB); 9(2)(a) ; ECC Operations (CDHB); 9(2)(a)
Cc: 9(2)(a)
Subject: Update following Imms Coordinator/IMAC visit to 9(2)(a) Wigram today

Importance: High

Kia ora all,

For your information please see the notes from 9(2)(a) visit to 9(2)(a) Wigram this afternoon at 2pm to meet the team and look at the root cause of the incident.

As discussed with 9(2)(a) on the phone just now, no patients will be contacted until the plan for next steps is confirmed with IMAC. 9(2)(a) will raise at the ECC on Monday the next steps for the programme.

Ngā mihi,

9(2)(a)
Canterbury Primary Care
COVID-19 Vaccination Operations Lead
M: 9(2)(a)
Canterbury District Health Board
Te Poari Hauora ō Waitaha

From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 16 July 2021 3:51 PM
To: 9(2)(a) @pegasus.org.nz>
Cc: 9(2)(a) @pegasus.org.nz>
Subject: RE: Touching base post Wigram visit

Re Wigram:
No one has been informed outside of the practice what has occurred there.
They are in the middle of an incident report being done and will forward a copy to us once complete.
They have changed a couple of their processes already to mitigate risk of this occurring again.
They will not contact patients until advised.
They are not entirely sure what happened but at the end of the clinic day on Wednesday it was identified that 11 slips of paper pertaining to drawing up vials was present but only 10 used vials.
It was identified then that something had occurred. The nurse who gave the last lot of vaccine for the day 9(2)(a) identified it and said 9(2) would teams message the clinic lead. The nurses we spoke to 9(2)(a) and 9(2)(a) – the initial drawing up nurses) were not sure if that happened that night or not.
The next day 9(2)(a) the clinic lead was not in the practice until late morning and met with 9(2)(a) . It was then that 9(2)(a) was asked to email 9 i re the situation. 9(2)(a) emailed at 12ish that day.
Every person vaccinated that day needs to be followed up because they have no idea when the faulty injections were given.

Give me a call if you need further info.

Noho ora mai (stay well),

9(2)(a)

Pegasus Health (Charitable) Ltd
9(2)(a)

From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 16 July 2021 3:34 pm
To: 9(2)(a) @pegasus.org.nz>; 9(2)(a) @auckland.ac.nz>
Subject: Touching base post Wigram visit

Kia ora 9(2)(a),

Can one of you please give me a call after you visit Wigram?

Ngā mihi,
9(2)(a)

9(2)(a)

Canterbury Primary Care
COVID-19 Vaccination Operations Lead
9(2)(a)

Kathleen Smitheram

From: 9(2)(a)@pegasus.org.nz>
Sent: Friday, 16 July 2021 8:42 AM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: RE: Visit to Wigram to address vaccination error

absolutely

Noho ora mai (stay well),

9(2)(a)
9(2)(a) | 9(2)(a)
Pegasus Health (Charitable) Ltd
9(2)(a)

From: 9(2)(a)@pegasus.org.nz>
Sent: Thursday, 15 July 2021 6:34 pm
To: 9(2)(a)@auckland.ac.nz>; 9(2)(a)@pegasus.org.nz>
Cc: 9(2)(a)@pegasus.org.nz>
Subject: Visit to Wigram to address vaccination error

Kia ora 9(2)(a)

Thank you for your response to the management following the error in the Wigram Vaccination Clinic.

I'm aware you will be visiting Wigram tomorrow to understand the details of how this error happened and identify the next steps including recommendations for support.

Please can make include in the discussion when/how the team realised there was a mistake made and the time between identifying the issue and notifying the Primary Care Ops Team?

The ECC would like to be kept well informed on this information so please can you link me and 9(into the outcome and steps that come from this so we can share with the parties who need to know.

Ngā mihi,

9(2)(a)

9(2)(a)
Operations Lead, Primary COVAX Team
9(2)(a)

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Kathleen Smitheram

From: 9(2)(a)
Sent: Tuesday, 17 August 2021 2:46 PM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: RE: Follow up request
Attachments: COVID vaccine Incident Slide for NCQSF.pptx

Kia ora 9(2)(a)

Please let me know if this is ok?

9(2)(a)

From: 9(2)(a)@health.govt.nz>
Sent: Friday, 13 August 2021 1:18 pm
To: 9(2)(a)@pegasus.org.nz>
Cc: 9(2)(a)@health.govt.nz>
Subject: Follow up request

Hi 9(2)(a)
May we ask for the a one slide summary of the Wigram experience to share with the Forum members
I thought we could do it but I realised we would be too clumsy in reflecting the considerable background work/ learning etc so I'm circling back to you...
If asking its time frame as COB Friday 20 August

Kind regards and many thx 9(2)(a)
9(2)(a) | *Noho ora mai* | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 9(2)(a)

Primary Care Vaccine Incident July 2021

What:

During the draw up process 1 vaccine vial was reconstituted twice. Resulting in 6 people being administer

RCA:

Nurse 1 and 2 working in draw up area. 10 trays of syringes prepared; 10 vials removed from fridge. Nurses allocated 5 vials each.

Covid vaccine records completed for each vial and placed into dish with each set of drawn up vaccines, along with vial.

During the drawing up, Nurse 3 took 3 trays of vaccines to begin vaccinating. After the 10 trays were filled the nurses noted that they had one vial of vaccine left and prepared another (11th) tray. Second checks undertaken following completion of drawing up.

At the end of the day, it was noted that there were more doses given than bookings.

ed diluent only.

How:

By mistake, Nurse 2 had not place a previously drawn up vial into kidney dish with syringes. The vial was left on the bench. Nurse 2 subsequently reconstituted this vial which produced 6 doses where all other vials that day 7 were obtained.

The tray containing 6 syringes was taken by Nurse 3 who did not notice lack of vial until completing vaccinations with these doses (noted on vaccine record).

What we did:

Based on the Covid vaccine records we were able to determine the exact time of dilution and time last of the 6 doses was administered. Six people were identified from the CIR records. They consisted of four people receiving dose 1 and two people receiving dose 2.

We were advised to revaccinate all 6 people as soon as possible. A GP from the clinic contacted all people by phone with an apology and explanation. All people were invited to make another appointment and have since been revaccinated.

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Monday, 19 July 2021 4:30 PM
To: 9(2)(a)
Subject: FW: Wigram 9(2)(a) - vaccination issue

Fyi – as discussed on Friday, this one's ongoing.
And things are sounding a bit vague (as per below)

From: Haidee Scott
Sent: Monday, 19 July 2021 4:17 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: Wigram 9(2)(a) - bullet points

Wednesday 14 July at 9(2)(a) Wigram:

- 76 doses administered during the course of the vaccination clinic
- At the end of the clinic one tray was found without a vial. Each vial is meant to be kept with the vaccines drawn out from the vial.
- 10 vials of vaccine used and 11 paper slips present (7x10 doses and 1x 6 doses)
- Vaccinators believe they may have reconstituted a vaccine vial twice by error, meaning they may have potentially administered 7 doses that did not include the vaccine.
- The vaccine log showed only 10 vials had been removed.

Now what?

- We currently don't have enough information to determine what happened – a vaccinator error or an administrative error.
- We have to complete a RCA – root cause analysis - by 4pm tomorrow for IMAC and 9(2)(a)
- 9(2)(a) working on getting that done before then.
- Reconvening at 3pm tomorrow ☺

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
Mob: 9(2)(a)
Email: haidee.scott@cdhb.health.nz
www.vaccinateCanterburyWestCoast.nz

Be a DOER!
KARAWHIUA
The stronger our immunity, the stronger our community

Kathleen Smitheram

From: 9(2)(a) @pegasus.org.nz>
Sent: Monday, 19 July 2021 10:59 AM
To: 9(2)(a)
Subject: Re: CVIP Incident Report Template V4

No I haven't. Thanks 9(2)(a)

Ngā mihi,

9(2)(a)

9(2)(a)

Canterbury Primary Care

COVID-19 Vaccination Operations Lead

9(2)(a)

From: 9(2)(a) @pegasus.org.nz>
Sent: Monday, July 19, 2021 10:52:33 AM
To: 9(2)(a) @pegasus.org.nz>
Subject: CVIP Incident Report Template V4

Hi 9(2)(a)

Have you completed this form for Wigram? I will do it but don't want to start if you've already sone it.

9(2)(a)

Out of Scope

[redacted]

From: 9(2)(a)
Sent: Monday, 19 July 2021 12:48 PM
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>; 9(2)(a) @siapo.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) @pegasus.org.nz)
9(2)(a)
Cc: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Subject: 9(2)(a) Wigram 16 July vaccine concerns- initial report

Tahnk you all for your help with this

9(2)(a)
ECC Controller
9(2)(a)

From: 9(2)(a) @auckland.ac.nz>
Sent: Monday, 19 July 2021 9:38 AM
To: 9(2)(a)
Subject: RE: Test email[EXTERNAL SENDER]

There you go this is our initial report.

9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

9(2)(a)
Immunisation Advisory Centre
The University of Auckland
Immunisation on time every time

Cell: 9(2)(a)
Email: 9(2)(a)
0800 IMMUNE/466863
www.immune.org.nz:
www.influenza.org.nz

From: 9(2)(a) >
Sent: Monday, 19 July 2021 9:36 AM

To: 9(2)(a) @auckland.ac.nz>
Subject: RE: Test email[EXTERNAL SENDER]

yes

From: 9(2)(a) @auckland.ac.nz>
Sent: Monday, 19 July 2021 9:35 AM
To: 9(2)(a)
Subject: Test email[EXTERNAL SENDER]

Hi 9(2) just wanting to check email correct before sending the report

9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wananga o Tamaki Makaurau

9(2)(a)
Immunisation Advisory Centre
The University of Auckland
Immunisation on time every time

Cell: 9(2)(a)
Email: 9(2)(a)
0800 IMMUNE/466863
www.immune.org.nz:
www.influenza.org.nz

9(2)(a) **Wigram meeting** 16 July 1400
9(2)(a), IMAC COVID Immunisation Advisor; 9(2)(a), Pegasus Health Immunisation Coordinator; 9(2)(a); 9(2)(a).

Background:
10 vials of vaccine used and 11 paper slips present, suggesting that 76 doses had been administered (7x10 doses and 1x 6 doses)
One of the 11 slips only had one signature check recorded, and not 2.
According to the staff the vaccine log showed only 10 vials had been removed.

Discussion:
70 syringes and needles were pre-pared and placed into 10 kidney dishes. 2 nurses were drawing up together, each with one box of 5 vials in the foam packing and 5 kidney dishes with syringes and needles. Each kidney dish held one diluent. 9(2)(a) said 9(2) diluted all 5 vials consecutively, using separate syringes, needles, and diluent for each vial.

9(2)(a) left towards the end of the afternoon and 9(2)(a) (not attending meeting) gave the final few doses. This was when the incident was recognised by 9(2)(a), as there were 11 slips of paper for 10 vials. 9(2)(a) said 9(2) would contact the lead 9(2)(a) that evening via text, the next morning the lead discussed with the staff involved and staff notified Pegasus Health 9(2)(a), at 12pm the following day.

Issue:
It appears that an empty vial has been diluted with saline. This raises the question as to where the vial was picked up from: the foam packing or somewhere else?

Observations:
From the discussion it appears that double checks were not being performed at key points and that standard advice was not being followed. E.g.,

- Preparing volumes of syringes in advance e.g., 70 in a kidney dish.
- Diluting multiple vials (5) at the same time instead of diluting one at a time.
- Not checking the diluent volumes with a second checker prior to dilution.
- Two checkers not signing the double check before the vaccine leaves the drawing up room.
- Staff appeared unfamiliar with current IMAC advice and guideline resources for drawing up and supporting the administration of Comirnaty vaccine.

9(2)(a)
18/07/2021

Kathleen Smitheram

From: 9(2)(a) on behalf of ECC Controller (CDHB)
Sent: Tuesday, 20 July 2021 3:16 PM
To: 9(2)(a)
Cc: 9(2)(a) @health.govt.nz'
Subject: Vaccine error report from 9(2)(a) Wigram July 2021
Attachments: 14 July Incident report.docx; Vaccine records 9(2)(a) 14.docx; CVIP Incident Report 9(2)(a) Wigram.docx

Please advise if you need further details and next steps

Thank you

9(2)(a)
ECC Controller
9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wananga o Tamaki Makaurau

Vaccine Incident reporting mRNA-CV

All Incidents/ errors/ near miss, should be reported in house, and local investigation undertaken, Clinical advice is provided by 0800 IMMUNE/466863, IMAC COVID Eduction Facilitators or Advisors

Part of an incident review should also include sending full information on incident to IMAC to allow for any lessons learnt to be shared via training and via ImmNuz. [MERP is no longer recording this information]

The form below shows the type of information we require, alternative layout, eg. in house forms are acceptable alternatives.

Please return to your local COIVID Regional Advisor, see emails below

All reports will be treated in confidence but if preferred identifying information can be removed]

Date and time 15/07/2021. Date of incident 14/07/2021
Name of Provider 9(2)(a) Wigram
Name of person reporting event 9(2)(a) – Covid-19 clinic lead
What went wrong? Two RN's drawing up Pfizer covid-19 vaccinations. 10 vials of the vaccine were removed from the fridge and begun to be drawn up when at correct temperature. Once three vials had been drawn up, the nurse vaccinating took these to the vaccination room, leaving a further 7 vials to be drawn up by the two remaining nurses. These vials were drawn up and given to the vaccinator. At the end of the clinic it was noted that there were 11 pre printed forms and only 10 vials. This indicated that we would have had 11 trays with 6-7 drawn up vaccines. Usually each empty vial is placed into the tray with the drawn up doses. It is thought that one nurse has diluted a vial, drawn up the doses and then this vial has been further diluted and an additional 6 or 7 doses taken from this vial. Therefore these doses are very diluted with a minimal or no amount of vaccine. Each dose when drawn up is recorded on a pre-printed form containing the date, time removed from fridge, time diluted, and number of doses along with the batch numbers and details of the Pfizer vaccine and diluent. We are very confident that the first three lots of vaccines (x3 vials, 21 doses) were reconstituted properly. A total of 76 doses were administered yesterday therefore there are 55 possible patients who may have received this incorrectly diluted vaccine.
How the event occurred: *Brief description* As above *Were there any contributing factors:*

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

Immediate actions taken:
14/07/21: RN noted discrepancy at the end of the clinic approximately 1700hrs. RN advised the clinical director upon finding the error. A meeting was set up the following day to discuss the error with RN who is the Covid lead as she was on her day off on the day the incident occurred.
15/07/21- Covid lead nurse + RN above meet to discuss incident. Covid lead nurse advised IMAC and imms coordinator.
One of the two RNs involved in the initial draw up process completed the incident form and contacted 9(2)(a) *(Covid liaison). Second RN involved in the initial draw up process was on a rostered day off today and was advised of the incident upon return to work on the 16/07/21.*
16/07/21: Both RN's involved in initial draw up process meet with IMAC liason + 9(2)(a) *(immunisation co-ordinator).*

Where any adverse events reported post incident?
Nil adverse events noted by patients.

Advice obtained
Document advice obtained and include where the advice came from.

15/07/2021 10am – Clinic lead 9(2)(a) was advised by RN's
15/07/2021 9(2)(a) (RN) spoke with 9(2)(a) – Pegasus Health
15/07/2021 9(2)(a) spoke with 9(2)(a) 2x & 9(2) from IMAC
9(2)(a) coming in for meeting with nurses involved 16/07/2021 1400.

What have you learnt from the incident review?
What went well and what did not go well, considering both the event itself and the management of the event
We have reduced the risk for distractions while drawing up by dedicating a private room for drawing up vaccines instead of in a communal area.
We will no longer prepare in advance the drawing up syringes and the diluent syringes. These will be done one at a time of drawing up each vial.
Each tray of 6-7 vaccines from a vial will have to be second checked before moving on to the next vial/ tray. In addition, all the vials are to be second checked again by both RN s to ensure all info is completed.
No trays should removed until all 10 vials have been drawn up and second checked.

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

What changes will you be making?
Any recommendations from review of the incident and actions planned or undertaken:

As above

Was the error reported to Centre for Adverse Reaction Monitoring (CARM]
For CARM see: 9(2)(a) [redacted]
Not at the stage because there was no adverse reaction involved. Happy to complete if advised.

Incidents that involve patients should be reported.

Identifiable information in this form is optional and will be treated in confidence. Providing this information give us the opportunity to contact you to offer further advice or support should we feel this is necessary.

Signature: Signed electronically

Name: 9(2)(a) [redacted]

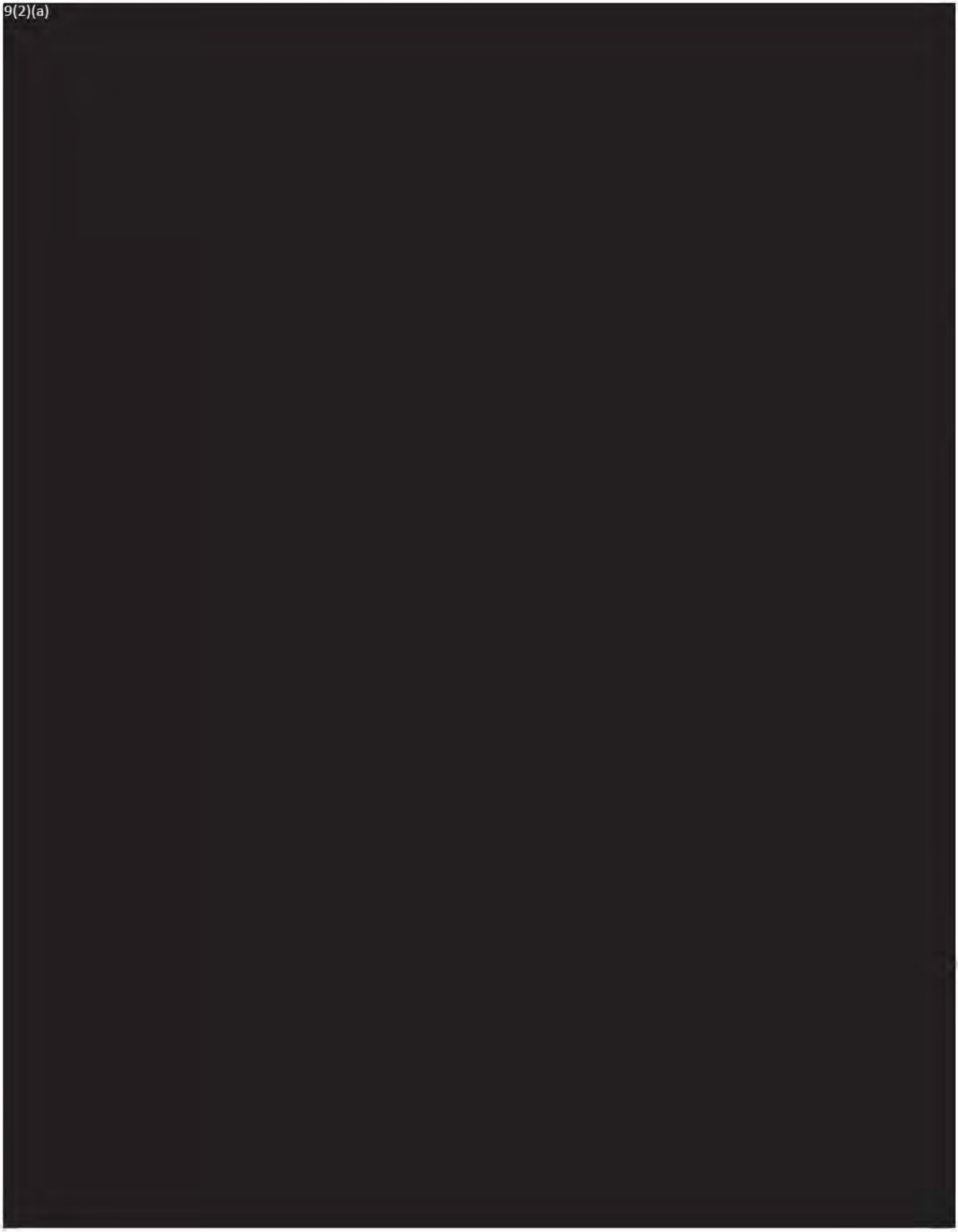
Designation: Covid vaccination clinic lead

Please email to your local Regional Advisor.

9(2)(a) [redacted]@auckland.ac.nz Auckland and Northland,
9(2)(a) [redacted]r@auckland.ac.nz Central region,
9(2)(a) [redacted]@auckland.ac.nz Midland region
9(2)(a) [redacted]@auckland.ac.nz South Island

Vaccine records 9(2)(a) 14/7/2021. Sequential order of doses given, Record 2 is the vial that was inadvertently reconstituted, and is record 4.

9(2)(a)



MINISTRY OF HEALTH
MANATŪ HAUORA

Provider with MoH Initial serious incident & adverse event notification form

Provider (sections A & B) and MoH (sections C onwards)

Section A: Provider Notification Details

Provider or DHB to complete:	
Time and Date of Incident:	**14/7/2021**
Time and Date Reported:	15/7/2021
Name of person reporting the incident:	Carol McSweeney, Nurse Consultant Immunisation CDHB
Your contact phone number:	9(2)(a)
Your email address:	carol.mcsweeney@cdhb.health.nz
Ministry to complete:	
Date and time received by Ministry:	
Person Receiving notification:	

Section B: Description

Type of Incident[1] or adverse event[2] or an AEFI[3] - it's possible two of the four options apply

Incident ☒ Serious adverse event ☐ AEFI ☐ Near miss ☐

Please provide a brief description of the Incident/Adverse Event/Near miss.

Nurse 1 and 2 drawing up vaccine. 10 trays prepared, 10 vials, allocated 5 each. Vials sitting on bench awaiting reconstitution. Covid vaccine records completed for each vial and placed into dish with each set of drawn up vaccines, along with vial. During the drawing up, Nurse 3 came and took 3 dishes of vaccines out to the floor. By mistake, Nurse 2 had not place vial into kidney dish with vaccine and this tray was taken by Nurse 3 who did not notice lack of vial until completing vaccinations with these doses (noted on vaccine record). Nurse 2 subsequently reconstituted this vial which produced 6 doses where all other vials that day 7 were obtained. After the 10 trays were used the nurses noted that they had an extra vial and prepared another (11th) tray and Nurse 1 reconstituted and prepared doses. Second checks undertaken following completion of drawing up.

[1] An incident means any unplanned event resulting in, or having a potential for injury, ill health, damage or other loss, an incident includes an accident.
[2] An adverse event is an incident resulting in harm, or with the potential to result in harm to a health consumer. Please assign an adverse event SAC rating. Refer to Appendix One. Report a SAC 1,2 or 3 SAC event, a cluster of SAC 3/ 4 events +/- near misses.
[3] Adverse event following immunisation (AEFI) - an untoward medical event which follows immunisation and does not necessarily have a causal relationship with the administration of the vaccine. The adverse event may be an unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.

At the end of the day it was noted that there were more doses than expected, and Nurse 1 reported to manager.
On investigation today, review of Vaccine register to confirm all vials accounted for.
Review of drawing up process that contributed to error, practice has already reviewed location of drawing up (separate room) to help avoid distraction. Drawing up single doses at a time, and second checks at critical parts of the process.
Based on the Covid vaccine records which identify the exact time of dilution and time last dose administered we have been able to determine that Nurse 2 prepared 7 dose tray, subsequently reconstituted the used vial obtaining 6 doses at 11.30, these were administered by Nurse 3 above, and, last dose given at 13.40. Based on the timeline established by the vaccine records we are able to determine that the 6 doses were given between 13.20 and 13.40. These were cross-referenced with CIR to determine which individuals would have received those 6 doses. Six people were identified from those records. They consisted of four people receiving dose 1 and two people receiving dose 2. We are able to identify each individual involved from CIR records. These findings were discussed onsite with the Clinics Covid Vaccination lead and Nurse 1 and 2. Who were able to confirm that this is an accurate timeline of events. Also present as part of the investigation team were 9(2)(a), Pegasus PHO and 9(2)(a) IMAC Facilitator.

Investigation into this event was greatly assisted by the accurate documentation by the clinic, and the fact that there was only one vaccinator vaccinating at the time.

- If an adverse event following immunisation, has this been reported to CARM? Yes ☐ ☐ No
- Has a preliminary investigation been undertaken? Yes ☐ ☐ No
- Has a preliminary SAC rating for an adverse event been assigned? Yes ☐ ☐ No
- Preliminary SAC rating: 4

Provider: When the concern is an adverse event or an AEFI, please arrange for open communication with affected person/s.

Section C: Initial Assessment and actions by Ministry of Health investigation team

Actions taken by Ministry of Health investigation team

Action	Description	By whom	By when

Section D: Decision making

Based on the assessment by the Ministry of Health assessment team and information gathered outline the decisions made - add rows as required.

Date	Decision	By whom	Authorised by

Decision matrix

Type of incident	Assessment team	Decision maker
Clinical	[Clinical Lead CVIP(Lead)] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	
Operational	[GM Operations] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	
Logistics	[GM Logistics] [SME] [Ops Lead] [Risk] [Comms] [Privacy or security advisors]	

Section E: Notification Checklist

Role	Yes	Not required and why	Date/time
National Director			
Comms involved			
Minister's office			
DG of Health			
DHB/Org CEO			
DHB/Org SRO			
DHB/Org Clinical Lead			
DHB/Org Ops Lead			
GM Operations			

Section F: Other

Section G: Appendices

Appendix One: CVIP SAC

Appendix Two: Please use this section to attach material relevant to this incident report.

APPENDIX ONE

If an adverse event, either following immunisation or other cause, please arrange for open communication with the affected person/s.

MINISTRY OF HEALTH MANATŪ HAUORA

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

COVID-19 Vaccine and Immunisation Programme Severity Assessment Code (SAC) examples

This list is for guidance only. All events should be rated on actual outcome for the consumer. To see more detailed information on SAC rating, see the SAC Rating and Triage Tool for Adverse Event Reporting

SAC 1 Death or permanent severe loss of function	SAC 2 Permanent major or temporary severe loss of function
• Medication or dose error resulting in death or causing renal failure and need for permanent renal replacement therapy • Anaphylaxis resulting in death or permanent loss of function • Wrong site of vaccine resulting in removal of healthy limb or organ • Delayed referral, treatment resulting in treatment options limited to palliation (delay direct contributor) • Delayed recognition of patient deterioration resulting in permanent disability or death	• Fall resulting in fracture • Serious adverse reaction with delayed administration of adrenaline or delayed presence of emergency services • Delayed recognition of patient deterioration resulting in unplanned transfer to intensive care or to another hospital for higher acuity care, cardiopulmonary resuscitation and/or intubation • Medication or dose error resulting in major harm (eg, requiring dialysis, intervention to sustain life, anaphylaxis) • Consumer serious assault occurring within vaccination care setting when a known safety plan in place is not upheld (eg, protection order)
SAC 3 **Permanent moderate or temporary major loss of function**	**SAC 4** **Requiring increased level of care** **OR no injury, no increased level of care; includes near misses**
• Fall resulting in laceration requiring sutures • Failure of essential service with moderate consequence to consumer • Temporary nerve damage or pain from vaccine administration • Severe injection site infection • Vasovagal event following immunisation resulting in injury	• Additional monitoring, investigations or interventions due to the event • Medication, dilution or dose error resulting in no increased level of care • Breach of confidentiality • Near miss events, such as not identifying a person is underage prior to the event

Version 1: Adapted for the COVID-19 Vaccine Programme (CVIP) from Severity Assessment Code (SAC) examples 2019–20 | Health Quality & Safety Commission 2019

APPENDIX TWO

Please use this section to attach material relevant to this incident report.

REPORT ENDS.

Out of Scope

[redacted]

From: ECC Operations (CDHB)
Sent: Tuesday, 20 July 2021 12:55 PM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Subject: FW:

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Monday, 19 July 2021 2:53 PM
To: ECC Operations (CDHB) <ECCOpsCDHB@cdhb.health.nz>
Subject: FW:

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Monday, 19 July 2021 2:37 PM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) @siapo.health.nz>; 9(2)(a) @pegasus.org.nz>
Subject: FW:

I found this template – you could start with this thank you

From: 9(2)(a) @health.govt.nz>
Sent: Friday, 16 July 2021 12:52 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: FW:

Double Up

[redacted]

Out of Scope [redacted]

From: Carol McSweeney
Sent: Tuesday, 20 July 2021 3:11 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>
Subject: FW: Vaccine error

From: Carol McSweeney
Sent: Tuesday, 20 July 2021 3:07 PM
To: 9(2)(a) [redacted]@ccn.health.nz>
Subject: Vaccine error

Hi 9(2) [redacted]
Here is the final report from me, picture of vaccine records, and Incident report from practice to be attached to report for 9(2)(a) [redacted]. When you circulate, please include 9(2)(a) [redacted] and she will ensure practice receives a copy.

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a) [redacted]
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs
COVID-19 Vaccination Programme

Unite against COVID-19

Kathleen Smitheram

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Tuesday, 20 July 2021 1:53 PM
To: 9(2)(a)
Subject: vaccine error report
Attachments: CVIP Incident Report 9(2)(a) Wigram.docx

Hi all,
Please find attached (draft) report based on this morning's visit to 9(2)(a). We were able to confidently identify exact details of the vaccine error, and the 6 individuals we believe were given saline instead of vaccine. CIR has also identified that four were dose 1, and two dose 2.

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a)
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs COVID-19 Vaccination Programme

Unite against COVID-19

****

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From: 9(2)(a) @pegasus.org.nz>
Sent: Tuesday, 20 July 2021 2:52 PM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Subject: Fwd: Incident Form

Get Outlook for Android

From: 9(2)(a) 9(2)(a)
Sent: Friday, July 16, 2021 5:31:59 PM
To: 9(2)(a) @pegasus.org.nz>
Subject: Re: Incident Form

Hi 9(2)(a)

Please find attached the completed incident report for 14 July.

9(2)(a) from IMAC did mention that it would be useful for our other nurse 9(2)(a) who completed the clinic yesterday to give a statement. 9(2)(a) , I have contacted 9(2) to ask if 9(2) could send this through and will forward to you if 9(2) gets back to me.

Kind regards

9(2)(a)
Registered Nurse

9(2)(a)

9(2)(a) [redacted]

From: 9(2)(a) [redacted] @pegasus.org.nz>
Sent: Thursday, July 15, 2021 4:24:31 PM
To: 9(2)(a) [redacted]
Cc: 9(2)(a) [redacted]
Subject: Incident Form

Kia ora 9(2)(a) [redacted]

Please find attached the incident form for you to complete please. Could you return to me in the first instance, and I will send on?

The incident form will be sent to:
IMAC
Canterbury ECC
Pegasus Health Clinical Lead.

Ngā mihi

9(2)(a) [redacted]

9(2)(a) [redacted]
Nursing Workforce Development Coordinator
Pegasus Health (Charitable) Ltd
P: 9(2)(a) [redacted]
E: 9(2)(a) [redacted] @pegasus.org.nz
401 Madras Street, Christchurch 8013
PO Box 741, Christchurch 8140

Kathleen Smitheram

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Tuesday, 20 July 2021 9:47 AM
To: 9(2)(a) [redacted]
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Thanks 9(2)(a)
Only other thing I can add is the reconciliation of vials at the end of the day, did they have same number of vials to discard, that they started with.

9(2)(a) [redacted]

From: 9(2)(a) [redacted]t@auckland.ac.nz>
Sent: Tuesday, 20 July 2021 9:40 AM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) [redacted]@auckland.ac.nz>; 9(2)(a) [redacted]@pegasus.org.nz>
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Hi 9(2)(a) [redacted],

Great to have your support with this. I am still waiting for final guidance from the Ministry but for now I am keen we are all concentrating on processes to try and see if we can scale this down to involving less people. I will share any templates if/ when I get them but main objective is a deep dive to try and establish if there is any way we can reduce the number of patients involved,

I totally take your point re too many people. I have asked 9(2)(a) to pull out of her earlier meeting and to join with you at 11.00. Much better use of resources for you and the staff concerned. The Ministry team were keen that IMCA should be involved but very happy for us to take a back seat and let you take the lead.

I am sure you have a list of questions you are planning to answer and I know 9(2) has already reviewed ways of working and I know you have 9(2 report on some of the areas that showed system weaknesses.

As you know we have a second incident under way as well so I have been sharing ideas for investigations between the two teams.

The following may be helpful although I know some have already been covered,

- How vaccine stock is managed, what paper work supports these systems
- How vaccine are prepared, what paper trails they have in place.
- Do they record of number of dose per vial? If so where is this stored and can we be confident re dates etc? I know some record on white board so ? whether this info is kept. Obtain copies if at all possible
- What checking systems are in place, are they following current guidance, are shortcuts being taken ?
- Checking which system of syringe and needles was being used on that day an hence and the number of doses obtained per vial my differ if this swapped during the day.
  - Since one of the theories we are working on is that an empty vial was diluted that should show as one less dose per vial than normal.
- Can they prove that every vial that was delivered to the site has been accounted for? Could someone have taken a vial for some reason?
- If we can identify a time when vial had less doses than expected [due to vial not having any vaccine in it only the diluent]
  - Then we need time lines for vaccinations, CIR appointment logs etc would be really important to try and identify a time when the error is likely to have occurred.

Less urgent for today but also important

Review of how staff are trained and supervised. What policies are being followed [and if they are being followed] Any specific distractions during the day either at the vaccination centre or for individuals. Staff training and experience ...Supervision, time allowed for appointments and for drawing up.....

Other idea welcome !

Hope this helps and let me know if I can be of any support.

9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

9(2)(a)
Immunisation Advisory Centre
The University of Auckland
Immunisation on time every time

Cell: 9(2)(a)
Email: 9(2)(a)
0800 IMMUNE/466863
www.immune.org.nz:
www.influenza.org.nz

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Tuesday, 20 July 2021 8:27 AM
To: 9(2)(a) @auckland.ac.nz>
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Hi 9(2)
Hope we aren't overwhelming the practice. I'm working with 9(2)(a) Pegasus PHO , as 9(2) has a connection to the practice. We are having a full team meeting there at 11am at the clinic to get a few more facts, I think everyone involved will be there. We can then review the timeline etc, based on the conversation we had yesterday in the zoom meeting with you. I spent the afternoon with 9(reviewing the info we have, and confirm our assumptions about exactly how it occurred and hopefully narrow down the scope of the people vaccinated.
The main thing we need at this point is an idea about what the RCA will require, so we can make sure we are getting all the information we need at 11. Then we have a meeting at DHB at 12.30 to put it all together for you, by 4. Yes, please share any further questions we should ask, thanks for that.

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a)
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs
COVID-19 Vaccination Programme
Unite against COVID-19

From: 9(2)(a) [redacted] @auckland.ac.nz>
Sent: Tuesday, 20 July 2021 8:18 AM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Carol,
I believe you will be leading the RCA from your end? I have just spoken to 9(2)(a) and she is visiting at 9.30 to review all the paper records around vaccinations. 9(2) has already made a start on reviewing system and identified some weaknesses but had not been able to reduce the number of staff concerned.

How do you want to play this ? Ministry need to have a report by 4 pm and I know we have a meeting this afternoon to pull together the main facts.

Ideally we can work out way of identify a time line as to when the error happened due to the number of doses per vial. If this does not work, we will just have to include as much information as possible to inform decisions and to learn for next time.

Out of Scope so will be doing a quick brain storm on questions that need to asked and I am happy to share with you so you can add in anything that you can think of that we have missed.

Your help is appreciated.

9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wananga o Tamaki Makaurau

9(2)(a)
Immunisation Advisory Centre
The University of Auckland
Immunisation on time every time

Cell: 9(2)(a)
Email: 9(2)(a)
0800 IMMUNE/466863
www.immune.org.nz:
www.influenza.org.nz

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Tuesday, 20 July 2021 8:04 AM
To: 9(2)(a) @auckland.ac.nz>
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Thanks 9(2)

From 9(2)(a) @auckland.ac.nz>
Sent: Monday, 19 July 2021 5:45 PM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) @auckland.ac.nz>
Subject: RE: Ops guidelines[EXTERNAL SENDER]

Yes your correct,
This is not correct based on the problem with LDS needles and the Vernacare syringes.
If using LDS syringes and needles we would expect 6 or 7 doses but if using non LDS needles ie 38mm then they would be getting 5 maybe 6. Same if there was a mix ie some longer ones.
New guidance should be on our website tomorrow AM and I need to follow up with operations

9(2)(a)

IMMUNISATION ADVISORY CENTRE
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www.immune.org.nz:
www.influenza.org.nz

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Monday, 19 July 2021 8:42 AM
To: 9(2)(a) @auckland.ac.nz>; 9(2)(a) @auckland.ac.nz>
Subject: Ops guidelines

Hi
Query....page 31 of ops guidelines says if we get **less than 6 doses** from a vial we quarantine and discard all doses. Is this correct? I thought it was licensed for 5 to 6 doses, and we can get 7??? We occasionally get 5, especially when drawing up with 38mm needles.

Thanks

Regards

Carol McSweeney

CDHB Covid Vaccination Programme

9(2)(a)
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs
COVID-19 Vaccination Programme

Unite against COVID-19

****

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Kathleen Smitheram

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 7:29 AM
To: 9(2)(a)
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021
Attachments: 14 July Incident report.docx; Vaccine records 9(2)(a) 14.docx; CVIP Incident Report 9(2)(a) Wigram.docx

Morena 9(2)(a)

Many thanks for the incident reports
May I ask if there has been contact with the affected people as open communication?

Nga mihi nui
9(2)(a)

9(2)(a) | Noho ora mai | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 20 July 2021 3:25 pm
To: 9(2)(a) @health.govt.nz>
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

FYI
9(2)(a)

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Tuesday, 20 July 2021 3:16 pm
To: 9(2)(a) t@auckland.ac.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: Vaccine error report from 9(2)(a) Wigram July 2021

Please advise if you need further details and next steps

Thank you

9(2)(a)
ECC Controller
9(2)(a)

****

Kathleen Smitheram

From: 9(2)(a)
Sent: Wednesday, 21 July 2021 9:09 AM
To: 9(2)(a); ECC Controller (CDHB)
Cc: Cheryl Brunton
Subject: RE: Vaccine error report from 9(2)(a) Wigram July 2021

Morena

There has been no communication with affected people

We were advised by MOH that the next steps including communication would be lead centrally

I await instructions from 9(2)(a) of IMAC who indicated there was a meeting today re next steps

Keep you posted

Nga mih 9(2)

From: 9(2)(a)@health.govt.nz>
Sent: Wednesday, 21 July 2021 7:29 AM
To: 9(2)(a)@health.govt.nz>; 9(2)(a)
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

Morena 9(2)(a)

Many thanks for the incident reports
May I ask if there has been contact with the affected people as open communication?

Nga mihi nui
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From: 9(2)(a)@health.govt.nz>
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FYI
9(2)(a)

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Sent: Tuesday, 20 July 2021 3:16 pm
To: 9(2)(a) @auckland.ac.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: Vaccine error report from 9(2)(a) Wigram July 2021

Please advise if you need further details and next steps

Thank you

9(2)(a)
ECC Controller
9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:56 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline

Hi there
I spoke to 9(2)(a) about this earlier this week to give her a heads-up. 9(2) was going to assign a comms advisor to get lines together on this.
Ok if I pass this onto 9(2)(a) staff to action, and we'll deal with them?
Cheers

Ngā mihi

9(2)(a) **I Media Lead I COVID-19 Vaccine and Immunisation Programme**
9(2)(a)
Ministry of Health I www.moh.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:51 am
To: 9(2)(a) @health.govt.nz>
Subject: CDHB saline

Hi 9(2)(a)

9(2)(a) has advised that the safety assessment on the saline issue at CDHB will be completed this morning – can you assign someone to touch base with KvD on the patient comms and reactive lines?

Thanks,

Ngā mihi

9(2)(a) **I GM Communications and Engagement I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I **Mobile** 9(2)(a) @health.govt.nz I www.health.govt.nz

Karalyn van Deursen

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:36 PM
To: Karalyn van Deursen
Subject: FW: RE: CDHB saline issue [EXTERNAL SENDER]

Hi Karalyn,
It might be best if I contact you as external emails to me seem to be bouncing back at this stage and my phone details are not yet fully established. Regards, 9(2)

9(2)(a) **I Senior Communications & Engagement Advisor I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I www.moh.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:26 pm
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; van Deursen, Karalyn <karalyn.vandeursen@cdhb.health.nz>
Subject: RE: CDHB saline issue

Hi 9(2)

The best person to discuss this with is Karalyn van Deursen so I've cced her into this.

Ngā mihi
9(2)(a)

9(2)(a) I Senior Communications Advisor I COVID-19 Vaccine and Immunisation Programme I Ministry of Health
p. 9(2)(a) I 9(2)(a) @health.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 10:30 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi both,
Let me know who you want to proceed In getting the info from CDHB? Regards, 9(2)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:14 am
To: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline issue

Lets catch up after the stand up

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:10 am
To: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline issue

Thanks, will do. The incident review meeting is at 12.30-1 today (I'm trying to work out how to save emails so I can forward them), do you want me to go?

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:08 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>; 9(2)(a) 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi 9(2)(a)

See below. This is the issue (one of two vaccine delivery incidents) we discussed earlier in the week –email from 9(2)(a) refers and I think you met with 9(2) also.

CDHB has completed its safety assessment of the issue now, and will draft comms about it. Can you please pull together some reactive lines both for the programme and for the minister's office.

You will need an introduction to CDHB comms via 9(2)(a) (from our stakeholder engagement team). 9(2)(a) can you please introduce 9(2) to the right person - KvD?

Any questions please get in touch. Deadline is asap today.

Thanks very much
9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:58 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline

Absolutely – good idea.

9(2)(a) CDHB will draft all the comms – we just need to be across and happy, and to have reactive lines both for on behalf of the programme and for MO.

Ngā mihi

9(2)(a) **GM Communications and Engagement I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I **Mobile** 9(2)(a) @health.govt.nz I www.health.govt.nz

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Wednesday, 21 July 2021 1:56 PM
To: 9(2)(a)
Subject: RE: RE: CDHB saline issue [EXTERNAL SENDER]

9(2) do you have a phone number?
Or can you call me on 9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:36 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: FW: RE: CDHB saline issue [EXTERNAL SENDER]

Hi Karalyn,
It might be best if I contact you as external emails to me seem to be bouncing back at this stage and my phone details are not yet fully established. Regards, 9(2)

9(2)(a) **I Senior Communications & Engagement Advisor I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I www.moh.govt.nz

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To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; van Deursen, Karalyn <karalyn.vandeursen@cdhb.health.nz>
Subject: RE: CDHB saline issue

Hi 9(2)

The best person to discuss this with is Karalyn van Deursen so I've cced her into this.

Ngā mihi
9(2)(a)

9(2)(a) I Senior Communications Advisor I COVID-19 Vaccine and Immunisation Programme I Ministry of Health
p. 9(2)(a) I e 9(2)(a) @health.govt.nz

From: 9(2)(a) @health.govt.nz>
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Sent: Wednesday, 21 July 2021 9:08 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>; 9(2)(a) 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi 9(2)(a)

See below. This is the issue (one of two vaccine delivery incidents) we discussed earlier in the week – email from 9(2)(a) refers and I think you met with 9(2 also.

CDHB has completed its safety assessment of the issue now, and will draft comms about it. Can you please pull together some reactive lines both for the programme and for the minister's office.

You will need an introduction to CDHB comms via 9(2)(a) (from our stakeholder engagement team). 9(2)(a) can you please introduce 9(2) to the right person - KvD?

Any questions please get in touch. Deadline is asap today.

Thanks very much
9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:58 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline

Absolutely – good idea.

9(2)(a) CDHB will draft all the comms – we just need to be across and happy, and to have reactive lines both for on behalf of the programme and for MO.

Ngā mihi

9(2)(a) | GM Communications and Engagement | COVID-19 Vaccine and Immunisation Programme
Ministry of Health | Mobile 9(2)(a) | 9(2)(a)@health.govt.nz | www.health.govt.nz

From: 9(2)(a)@health.govt.nz>
Sent: Wednesday, 21 July 2021 8:56 am
To: 9(2)(a)@health.govt.nz>
Cc: 9(2)(a)@health.govt.nz>
Subject: RE: CDHB saline

Hi there
I spoke to 9(2)(a) about this earlier this week to give 9(2 a heads-up. 9(2) was going to assign a comms advisor to get lines together on this.
Ok if I pass this onto her for her staff to action, and we'll deal with them?
Cheers

Ngā mihi

9(2)(a) | Media Lead | COVID-19 Vaccine and Immunisation Programme
9(2)(a)
Ministry of Health | www.moh.govt.nz

From: 9(2)(a)@health.govt.nz>
Sent: Wednesday, 21 July 2021 8:51 am
To: 9(2)(a)@health.govt.nz>
Subject: CDHB saline

Hi 9(

9(2)(a) has advised that the safety assessment on the saline issue at CDHB will be completed this morning – can you assign someone to touch base with KvD on the patient comms and reactive lines?

Thanks,

Ngā mihi

9(2)(a) | GM Communications and Engagement | COVID-19 Vaccine and Immunisation Programme
Ministry of Health | Mobile 9(2)(a)@health.govt.nz | www.health.govt.nz

Karalyn van Deursen

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 3:47 PM
To: Karalyn van Deursen
Subject: FW: RE: CDHB saline issue [EXTERNAL SENDER]

Looks like my emails have been fixed and I ca now get them form enteral sources, 9(2)

From: 9(2)(a)
Sent: Wednesday, 21 July 2021 1:36 pm
To: karalyn.vandeursen@cdhb.health.nz
Subject: FW: RE: CDHB saline issue

Hi Karalyn,
It might be best if I contact you as external emails to me seem to be bouncing back at this stage and my phone details are not yet fully established. Regards 9(2)(a)

9(2)(a) **I Senior Communications & Engagement Advisor I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I www.moh.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:26 pm
To: 9(2)(a) @health.govt.nz>
Cc 9(2)(a) @health.govt.nz>; van Deursen, Karalyn <karalyn.vandeursen@cdhb.health.nz>
Subject: RE: CDHB saline issue

Hi 9(2)

The best person to discuss this with is Karalyn van Deursen so I've cced her into this.

Ngā mihi
9(2)(a)

9(2)(a) I Senior Communications Advisor I COVID-19 Vaccine and Immunisation Programme I Ministry of Health
9(2)(a) I e: 9(2)(a) @health.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 10:30 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi both,
Let me know who you want to proceed In getting the info from CDHB? Regards, 9(2)

Double Up

[redacted]

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:08 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a)
Subject: FW: CDHB saline issue

Hi 9(2)(a)

See below. This is the issue (one of two vaccine delivery incidents) we discussed earlier in the week – email from 9(2)(a) refers and I think you met with her also.

CDHB has completed its safety assessment of the issue now, and will draft comms about it. Can you please pull together some reactive lines both for the programme and for the minister's office.

You will need an introduction to CDHB comms via 9(2)(a) (from our stakeholder engagement team). 9(2)(a) can you please introduce Lloyd to the right person - KvD?

Any questions please get in touch. Deadline is asap today.

Thanks very much
9(2)(a)

Double Up

[redacted]

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:51 am
To: 9(2)(a) @health.govt.nz>
Subject: CDHB saline

Hi 9(2)(a)

9(2)(a) has advised that the safety assessment on the saline issue at CDHB will be completed this morning – can you assign someone to touch base with KvD on the patient comms and reactive lines?

Thanks,

Ngā mihi

9(2)(a)) | **GM Communications and Engagement | COVID-19 Vaccine and Immunisation Programme**
Ministry of Health | **Mobile** 9(2)(a) | 9(2)(a) @health.govt.nz | www.health.govt.nz

Kathleen Smitheram

From: 9(2)(a)
Sent: Thursday, 22 July 2021 1:50 PM
To: Haidee Scott; 9(2)(a)
Cc: Cathy Rewiri; ECC Controller (CDHB); Carol McSweeney; 9(2)(a); 9(2)(a) @pegasus.org.nz); 9(2)(a); John Hewitt; Cheryl Brunton; 9(2)
Subject: follow up 9(2)(a) Wigram investigation

Afternoon

In discussion with the MOH the plan is to

1 Contact (by a clinical person) the individuals to
- Inform them of vaccine error
- Apologise
- Arrange Rebooking

2 Put above detail in letter to the individuals
We will need a script for the letter and phone call which Haidee will assist with; thank you

3 Make a note on their patient file that they were given saline not vaccine when where etc and remedial action

4 Prepare a draft media release should we be asked to comment about this matter – to agree words with MOH

5 Provide feedback to the staff and owners of 9(2)(a) Wigram

The plan is to have calls to individuals completed by the end of Monday 26 July 2021.

I have asked 9(2)(a) and Cathy to oversee this work.

Thank you all

Out of Scope

[redacted]

---------- Forwarded message ---------
From: **Cathy Rewiri** <Cathy.Rewiri@cdhb.health.nz>
Date: Thu, Jul 22, 2021 at 3:28 PM
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]
To: 9(2)(a) @pegasus.org.nz>, 9(2)(a)
Cc: Haidee Scott <Haidee.Scott@cdhb.health.nz>, 9(2)(a) @siapo.health.nz>, ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>, Carol McSweeney <Carol.McSweeney@cdhb.health.nz>, 9(2)(a) 9(2)(a) @gmail.com>, 9(2)(a) @pegasus.org.nz>, John Hewitt <john.hewitt@cdhb.health.nz>, 9(2)(a) @pegasus.org.nz>, 9(2)(a) @ccn.health.nz>

Hi 9(2)(a)
9(2) and I will identify who can contact the patients, it is best for this to be done by a senior clinician.
Do you have the details of the patients involved?

Thanks
Cathy

From: 9(2)(a) @pegasus.org.nz>
Sent: Thursday, 22 July 2021 2:34 PM
To: 9(2)(a)
Cc: Haidee Scott <Haidee.Scott@cdhb.health.nz>; 9(2)(a) @siapo.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) @gmail.com>; 9(2)(a) 9(2)(a) @pegasus.org.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; 9(2)(a) 9(2)(a) @pegasus.org.nz>; 9(2)(a) @ccn.health.nz>
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Thanks 9(2)

I have some questions:

Does this mean that 9(2) and 9(2)(a) will contact the patients?
There's also no mention of who will contact the practice. Do you want me to do that?
The practice will not have patient files for these events as the records are all on the CIR. I am unsure if these people were patients of Wigrams or somewhere else. If not, their own GPs will also need to be notified. If the Ministry want patient notes then casual patient files will need to be created. Otherwise CIR records will need to be updated.

9(2)(a)

From: 9(2)(a) >
Sent: Thursday, 22 July 2021 1:50 pm
To: Haidee Scott <Haidee.Scott@cdhb.health.nz<mailto:Haidee.Scott@cdhb.health.nz>>; 9(2)(a)
9(2)(a) @siapo.health.nz>>
Cc: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz<mailto:Cathy.Rewiri@cdhb.health.nz>>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz<mailto:ECCControllerCDHB@cdhb.health.nz>>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz<mailto:Carol.McSweeney@cdhb.health.nz>>; 9(2)(a)
9(2)(a) @gmail.com>>; 9(2)(a)
9(2)(a) @pegasus.org.nz>>; 9(2)(a)
9(2)(a) @pegasus.org.nz>>; John Hewitt <john.hewitt@cdhb.health.nz<mailto:john.hewitt@cdhb.health.nz>>; Cheryl Brunton <Cheryl.Brunton@cdhb.health.nz<mailto:Cheryl.Brunton@cdhb.health.nz>>; 9(2)(a)
@ccn.health.nz<mailto:9(2)(a) @ccn.health.nz>>
Subject: follow up 9(2)(a) Wigram investigation

Afternoon

In discussion with the MOH the plan is to

1 Contact (by a clinical person) the individuals to

* Inform them of vaccine error
* Apologise
* Arrange Rebooking

2 Put above detail in letter to the individuals
We will need a script for the letter and phone call which Haidee will assist with; thank you

3 Make a note on their patient file that they were given saline not vaccine when where etc and remedial action

4 Prepare a draft media release should we be asked to comment about this matter - to agree words with MOH

5 Provide feedback to the staff and owners of 9(2)(a) Wigram

The plan is to have calls to individuals completed by the end of Monday 26 July 2021.

I have asked 9(2) and Cathy to oversee this work.

Thank you all

****

Kathleen Smitheram

From: John Hewitt <john.hewitt@cdhb.health.nz>
Sent: Thursday, 22 July 2021 3:21 PM
To: 9(2)(a)
Cc: Carol McSweeney; 9(2)(a)
Subject: RE: 9(2)(a) Wigram RCA[EXTERNAL SENDER]

Yes that is what I would like to see. If someone can direct me to it then I would be very happy.
Cheers
John

From: 9(2)(a)@pegasus.org.nz>
Sent: Thursday, 22 July 2021 2:26 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>
Cc: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a)@gmail.com>; 9(2)(a)@pegasus.org.nz>
Subject: RE: 9(2)(a) Wigram RCA[EXTERNAL SENDER]

Kia ora John

Do you mean the final Incident report that went to the Ministry? Carol or 9(2)(a) have all of the documentation for this which I would assume is filed somewhere in the CDHB teams site.

Carol can you add to this?

I see that 9(2) has sent through the recommendations from the Incident report which is the final piece of the puzzle.

9(2)(a)

From: 9(2)(a)@pegasus.org.nz>
Sent: Thursday, 22 July 2021 1:35 pm
To: 9(2)(a)@pegasus.org.nz>
Cc: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a)@gmail.com>; john.hewitt@cdhb.health.nz
Subject: 9(2)(a) Wigram RCA

Kia ora 9(2)(a)

When the RCA for Wigram is completed can you please share this with John for his information from a programme quality perspective?

Ngā mihi,
9(2)(a)

9(2)(a)
COVID-19 Vaccination Operations Lead
M: 9(2)(a)
@pegasus.health.nz

Canterbury
District Health Board
Te Poari Hauora o Waitaha

From: John Hewitt <john.hewitt@cdhb.health.nz>
Sent: Thursday, 22 July 2021 1:32 PM
To: 9(2)(a) @pegasus.org.nz>
Subject: RE: Update following Imms Coordinator/IMAC visit to 9(2)(a) Wigram today

Hi 9(2)(a)
Is there any chance that I could be privy to the written RCA when it is completed.
Cheers
John

From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 16 July 2021 4:25 PM
To: ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; 9(2)(a) @ccn.health.nz>; Alan Pithie <Alan.Pithie@cdhb.health.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; ECC Operations (CDHB) <ECCOpsCDHB@cdhb.health.nz>; 9(2)(a) @pegasus.org.nz>; ECC Operations (CDHB) <ECCOpsCDHB@cdhb.health.nz>; 9(2)(a) @pegasus.org.nz>; 9(2)(a) 9(2)(a) @pegasus.org.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a) @pegasus.org.nz>; 9(2)(a) @pegasus.org.nz>; 9(2) @auckland.ac.nz>
Subject: Update following Imms Coordinator/IMAC visit to 9(2)(a) Wigram today
Importance: High

Kia ora all,

For your information please see the notes from 9(2)(a) visit to 9(2)(a) Wigram this afternoon at 2pm to meet the team and look at the root cause of the incident.

As discussed with 9(2)(a) on the phone just now, no patients will be contacted until the plan for next steps is confirmed with IMAC. 9(2)(a) will raise at the ECC on Monday the next steps for the programme.

Ngā mihi,
9(2)(a)

[redacted]
Canterbury Primary Care
COVID-19 Vaccination Operations Lead
M: 9(2)(a)
[redacted]

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 16 July 2021 3:51 PM
To: 9(2)(a) @pegasus.org.nz>
Cc: 9(2)(a) @pegasus.org.nz>
Subject: RE: Touching base post Wigram visit

Re Wigram:
No one has been informed outside of the practice what has occurred there.
They are in the middle of an incident report being done and will forward a copy to us once complete.
They have changed a couple of their processes already to mitigate risk of this occurring again.
They will not contact patients until advised.
They are not entirely sure what happened but at the end of the clinic day on Wednesday it was identified that 11 slips of paper pertaining to drawing up vials was present but only 10 used vials.

It was identified then that something had occurred. The nurse who gave the last lot of vaccine for the day [redacted] identified it and said [redacted] would teams message the clinic lead. The nurses we spoke to [redacted] and [redacted] – the initial drawing up nurses) were not sure if that happened that night or not.
The next day [redacted] the clinic lead was not in the practice until late morning and met with [redacted] when she got in. It was then that [redacted] was asked to email [redacted] re the situation. [redacted] emailed at 12ish that day.
Every person vaccinated that day needs to be followed up because they have no idea when the faulty injections were given.

Give me a call if you need further info.

Noho ora mai (stay well),

[redacted]
Lead Immunisation Coordinator | Kaiarataki Tuku Awhikiri
Pegasus Health (Charitable) Ltd
[redacted]

From: [redacted]@pegasus.org.nz>
Sent: Friday, 16 July 2021 3:34 pm
To: [redacted]@pegasus.org.nz>; [redacted]auckland.ac.nz>
Subject: Touching base post Wigram visit

Kia ora [redacted]

Can one of you please give me a call after you visit Wigram?

Ngā mihi,
[redacted]

[redacted]
Canterbury Primary Care
COVID-19 Vaccination Operations Lead
[redacted]

Kathleen Smitheram

From: 9(2)(a)
Sent: Thursday, 22 July 2021 4:34 PM
To: Haidee Scott 9(2)(a)
Cc: Cathy Rewiri; ECC Controller (CDHB); Carol McSweeney; 9(2)(a) @pegasus.org.nz); 9(2)(a) ; John Hewitt; Cheryl Brunton; 9(2)
Subject: RE: follow up 9(2)(a) Wigram investigation

Hi media release is not to be sent out

It is to be checked only by MOH via 9(2)(a) then kept in case we as CDHB need to respond

Re – timing of calls I will take lead from the clinical people who need to feel confident/ ready to do so

Thank you

From: Haidee Scott
Sent: Thursday, 22 July 2021 4:07 PM
To: 9(2)(a) @siapo.health.nz>
Cc: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; ECC Controller (CDHB) <ECCControllerCDHB@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) @gmail.com>; 9(2)(a) l@pegasus.org.nz) 9(2)(a) l@pegasus.org.nz>9(2)(a) @pegasus.org.nz>; John Hewitt <john.hewitt@cdhb.health.nz>; Cheryl Brunton <Cheryl.Brunton@cdhb.health.nz>; 9(2)(a) @ccn.health.nz>
Subject: RE: follow up 9(2)(a) Wigram investigation

Hi 9(2)

Could you please confirm:

- Does MoH want us to send out a media release, or
- Provide a statement to them to send out, or
- Prepare a reactive statement for us to have ready?

Also, when will we start making phone calls? 9(2)(g)(i)

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

Be a DOER!
KARAWHIUA
The stronger our immunity, the stronger our community

Double Up

Kathleen Smitheram

From: 9(2)(a) @gmail.com>
Sent: Thursday, 22 July 2021 6:16 PM
To: Cathy Rewiri
Cc: Carol McSweeney; Cheryl Brewer; 9(2)(a) ; ECC Controller (CDHB); Haidee Scott; 9(2)(a) ; John Hewitt; 9(2)(a)
Subject: Re: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi Kathy,
I'd be happy to work with 9(and the practice on this part as primary care clinical lead for the programme.

There's some work that will need to be done in terms of accessing CIR records to document for each case. As 9(suggested to 9(2) , we should also work to notify their GP's so that a record exists outside of CIR.

I think a good background understanding of primary care processes will be important for this work.

Thanks
9(2)(a)

Double Up

Double Up

Kathleen Smitheram

From: Carol McSweeney
Sent: Thursday, 22 July 2021 2:40 PM
To: 9(2)(a) ; Haidee Scott
Subject: RE: follow up 9(2)(a) Wigram investigation
Attachments: Phone script vaccine error draft.docx; Template letter Vaccine error.docx; FAQs Vaccine error draft.docx

Hi Haidee
Initial scripts....very draft
Hope that helps

C

Double Up

[redacted]

Template SCRIPT for phoning re: vaccine incident

1) Introduce yourself by name and from 9(2)(a) Wigram.

2) Calling about the Covid vaccination you had on the Date at 9(2)(a) Wigram

3) At the end of the clinic it was identified that there had been an error made preapring the vaccine you received, and you were given saline with no vaccine.

4) We sought advice from MOH and Immunisation Advisory Centre (IMAC) they have advised that there are no safety concerns with 9(2) having the saline, however you have not received the vaccine.

5) We apologise to you that this incident has occurred.

6) We have reviewed our processes for preparing vaccines and made sure additional checking takes place to ensure this does not happen again.

7) We would like you to come back for us to give you the vaccine, or you can have this at an alternative vaccination location if you prefer.

8) If they want further medical information we can offer Ramon?

Date

Dear .....

Vaccine preparation Incident

..... received a Covid-19 vaccine from the _____Vaccination Service at ..... on day and date.

At the end of the day's vaccination clinics it was identified that an error had been made drawing up the vaccine, and you have been given saline, without the vaccine.

We have sought advice from our Ministry of Health, IMAC and the Medical Officer of Health, they have advised that re-immunisation is recommended.

We are sincerely sorry for any distress and inconvenience this may cause you.

Further expert guidance from our Immunisation Co-ordinator and the Immunisation Advisory Centre (IMAC) advises that there are no safety concerns expected from

We have reviewed our vaccine management processes and are now confident that we can ensure that we have prepared vaccines correctly.

If you would you like to discuss this further with our service, please contact_____
You are welcome to make an appointment for the repeat immunisation at this practice or an alternative if you would prefer. (Include details of how to book)

Yours sincerely

.....

Possible Questions:

- **Should we wait a certain length of time before coming back in for re-vaccination?**

No, because we consider the vaccine dose(s) you have received did not contain vaccine.

- **Will I have to pay for my vaccination again?**

No, the re-vaccination will be free.

- **What if I choose not to have my vaccination repeated?**

The expert advice given to us from IMAC is that you should have it repeated, as you would not have received any protection from the injection you received.

- **I really don't want to have to go through the trauma of having the vaccine again.**

We understand that, however, according to expert advice it is important for you to have the vaccine(s) again to ensure you are best protected against Covid 19

- **How can we trust the re-vaccination and can we be sure it won't happen again in future?**

As a service we have worked hard to ensure that vaccines are managed and prepared safely here, and failures in preparing vaccines are consequently very rare. The issue was quickly identified by our nursing team and we have informed you quickly in order to take corrective action to ensure you receive a valid dose of the vaccine for your protection against Covid 19.

- **How did this happen, don't you take care when preparing vaccines?**

Preparing this vaccine involves many steps in the process, and this has happened in one step which has resulted in this. 9(2)(g)(i) 9(2)(g)(i) 9(2)(g)(i)

- **Can we continue to trust vaccinations and the people that give them?**

This is not a vaccine failure, it is a systems problem (preparation error). Vaccines need to be prepared following a strict process including second checking, to make sure all steps have been done correctly.

Vaccination are still the most effective way to protect people from Covid 19. When we discovered the error, we contacted you immediately and always would if anything has occurred that might make a vaccine less effective.

- **Can I be tested to see if I've gained immunity – either now or in the future.**

Testing is not routinely available for Covid 19 immunity.

Can I make a complaint to someone?

Yes, you can make a complaint to the Health and Disability Commission (HDC) as is your right as a health service consumer. If you would you like to discuss this further with the Practice Manager they can provide information on how to make an official complaint to the HDC.

Kathleen Smitheram

From: Haidee Scott
Sent: Thursday, 22 July 2021 3:16 PM
To: 9(2)(a) ; 9(2)(a) ; Karalyn van Deursen
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation
Attachments: Phone script for saline vaccination.docx; Letter for saline vaccination.docx; FAQs saline vaccination.docx

Draft documents attached for review (thanks Carol!), will work on the media statement now

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

Be a **DOER!**
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The stronger our immunity, the stronger our community

Double Up

Phone script for calling people who were vaccinated with saline

Hi [name]

I'm calling to talk to you about your COVID-19 vaccination you received at 9(2)(a) Wigram on Wednesday the 14th July.

Unfortunately, because of an error, you are one of six people who received a dose of saline that day, instead of a saline and Pfizer vaccine mix.

We identified this error at the end of the clinic on the 14th when we found an additional vial of Pfizer vaccine.

We have sought advice from IMAC, or the Immunisation Advisory Centre, and I want to reassure you that there are absolutely no safety concerns. You will unfortunately be inconvenienced, because we now need to book you in for a dose of the vaccine.

We have also reviewed our processes for preparing vaccines and made sure additional checking takes place to make sure this does not happen again.

I'm really sorry about this, and I'm sorry about the inconvenience this causes you.

[can we offer a $20 petrol voucher??]

Can I book you in?

[Date]
[Name]
[Address line 1]
[Address line 2]

Dear [Name]

Re: Pfizer vaccine preparation error

You were scheduled to receive your [number of doses] dose[s] of the Pfizer-BioNTech COVID 19 vaccine, at Wigram 9(2)(a) on Wednesday July 14.

At the end of the day's vaccination clinic we identified an error was made when drawing up the vaccine, which resulted in you receiving a dose of saline, without the vaccine.

We have sought advice from our Ministry of Health, the Immunisation Advisory Centre (IMAC) and our Medical Officer of Health. They have advised that re-immunisation is recommended.

We are sincerely sorry for any distress and inconvenience this may cause you.

Further expert guidance from our Immunisation Co-ordinator and the IMAC advises that there are no safety concerns expected from this error.

We have reviewed our vaccine management processes and are confident that we can ensure that we prepare vaccines correctly.

If you would you like to discuss this further, please contact [who and how?].

You are welcome to make an appointment for the repeat immunisation at Wigram 9(2)(a) or an alternate location if you would prefer.

You can book your appointment online: https://book.vaccine.covid19.health.nz or by calling 0800 28 29 26 and providing your code 9(2)(a).

Yours sincerely

[signature]

[name]

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Unite against COVID-19

Possible Questions:

- **Should we wait a certain length of time before coming back in for re-vaccination?**

No, because the vaccine dose(s) you received did not contain vaccine.

- **Will I have to pay for my vaccination again?**

No, the re-vaccination is free.

- **What if I choose not to have my vaccination repeated?**

The expert advice given to us from IMAC is that you should have it repeated, as you would not have received any protection from the injection you received.

- **I really don't want to have to go through the trauma of having the vaccine again.**

We understand that, however, according to expert advice it is important for you to have the vaccine(s) again to ensure you are best protected against Covid 19

- **How can we trust the re-vaccination and can we be sure it won't happen again in future?**

As a service we have worked hard to ensure that vaccines are managed and prepared safely here, and failures in preparing vaccines are consequently very rare. The issue was quickly identified by our nursing team and we have informed you as quickly as possible to take corrective action to ensure you receive a valid dose of the vaccine for your protection against COVID-19.

- **How did this happen, don't you take care when preparing vaccines?**

There are many steps required when preparing the Pfizer vaccine. Unfortunately, in this instance, one vial of vaccine was not placed into a tray with the syringes that were used to administer it. This resulted in .....?

- **Can we continue to trust vaccinations and the people that give them?**

This is not a vaccine failure, it is a systemic problem (preparation error). Vaccines must be prepared following a strict process including second checking, to make sure all steps are done correctly.

Vaccination is still the most effective way to protect people from COVID-19.

When we discovered our error, we contacted you as soon as possible. You can trust that we will always notify our patients if anything occurs that might make their vaccine less effective, and to rectify the issue as quickly as we can.

- **Can I be tested to see if I've gained immunity – either now or in the future.**

Testing is not routinely available for COVID-19 immunity in New Zealand.

Can I make a complaint to someone?

Yes, you can make a complaint to the Health and Disability Commission (HDC). If you would like to pursue this, the Practice Manager can provide information on how to make an official complaint to the HDC.

Kathleen Smitheram

From: Haidee Scott
Sent: Thursday, 22 July 2021 3:50 PM
To: Alex Taylor (Communications)
Cc: Karalyn van Deursen; 9(2)(a)
Subject: Wigram 9(2)(a) draft statement

Hi Alex, would you be so kind to work some magic on the below?

Six people were injected with only saline recently, instead of the required Pfizer vaccine and saline mix, at 9(2)(a) Health Wigram, a vaccination clinic in Christchurch.

The error was picked up at the end of the day when staff were carrying out a stocktake and identified they had an extra vial of vaccine.

Staff immediately notified Canterbury DHB and a comprehensive investigation was undertaken.

[Quote here from someone about the clinics outstanding record keeping, which allowed us to pinpoint the six people affected out of the 77 vaccinated that day].

There is no health risk to the affected individuals. Canterbury DHB has contacted and apologised to all six people, who have all booked re-vaccination appointments.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
Mob 9(2)(a)
Email: haidee.scott@cdhb.health.nz
www.vaccinateCanterburyWestCoast.nz

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Kathleen Smitheram

From: Karalyn van Deursen
Sent: Thursday, 22 July 2021 7:47 PM
To: Alex Taylor (Communications)
Cc: Haidee Scott; 9(2)(a) [redacted]; Mick O'Donnell
Subject: Re: Wigram 9(2)(a) [redacted] draft statement

A tweak below - but happy to look at the final final tomoz.

Karalyn van Deursen

Executive Director, Communications
Canterbury & West Coast District Health Boards
Phone 03 364 4103
027 531 4796

On 22/07/2021, at 4:58 PM, Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz> wrote:

Suggest something along the lines of this?

Haidee can you help with gaps?

KVD to have input tomorrow, before this goes any further please.

Robust audit processes identify vaccination error

Canterbury DHB is today confirming that a COVID-19 vaccination error occurred at a primary care clinic earlier this month.

On 14 July, XX people attended a COVID-19 vaccination clinic at 9(2)(a) [redacted] Health Wigram.

At the end of the clinic when staff were carrying out a routine audit and stocktake of the doses administered throughout the day, it was identified that there was an extra vial of vaccine leftover. This meant six doses administered only contained the diluent (saline) solution.

Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).
Thanks to the robust and thorough processes in place at 9(2)(a) [redacted] Health Wigram, we were able to identify that (description of how it occurred). Therefore, the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

XXX, job title, says while this is far from ideal and the affected individuals will need to COME BACK IN TO BE VACCINATED **()be re-vaccinated with a proper dose) We are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the XX doses provided that day, is a testament to the training provided to vaccinators and the robust processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says XXX.

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Double Up

[redacted]

From: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>
Sent: Friday, 23 July 2021 9:32 AM
To: 9(2)(a) @gmail.com>
Cc: 9(2)(a) [redacted]
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi 9(2)(a)
Thanks. That sounds good, I have affected patient details which I will send to you and 9(2)(a)

Thinking process for contacting GP's and amending CIR can be started ASAP. Then we will be ready to proceed with contacting patients when all aspects are sorted there.
Plan is for booking team to contact patients directly for rebooking.

Happy to discus

Thanks
Cathy

Kathleen Smitheram

From: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>
Sent: Friday, 23 July 2021 2:10 PM
To: 9(2)(a) ; Haidee Scott; 9(2)(a)
Cc: 9(2)(a)
9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Thanks 9(2)(a)- yes agree re privacy, I have restricted access to the spreadsheet. If anyone requires access please let me know and I can add

From 9(2)(a) @pegasus.org.nz>
Sent: Friday, 23 July 2021 12:18 PM
To: 9(2)(a) @siapo.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Would it be useful to upload the Incident report into the same folder that the spreadsheet is currently? I can't find it on your teams' site so not sure where it sits. I have copies and am happy to upload.

9(2)(g)(i) . I would like to suggest that we move the Spreadsheet to a more private place that only 9(2)(a) and I can access to remove the potential confidentiality risk.

Ngā mihi

9(2)(a)

From: 9(2)(a) @siapo.health.nz>
Sent: Friday, 23 July 2021 10:42 am
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi Haidee, those who can give more info on what went wrong will be either Carol or 9(Carol is at PMH today. The signature should come from a senior clinician. Hope this helps.

9(2)(a)

From: Haidee Scott
Sent: Friday, 23 July 2021 10:15 AM

To: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
[redacted] [EXTERNAL SENDER]

Hi all, updated documents attached. Also stored in Teams here.

Please note, we're still missing:
- A person to sign the letter and be quoted in Alex's media statement
- A clear description of what went wrong.

Could someone please advise?

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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Double Up
[redacted]

Out of Scope

[redacted]

---------- Forwarded message ---------
From: 9(2)(a) [redacted] @pegasus.org.nz>
Date: Fri, Jul 23, 2021 at 2:41 PM
Subject: COVID vaccine incident
To: 9(2)(a) [redacted] 9(2)(a) [redacted] 9(2)(a) [redacted] @wigramhealth.co.nz>
Cc: 9(2)(a) [redacted] @gmail.com>

Kia ora

We have received the Ministry of Health management plan for the recent vaccine incident at your clinic. There are a few components to the plan, and we would like to engage with you on the next steps.

1. Contact the six individuals to inform them of the vaccine error, apologise and arrange rebooking. This should be done by a senior clinical person by the end of Monday 26 July 2021. We feel that this would be best coming from your team but are happy to take your advice on who you suggest should do this?
2. Follow up the phone call with a letter. We have a script available for the letter and the phone call. Again, we feel that this would be best coming from you but should come from the same organisation as the phone call.
3. Note in the patient file that they were given Saline not vaccine and remedial action implemented. I will work with our CIR advisor to do this as it involves accessing past CIR records.
4. Contact patients' GPs if not Wigram patients. We could do this either on your behalf or from the programme (this would allow the practice to be anonymous).
5. Prepare a draft media release should we be asked to comment about the matter – CDHB Communications lead is working on this, and we will share with you as soon as available. CDHB team would manage all media communications.
6. Provide feedback to staff at the clinic. How do you want to do this or are you happy with the level of feedback given to your nursing team already?

I want to again commend your team on the handling of this incident. Their documentation of the vaccines given was so detailed that finding the affected people was very easy. Your team was also approachable and able to provide all the information that we requested in a timely manner. We acknowledge that errors can happen and thank your team for reporting this early and assisting us with the investigation.

Ngā mihi nui

9(2)(a)

9(2)(a)

Pegasus Health (Charitable) Ltd

P: 9(2)(a)

E: 9(2)(a)

401 Madras Street, Christchurch 8013

PO Box 741, Christchurch 8140

Kathleen Smitheram

From: John Hewitt <john.hewitt@cdhb.health.nz>
Sent: Friday, 23 July 2021 10:57 AM
To: Cathy Rewiri
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

I do not have access to this.
J

From: Cathy Rewiri
Sent: Friday, 23 July 2021 10:51 AM
To: 9(2)(a) @siapo.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi all
Spreadsheet with affected patients in teams and can be used to track completed steps i.e GP contact, phone call, letter
Please let me know if you need to access and can't

Thanks
Cathy

Double Up

Kathleen Smitheram

From: John Hewitt <john.hewitt@cdhb.health.nz>
Sent: Friday, 23 July 2021 1:49 PM
To: Cathy Rewiri
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Yep I can still see it

From: Cathy Rewiri
Sent: Friday, 23 July 2021 1:48 PM
To: John Hewitt <john.hewitt@cdhb.health.nz>
Subject: FW: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi – can you do me a favour, trying to restrict access to this – can you check if you can still open via this link

9(2)(a) [redacted]

thnx

From: Cathy Rewiri
Sent: Friday, 23 July 2021 11:10 AM
To: John Hewitt <john.hewitt@cdhb.health.nz>
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

9(2)(a) [redacted]

Double Up [redacted]

Back pocket questions and answers

Should we wait a certain length of time before coming back in for re-vaccination?

No, there's no need because the vaccine dose(s) you received did not contain vaccine.

Will I have to pay for my vaccination?

No, the vaccine is free.

What if I choose not to have my vaccination repeated?

The expert advice given to us from IMAC, or the Immunisation Advisory Centre, is that we should get you booked in to get a dose of the vaccine, as you will not have received any protection from the injection you received.

I really don't want to have to go through the trauma of being injected again.

I understand that completely. However, given IMAC's advice it is important that you receive a dose of the vaccine to ensure you are best protected against COVID-19

How can I trust that I'll actually get a dose of the vaccine at my next appointment? How can you be sure it won't happen again in future?

We've worked hard to make sure that vaccines are managed and prepared safely here, and as a result, failures in preparing vaccines are very rare.

The error was quickly identified by our nursing team and we've informed you as quickly as possible following getting advice from IMAC to take corrective action to make sure you receive a dose of the vaccine for your protection against COVID-19.

How did this happen, don't you take care when preparing vaccines?

There are many steps required when preparing the Pfizer vaccine. Unfortunately, in this instance, one vial of vaccine was not placed into a tray with the syringes that were used to administer it. This resulted in .....?

Can we continue to trust vaccinations and the people that give them?

This was not a vaccine failure, it was a systemic error, or preparation error. Vaccines must be prepared following a strict process including second checking, to make sure all steps are done correctly.

Vaccination is still the most effective way to protect people from COVID-19.

When we discovered our error, we contacted you as soon as possible after getting expert advice from IMAC. You can trust that we'll always notify our patients if anything occurs that might make their vaccine less effective, and to fix the problem as quickly as we can.

Can I be tested to see if I've gained immunity – either now or in the future?

Testing is not routinely available for COVID-19 immunity in New Zealand.

Can I make a complaint to someone?

Yes, you can speak with the managers at 9(2)(a) Wigram or you can make a complaint to the Health and Disability Commission (HDC).

You can call 9(2)(a) Wigram on 9(2)(a) and ask to speak with ....?

You can contact the Health and Disability Commission local advocacy service on 0800 555 050 or the Health and Disability Commissioner on 0800 11 22 33.

[Date]
[Name]
[Address line 1]
[Address line 2]

Dear [Name]

Re: Pfizer vaccine preparation error

You were scheduled to receive your [number of doses] dose[s] of the Pfizer-BioNTech COVID 19 vaccine, at Wigram 9(2)(a) on Wednesday July 14.

At the end of the day's vaccination clinic we identified an error was made when drawing up the vaccine, which resulted in you receiving a saline injection, instead of a vaccine dose.

We are sincerely sorry for any distress and inconvenience this may cause you.

We have sought advice from our Ministry of Health, the Immunisation Advisory Centre (IMAC) and our Medical Officer of Health. They have recommended that we book you in as soon as possible to receive a dose of the vaccine.

Further expert guidance from our Immunisation Co-ordinator and the IMAC advises that there are no safety concerns expected from this error.

We have reviewed our vaccine management processes and are confident that we can ensure that we prepare vaccines correctly.

If you would you like to discuss this further, please contact [who and how?].

We'll contact you by phone, if we haven't already, to arrange an appointment for you to receive a dose of the vaccine.

Yours sincerely

[signature]

[name]

Media statement

Robust audit processes identify vaccination error

Canterbury DHB is today confirming that a COVID-19 vaccination error occurred at a primary care clinic earlier this month.

On 14 July, 77 people attended a COVID-19 vaccination clinic at 9(2)(a) Wigram.

At the end of the clinic when staff were carrying out a routine audit and stocktake of the doses administered throughout the day, it was identified that there was an extra vial of vaccine leftover. This meant six doses administered only contained the diluent (saline) solution.

Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).

Thanks to the robust and thorough processes in place at 9(2)(a) Wigram, we were able to identify that (description of how it occurred). Therefore, the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

9(2)(a), primary health care clinical director for Canterbury's COVID-19 vaccination programme, says while this is far from ideal and the affected individuals will need to come back in to be vaccinated, we are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the 77 doses provided that day, is a testament to the training provided to vaccinators and the robust processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says 9(2)(a)

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Phone script for calling people who were vaccinated with saline

Hi [name]

I'm calling to talk to you about your COVID-19 vaccination appointment at 9(2)(a) Wigram on Wednesday the 14th July.

I'm sorry to advise you that because of an error, you are one of six people who was injected with saline that day, instead of a saline and Pfizer vaccine mix.

I'm really sorry about this.

We identified this error at the end of the clinic on the 14th when we found an additional vial of Pfizer vaccine.

We've sought advice from IMAC, or the Immunisation Advisory Centre, and I want to reassure you that there are absolutely no safety concerns. You will of course be inconvenienced, because we now need to book you in for a dose of the vaccine.

We've reviewed our processes for preparing vaccines and made sure additional checking takes place to make sure this does not happen again.

Again, we're really sorry about this, and I apologise for the inconvenience this causes you.

[can we offer a $20 petrol voucher??]

I'll arrange for our booking team to give you a call to book in your appointment as soon as possible. What's the best time and number to contact you on please?

Kathleen Smitheram

From: Cheryl Brunton
Sent: Friday, 23 July 2021 9:12 AM
To: Haidee Scott; Jane Cartwright; 9(2)(a) ; Karalyn van Deursen
Cc: Cathy Rewiri; ECC Controller (CDHB); Carol McSweeney; 9(2)(a) @pegasus.org.nz); 9(2)(a) John Hewitt; 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation

Kia ora koutou

Sorry to be a pedant but none of these people were vaccinated with saline -they were given a saline injection instead of a vaccine dose. Along the same lines, we are not inviting them to be re-vaccinated because they haven't actually been vaccinated yet. We are inviting them to receive their first dose of actual vaccine. They will need two doses in total as the first "dose" of saline doesn't count immunity-wise.

Our communication should convey this to avoid any confusion about what vaccination actually means (i.e. the administration of a vaccine)

Cheers, Cheryl

Dr Cheryl Brunton
Medical Officer of Health/Āpiha Hauora o te Hauora
Community and Public Health/Te Mana Ora
Canterbury District Health Board/Te Poari Hauora ō Waitaha
PO Box 1475
310 Manchester Street
Christchurch/Ōtautahi

Phone 03 364 1777

From: Haidee Scott
Sent: Thursday, 22 July 2021 3:16 PM
To: 9(2)(a) @siapo.health.nz>; Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation

Draft documents attached for review (thanks Carol!), will work on the media statement now

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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Double Up

Kathleen Smitheram

From: Cheryl Brunton
Sent: Friday, 23 July 2021 9:39 AM
To: Haidee Scott; 9(2)(a) ; Karalyn van Deursen
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation

If that's the case then re-vaccination is correct term.

From: Haidee Scott
Sent: Friday, 23 July 2021 9:30 AM
To: Cheryl Brunton <Cheryl.Brunton@cdhb.health.nz>; 9(2)(a) @siapo.health.nz>; Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation

Thanks heaps Cheryl. I'm updating our docs now with everyone's feedback that's been sent through.

My understanding is that some of the people have already had a first dose.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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Double Up

Kathleen Smitheram

From: Cathy Rewiri
Sent: Friday, 23 July 2021 11:24 AM
To: Haidee Scott; 9(2)(a)
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Thanks- here's the link 9(2)(a)

From: Haidee Scott
Sent: Friday, 23 July 2021 11:13 AM
To: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>9(2)(a) @siapo.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Cathy I think that link is blank

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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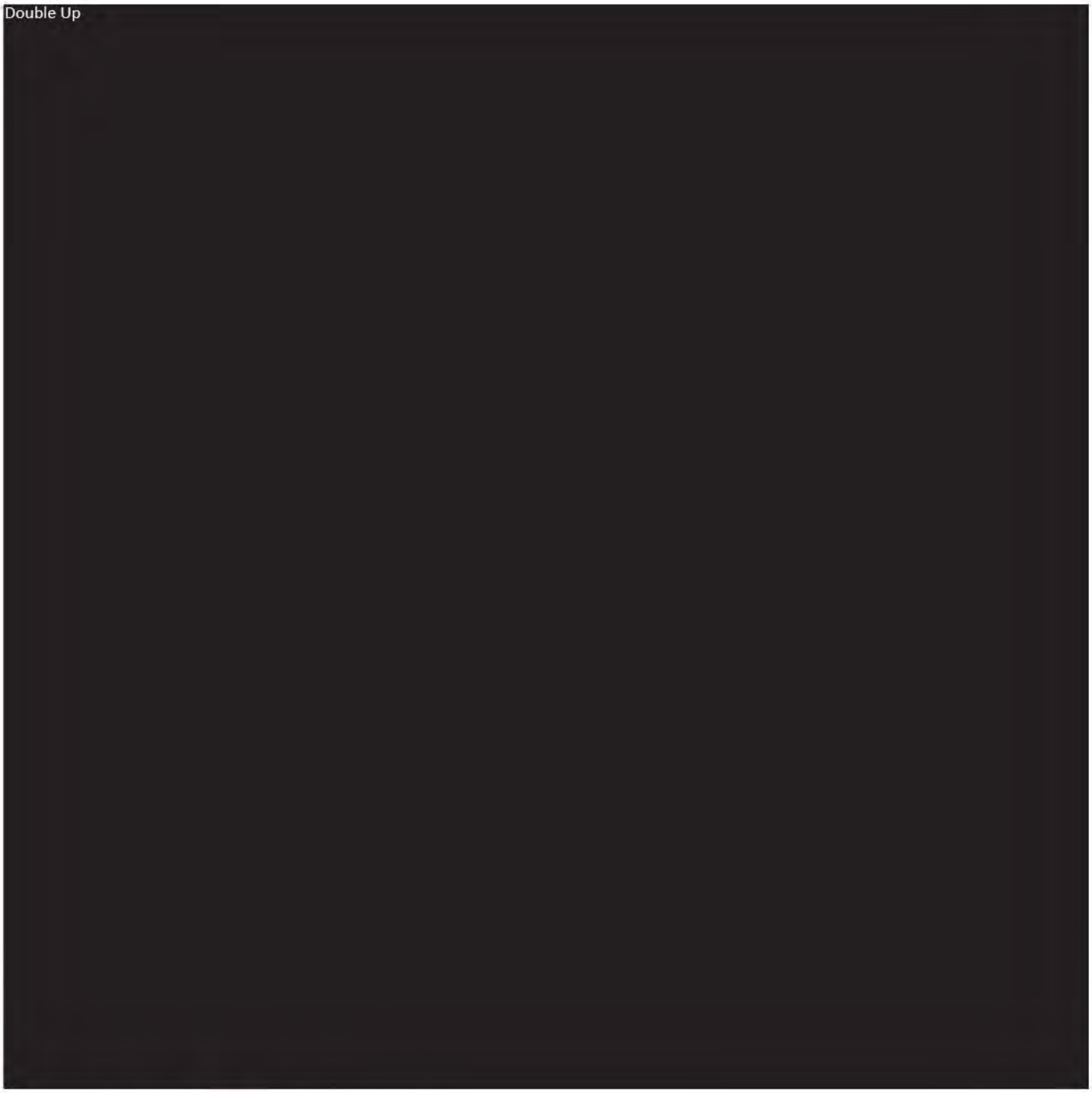
From: Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>
Sent: Friday, 23 July 2021 10:51 AM
To: 9(2)(a) @siapo.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>9(2)(a) @gmail.com>
9(2)(a)
Subject: RE: follow up9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi all

Spreadsheet with affected patients in teams and can be used to track completed steps i.e GP contact, phone call, letter
Please let me know if you need to access and can't

Thanks
Cathy



Be a **DOER!**
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Kathleen Smitheram

From: Cathy Rewiri
Sent: Friday, 23 July 2021 2:10 PM
To: 9(2)(a) ; Haidee Scott; 9(2)(a)
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Thanks 9(2)(a) - yes agree re privacy, I have restricted access to the spreadsheet. If anyone requires access please let me know and I can add

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9(2)(g)(i)

9(2)(g)(i) . I would like to suggest that we move the Spreadsheet to a more private place that only Hannah and I can access to remove the potential confidentiality risk.

Ngā mihi

9(2)(a)

Double Up

Back pocket questions and answers

Should we wait a certain length of time before coming back in for re-vaccination?

No, there's no need because the vaccine dose(s) you received did not contain vaccine.

Will I have to pay for my vaccination?

No, the vaccine is free.

What if I choose not to have my vaccination repeated?

The expert advice given to us from IMAC, or the Immunisation Advisory Centre, is that we should get you booked in to get a dose of the vaccine, as you will not have received any protection from the injection you received.

I really don't want to have to go through the trauma of being injected again.

I understand that completely. However, given IMAC's advice it is important that you receive a dose of the vaccine to ensure you are best protected against COVID-19

How can I trust that I'll actually get a dose of the vaccine at my next appointment? How can you be sure it won't happen again in future?

We've worked hard to make sure that vaccines are managed and prepared safely here, and as a result, failures in preparing vaccines are very rare.

The error was quickly identified by our nursing team and we've informed you as quickly as possible following getting advice from IMAC to take corrective action to make sure you receive a dose of the vaccine for your protection against COVID-19.

How did this happen, don't you take care when preparing vaccines?

There are many steps required when preparing the Pfizer vaccine. Unfortunately, in this instance, one vial of vaccine was not placed into a tray with the syringes that were used to administer it. This resulted in .....?

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Can I be tested to see if I've gained immunity – either now or in the future?

Testing is not routinely available for COVID-19 immunity in New Zealand.

Can I make a complaint to someone?

Yes, you can speak with the managers at 9(2)(a) Wigram or you can make a complaint to the Health and Disability Commission (HDC).

You can call 9(2)(a) Wigram on 9(2)(a) and ask to speak with ....?

You can contact the Health and Disability Commission local advocacy service on 0800 555 050 or the Health and Disability Commissioner on 0800 11 22 33.

[Date]
[Name]
[Address line 1]
[Address line 2]

Dear [Name]

Re: Pfizer vaccine preparation error

You were scheduled to receive your [number of doses] dose[s] of the Pfizer-BioNTech COVID 19 vaccine, at Wigram 9(2)(a) on Wednesday July 14.

At the end of the day's vaccination clinic we identified an error was made when drawing up the vaccine, which resulted in you receiving a saline injection, instead of a vaccine dose.

We are sincerely sorry for any distress and inconvenience this may cause you.

We have sought advice from our Ministry of Health, the Immunisation Advisory Centre (IMAC) and our Medical Officer of Health. They have recommended that we book you in as soon as possible to receive a dose of the vaccine.

Further expert guidance from our Immunisation Co-ordinator and the IMAC advises that there are no safety concerns expected from this error.

We have reviewed our vaccine management processes and are confident that we can ensure that we prepare vaccines correctly.

If you would you like to discuss this further, please contact [who and how?].

We'll contact you by phone, if we haven't already, to arrange an appointment for you to receive a dose of the vaccine.

Yours sincerely

[signature]

[name]

Media statement

Robust audit processes identify vaccination error

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Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).

Thanks to the robust and thorough processes in place at 9(2)(a) Wigram, we were able to identify that (description of how it occurred). Therefore, the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

9(2)(a), primary health care clinical director for Canterbury's COVID-19 vaccination programme, says while this is far from ideal and the affected individuals will need to come back in to be vaccinated, we are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the 77 doses provided that day, is a testament to the training provided to vaccinators and the robust processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says 9(2)(a).

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Phone script for calling people who were vaccinated with saline

Hi [name]

I'm calling to talk to you about your COVID-19 vaccination appointment at 9(2)(a) Wigram on Wednesday the 14th July.

I'm sorry to advise you that because of an error, you are one of six people who was injected with saline that day, instead of a saline and Pfizer vaccine mix.

I'm really sorry about this.

We identified this error at the end of the clinic on the 14th when we found an additional vial of Pfizer vaccine.

We've sought advice from IMAC, or the Immunisation Advisory Centre, and I want to reassure you that there are absolutely no safety concerns. You will of course be inconvenienced, because we now need to book you in for a dose of the vaccine.

We've reviewed our processes for preparing vaccines and made sure additional checking takes place to make sure this does not happen again.

Again, we're really sorry about this, and I apologise for the inconvenience this causes you.

[can we offer a $20 petrol voucher??]

I'll arrange for our booking team to give you a call to book in your appointment as soon as possible. What's the best time and number to contact you on please?

Out of Scope

[redacted]

From: Haidee Scott
Sent: Friday, 23 July 2021 3:43 PM
To: 9(2)(a) pegasus.org.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Excellent, thanks both so much! Will add in to those documents sent around earlier.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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From: 9(2)(a) @pegasus.org.nz>
Sent: Friday, 23 July 2021 3:40 PM
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>; Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Subject: Re: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Have added one small line at the end

Get Outlook for Android

From: Haidee Scott <Haidee.Scott@cdhb.health.nz>
Sent: Friday, 23 July 2021, 3:21 pm
To: Carol McSweeney; 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Okay. Here's my take on it! Does this sound right?

During the drawing up process, vaccine vials are usually placed into the tray along with the syringes that were used to draw up the vaccine from the vial.

In this instance, one vaccine vial was not placed into its tray. The nurses drawing up then used it for the next set of syringes, thinking it was a fresh vial. This resulted in some patients receiving normal saline without vaccine.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Friday, 23 July 2021 12:26 PM
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>
Cc: 9(2)(a) @pegasus.org.nz>
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi Haidee
Can I call you, or you call me and I'll talk you through it ☺ and we can go from there??

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a)
carol.mcsweeney@cdhb.health.nz

From: Haidee Scott
Sent: Friday, 23 July 2021 12:25 PM
To: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>; 9(2)(a) pegasus.org.nz>; 9(2)(a) @siapo.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Sorry 9(2)(a) Carol, but the incident form doesn't clarify anything for me at all.

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

From: Carol McSweeney <Carol.McSweeney@cdhb.health.nz>
Sent: Friday, 23 July 2021 12:24 PM
To: 9(2)(a) @pegasus.org.nz>9(2)(a) siapo.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) @gmail.com>
Cc: 9(2)(a)
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Hi
I agree with 9(2) comments.
Haidee, come back to us if you need any clarification about description.

Regards

Carol McSweeney
Nurse Consultant Immunisation
CDHB Covid Vaccination Programme
9(2)(a)
carol.mcsweeney@cdhb.health.nz

Canterbury & West Coast DHBs
COVID-19 Vaccination Programme

Unite against COVID-19

From: [redacted] 9(2)(a) [redacted]@pegasus.org.nz>
Sent: Friday, 23 July 2021 12:20 PM
To: 9(2)(a) [redacted]@siapo.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>; Cathy Rewiri <Cathy.Rewiri@cdhb.health.nz>; 9(2)(a) [redacted]@gmail.com>
9(2)(a) [redacted]
Subject: RE: follow up 9(2)(a) [redacted] Wigram investigation [EXTERNAL SENDER]

Oops forgot to add. Carol and I were talking about the request from Haidee for more information re the Incident. We both feel that by sharing the Incident form Haidee can hopefully get the information from there.

Double Up [redacted]

Kathleen Smitheram

From: Haidee Scott <Haidee.Scott@cdhb.health.nz>
Sent: Monday, 26 July 2021 10:45 AM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: RE: URGENT [EXTERNAL SENDER]
Attachments: 210723 phone script_saline injection.docx; 210723 back pocket Q&As_saline injection.docx

Here you go 9(2)(a) – best of luck, let us know how you get on!

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

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From: 9(2)(a) @pegasus.org.nz>
Sent: Monday, 26 July 2021 10:38 AM
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>
Cc: 9(2)(a) 9(2)(a)
Subject: FW: URGENT [EXTERNAL SENDER]
Importance: High

Kia ora Haidee

Can you please send through the scripts that you would like 9(2)(a) to use?

9(2)(a) Haidee is the CDHB Communications Lead who will be your key contact for media etc.

Ngā mihi

9(2)(a)

From: 9(2)(a) 9(2)(a)
Sent: Monday, 26 July 2021 9:25 am
To: 9(2)(a) @pegasus.org.nz>
Subject: URGENT
Importance: High

Hi 9(2)(a)

Could you please send through the script supplied by the MoH for 9(2)(a) to use when contacting patients today.

Kind regards

9(2)(a)

9(2)(a)

Phone script for calling people who were vaccinated with saline

Hi [name]

I'm calling to talk to you about your COVID-19 vaccination appointment at 9(2)(a) Wigram on Wednesday the 14th July.

I'm sorry to advise you that because of an error, you are one of six people who was injected with saline that day, instead of a saline and Pfizer vaccine mix.

I'm really sorry about this.

We identified this error at the end of the clinic on the 14th when we found an additional vial of Pfizer vaccine.

We've sought advice from IMAC, or the Immunisation Advisory Centre, and I want to reassure you that there are absolutely no safety concerns. You will of course be inconvenienced, because we now need to book you in for a dose of the vaccine.

We've reviewed our processes for preparing vaccines and made sure additional checking takes place to make sure this does not happen again.

Again, we're really sorry about this, and I apologise for the inconvenience this causes you.

I'll arrange for our booking team to give you a call to book in your appointment as soon as possible. What's the best time and number to contact you on please?

Back pocket questions and answers

Should we wait a certain length of time before coming back in for re-vaccination?

No, there's no need because the vaccine dose(s) you received did not contain vaccine.

Will I have to pay for my vaccination?

No, the vaccine is free.

What if I choose not to have my vaccination repeated?

The expert advice given to us from IMAC, or the Immunisation Advisory Centre, is that we should get you booked in to get a dose of the vaccine, as you will not have received any protection from the injection you received.

I really don't want to have to go through the trauma of being injected again.

I understand that completely. However, given IMAC's advice it is important that you receive a dose of the vaccine to ensure you are best protected against COVID-19

How can I trust that I'll actually get a dose of the vaccine at my next appointment? How can you be sure it won't happen again in future?

We've worked hard to make sure that vaccines are managed and prepared safely here, and as a result, failures in preparing vaccines are very rare.

The error was quickly identified by our nursing team and we've informed you as quickly as possible following getting advice from IMAC to take corrective action to make sure you receive a dose of the vaccine for your protection against COVID-19.

How did this happen, don't you take care when preparing vaccines?

There are many steps required when preparing the Pfizer vaccine. During the drawing up process, vaccine vials are usually placed into the tray along with the syringes that were used to draw up the vaccine from the vial.

In this instance, one vaccine vial was not placed into its tray. The nurses drawing up then used it for the next set of syringes, thinking it was a fresh vial. This resulted in some patients receiving normal saline without vaccine.

Can we continue to trust vaccinations and the people that give them?

This was not a vaccine failure, it was a systemic error, or preparation error. Vaccines must be prepared following a strict process including second checking, to make sure all steps are done correctly.

Vaccination is still the most effective way to protect people from COVID-19.

When we discovered our error, we contacted you as soon as possible after getting expert advice from IMAC. You can trust that we'll always notify our patients if anything occurs that might make their vaccine less effective, and to fix the problem as quickly as we can.

Can I be tested to see if I've gained immunity – either now or in the future?

Testing is not routinely available for COVID-19 immunity in New Zealand.

Can I make a complaint to someone?

Yes, you can speak with the managers at 9(2)(a) Wigram or you can make a complaint to the Health and Disability Commission (HDC).

You can call 9(2)(a) Wigram on 9(2)(a) and ask to speak with ....?

You can contact the Health and Disability Commission local advocacy service on 0800 555 050 or the Health and Disability Commissioner on 0800 11 22 33.

Karalyn van Deursen

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 27 July 2021 9:00 AM
To: Karalyn van Deursen
Subject: Update[EXTERNAL SENDER]

Hi Karalyn,
Any update on the status of the IMAC report or any comms you've done on the Wigram issue? Regards, 9(2)

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 9:24 AM
To: 9(2)(a)
Subject: RE: Update[EXTERNAL SENDER]

Yes! I can sent you the draft comms – people are being called this week.
9(2)(g)(i)

kvd

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 27 July 2021 9:00 AM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: Update[EXTERNAL SENDER]

Hi Karalyn,
Any update on the status of the IMAC report or any comms you've done on the Wigram issue? Regards, 9(2)

Media statement

Robust audit processes identify vaccination error

Canterbury DHB is today confirming that a COVID-19 vaccination error occurred at a primary care clinic earlier this month.

On 14 July, 77 people attended a COVID-19 vaccination clinic at 9(2)(a) Wigram.

At the end of the clinic when staff were carrying out a routine audit and stocktake of the doses administered throughout the day, it was identified that there was an extra vial of vaccine leftover. This meant six doses administered only contained the diluent (saline) solution.

Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).

During the drawing up process, vaccine vials are usually placed into the tray along with the syringes that were used to draw up the vaccine from the vial. Thanks to the robust and thorough processes in place at 9(2)(a) Wigram, we were able to identify that one vaccine vial was not placed into its tray. The nurses drawing up then used it for the next set of syringes, thinking it was a fresh vial. This resulted in some patients receiving normal saline without vaccine.

Therefore, the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

9(2)(a), primary health care clinical director for Canterbury's COVID-19 vaccination programme, says while this is far from ideal and the affected individuals will need to come back in to be vaccinated, we are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the 77 doses provided that day, is a testament to the training provided to vaccinators and the robust processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says 9(2)(a).

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 9:28 AM
To: 9(2)(a)
Subject: FW: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]
Attachments: 210723 back pocket Q&As_saline injection.docx; 210723 letter_saline injection.docx; 210723 media statement_saline injection.docx; 210723 phone script_saline injection.docx

Other bits and pieces which I need to review.

Kvd

Ngā mihi

Karalyn van Deursen
Executive Director Communications
Canterbury and West Coast District Health Boards
Corporate Office, 32 Oxford Terrace, Christchurch
T: +64 3 364 4103 or ext. 62103| M: 027 531 4796

Our Values – *Ā mātou uara*
Care and respect for others – *Manaaki me te kotua i ētahi*
Integrity in all we do – *Hāpai i ā mātou mahi*
Responsibility for outcomes - *Kaiwhakarite i kā hua*

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Back pocket questions and answers

Should we wait a certain length of time before coming back in for re-vaccination?

No, there's no need because the vaccine dose(s) you received did not contain vaccine.

Will I have to pay for my vaccination?

No, the vaccine is free.

What if I choose not to have my vaccination repeated?

The expert advice given to us from IMAC, or the Immunisation Advisory Centre, is that we should get you booked in to get a dose of the vaccine, as you will not have received any protection from the injection you received.

I really don't want to have to go through the trauma of being injected again.

I understand that completely. However, given IMAC's advice it is important that you receive a dose of the vaccine to ensure you are best protected against COVID-19

How can I trust that I'll actually get a dose of the vaccine at my next appointment? How can you be sure it won't happen again in future?

We've worked hard to make sure that vaccines are managed and prepared safely here, and as a result, failures in preparing vaccines are very rare.

The error was quickly identified by our nursing team and we've informed you as quickly as possible following getting advice from IMAC to take corrective action to make sure you receive a dose of the vaccine for your protection against COVID-19.

How did this happen, don't you take care when preparing vaccines?

There are many steps required when preparing the Pfizer vaccine. Unfortunately, in this instance, one vial of vaccine was not placed into a tray with the syringes that were used to administer it. This resulted in .....?

Can we continue to trust vaccinations and the people that give them?

This was not a vaccine failure, it was a systemic error, or preparation error. Vaccines must be prepared following a strict process including second checking, to make sure all steps are done correctly.

Vaccination is still the most effective way to protect people from COVID-19.

When we discovered our error, we contacted you as soon as possible after getting expert advice from IMAC. You can trust that we'll always notify our patients if anything occurs that might make their vaccine less effective, and to fix the problem as quickly as we can.

Can I be tested to see if I've gained immunity – either now or in the future?

Testing is not routinely available for COVID-19 immunity in New Zealand.

Can I make a complaint to someone?

Yes, you can speak with the managers at 9(2)(a) Wigram or you can make a complaint to the Health and Disability Commission (HDC).

You can call 9(2)(a) Wigram on 9(2)(a) and ask to speak with ....?

You can contact the Health and Disability Commission local advocacy service on 0800 555 050 or the Health and Disability Commissioner on 0800 11 22 33.

[Date]
[Name]
[Address line 1]
[Address line 2]

Dear [Name]

Re: Pfizer vaccine preparation error

You were scheduled to receive your [number of doses] dose[s] of the Pfizer-BioNTech COVID 19 vaccine, at Wigram 9(2)(a) on Wednesday July 14.

At the end of the day's vaccination clinic we identified an error was made when drawing up the vaccine, which resulted in you receiving a saline injection, instead of a vaccine dose.

We are sincerely sorry for any distress and inconvenience this may cause you.

We have sought advice from our Ministry of Health, the Immunisation Advisory Centre (IMAC) and our Medical Officer of Health. They have recommended that we book you in as soon as possible to receive a dose of the vaccine.

Further expert guidance from our Immunisation Co-ordinator and the IMAC advises that there are no safety concerns expected from this error.

We have reviewed our vaccine management processes and are confident that we can ensure that we prepare vaccines correctly.

If you would you like to discuss this further, please contact [who and how?].

We'll contact you by phone, if we haven't already, to arrange an appointment for you to receive a dose of the vaccine.

Yours sincerely

[signature]

[name]

Media statement

Robust audit processes identify vaccination error

Canterbury DHB is today confirming that a COVID-19 vaccination error occurred at a primary care clinic earlier this month.

On 14 July, 77 people attended a COVID-19 vaccination clinic at 9(2)(a) Wigram.

At the end of the clinic when staff were carrying out a routine audit and stocktake of the doses administered throughout the day, it was identified that there was an extra vial of vaccine leftover. This meant six doses administered only contained the diluent (saline) solution.

Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).

Thanks to the robust and thorough processes in place at 9(2)(a) Wigram, we were able to identify that (description of how it occurred). Therefore, the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

9(2)(a), primary health care clinical director for Canterbury's COVID-19 vaccination programme, says while this is far from ideal and the affected individuals will need to come back in to be vaccinated, we are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the 77 doses provided that day, is a testament to the training provided to vaccinators and the robust processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says 9

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Phone script for calling people who were vaccinated with saline

Hi [name]

I'm calling to talk to you about your COVID-19 vaccination appointment at 9(2)(a) Wigram on Wednesday the 14th July.

I'm sorry to advise you that because of an error, you are one of six people who was injected with saline that day, instead of a saline and Pfizer vaccine mix.

I'm really sorry about this.

We identified this error at the end of the clinic on the 14th when we found an additional vial of Pfizer vaccine.

We've sought advice from IMAC, or the Immunisation Advisory Centre, and I want to reassure you that there are absolutely no safety concerns. You will of course be inconvenienced, because we now need to book you in for a dose of the vaccine.

We've reviewed our processes for preparing vaccines and made sure additional checking takes place to make sure this does not happen again.

Again, we're really sorry about this, and I apologise for the inconvenience this causes you.

[can we offer a $20 petrol voucher??]

I'll arrange for our booking team to give you a call to book in your appointment as soon as possible. What's the best time and number to contact you on please?

Karalyn van Deursen

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 27 July 2021 11:01 AM
To: Karalyn van Deursen
Subject: RE: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks for this, two quick questions:

- When will the 6 people be told?
- Were the process changes suggested done just at Wigram, or across all CDHB vaccination centres?

Thanks, 9(2)(a)

From: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Sent: Tuesday, 27 July 2021 9:28 am
To: 9 @health.govt.nz>
Subject: FW: follow up 9(2)(a) Wigram investigation [EXTERNAL SENDER]

Other bits and pieces which I need to review.

Kvd

Ngā mihi

Karalyn van Deursen
Executive Director Communications
Canterbury and West Coast District Health Boards
Corporate Office, 32 Oxford Terrace, Christchurch
T: +64 3 364 4103 or ext. 62103| M: 027 531 4796

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Responsibility for outcomes - *Kaiwhakarite i kā hua*

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Kathleen Smitheram

From: 9(2)(a)
Sent: Tuesday, 27 July 2021 2:55 PM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: 9(2)(a) wigram saline dose update

Good afternoon
I was wanting to confirm that the patients have been informed, rebooked and letters etc sent as we agreed.

In addition the clinic have made a no. of changes to their processes to ensure this mistake does not recur

Nga mihi

9(2)(a)
ECC Controller
9(2)(a)

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 5:35 PM
To: 9(2)(a)
Cc: Haidee Scott; Alex Taylor (Communications)
Subject: FW: 210723 media statement_saline injection.docx
Attachments: 210723 media statement_saline injection.docx

Kia ora 9(2)(a) further to my earlier emails, see attached my tracked changes.

We haven't introduced any new systems as a result of this – the reality is the tracking system we used, which was developed in Canterbury, meant we could quickly identify which batch was saline only.

We have shown our system to IMAC and suggested that it's introduced nationwide.

I understand 4/6 people have been spoken with and rebooked. I've copied in Haidee Scott our covid lead and Alex Taylor our snr media advisor as I'm out of the office tomorrow.

Cheers
Karalyn

From: Alex Taylor (Communications)
Sent: Tuesday, 27 July 2021 5:27 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: FW: 210723 media statement_saline injection.docx

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 11:29 a.m.
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>; Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Subject: 210723 media statement_saline injection.docx

A couple of suggested tracked changes.
Is there something we've changed to tighten processes/avoid a recurrence of this situation?
If so can we put that in the media release?

Cheers
Kvd

Ngā mihi

Karalyn van Deursen
Executive Director Communications
Canterbury and West Coast District Health Boards
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Media statement

Robust audit processes identify vaccination error

Canterbury DHB is today confirming that a COVID-19 vaccination error occurred at a primary care clinic earlier this month.

On 14 July, 77 people attended a COVID-19 vaccination clinic at 9(2)(a) Wigram.

At the end of the clinic when staff were carrying out a routine audit and stocktake of the doses administered throughout the day, it was identified that there was an extra vial of vaccine left over. Following a review of the process to draw up the day's vaccines (mix the vaccine powder with saline liquid, known as a 'diluent') an error was identified. This resulted~~meant~~ in six doses being administered which only contained the diluent (saline) solution.

Staff immediately notified Canterbury DHB, and a comprehensive investigation was undertaken in collaboration with the Immunisation Advisory Centre (IMAC).

During the drawing up process, vaccine vials are usually placed into the tray along with the syringes that were used to draw up the vaccine from the vial.

Thanks to the ~~robust and~~ thorough audit processes in place at 9(2)(a) Wigram, they~~we~~ were able to identify that one vaccine vial was not placed into its tray. The nurses drawing up the vaccines then used it for the next set of syringes, thinking it was a fresh vial. This resulted in some patients receiving ~~normal saline~~ saline only, without vaccine.

~~Therefore,~~T~~-~~the six people who had not received their COVID-19 vaccination were able to be identified based on the vaccine record-keeping from the day.

The saline solution used as the diluent in vaccinations is not harmful and there is absolutely no health risk to the affected individuals.

The vaccine itself is a powder which comes in each vial. Saline is added to the vial before use so it's injectable.

9(2)(a) primary health care clinical director for Canterbury's COVID-19 vaccination programme, says while this is far from ideal and the affected individuals will need to come back in to be vaccinated, we are pleased this was picked up promptly.

"If the error was not identified, six people would not have the protection two doses of the Pfizer vaccine provides.

"The fact those affected have been identified within the 77 doses provided that day, is a testament to the training provided to vaccinators and the thorough checking ~~robust~~ processes in place at clinics across New Zealand to support our vaccination rollout.

"We would like to thank the staff involved for their cooperation in identifying and resolving this issue," says 9(2)(a)

The DHB has contacted and apologised to all six people, who have all have all been booked in for new vaccination appointments.

ENDS

Kathleen Smitheram

From: 9(2)(a) @auckland.ac.nz>
Sent: Tuesday, 27 July 2021 5:54 PM
To: 9(2)(a)
Subject: RE: 9(2)(a) wigram saline dose update[EXTERNAL SENDER]

Thanks for the update

9(2)(a)

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

9(2)(a)
Immunisation Advisory Centre
The University of Auckland
Immunisation on time every time

Cell: 9(2)(a)
Email: 9(2)(a)
0800 IMMUNE/466863
www.immune.org.nz:
www.influenza.org.nz

From: 9(2)(a)
Sent: Tuesday, 27 July 2021 2:55 PM
To: 9(2)(a) @auckland.ac.nz>
Cc: 9(2)(a) @health.govt.nz>; 9(2)(a) @ccn.health.nz>
Subject: 9(2)(a) wigram saline dose update

Good afternoon
I was wanting to confirm that the patients have been informed, rebooked and letters etc sent as we agreed.

In addition the clinic have made a no. of changes to their processes to ensure this mistake does not recur

Nga mihi

9(2)(a)
ECC Controller
9(2)(a)

individual sender, and do not necessarily reflect those of the Canterbury District Health Board unless otherwise stated.

Out of Scope

[redacted]

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 5:35 p.m.
To: 9(2)(a) [redacted] @health.govt.nz>
Cc: Haidee Scott <Haidee.Scott@cdhb.health.nz>; Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Subject: FW: 210723 media statement_saline injection.docx

Kia ora 9(2) [redacted], further to my earlier emails, see attached my tracked changes.

We haven't introduced any new systems as a result of this – the reality is the tracking system we used, which was developed in Canterbury, meant we could quickly identify which batch was saline only.

We have shown our system to IMAC and suggested that it's introduced nationwide.

I understand 4/6 people have been spoken with and rebooked. I've copied in Haidee Scott our covid lead and Alex Taylor our snr media advisor as I'm out of the office tomorrow.

Cheers
Karalyn

From: Alex Taylor (Communications)
Sent: Tuesday, 27 July 2021 5:27 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: FW: 210723 media statement_saline injection.docx

From: Karalyn van Deursen
Sent: Tuesday, 27 July 2021 11:29 a.m.
To: Haidee Scott <Haidee.Scott@cdhb.health.nz>; Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Subject: 210723 media statement_saline injection.docx

A couple of suggested tracked changes.
Is there something we've changed to tighten processes/avoid a recurrence of this situation?
If so can we put that in the media release?

Cheers
Kvd

Ngā mihi

Karalyn van Deursen
Executive Director Communications
Canterbury and West Coast District Health Boards
Corporate Office, 32 Oxford Terrace, Christchurch
T: +64 3 364 4103 or ext. 62103| M: 027 531 4796

Our Values – *Ā mātou uara*
Care and respect for others – *Manaaki me te kotua i ētahi*
Integrity in all we do – *Hāpai i ā mātou mahi*
Responsibility for outcomes - *Kaiwhakarite i kā hua*

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Wednesday, 21 July 2021 1:56 PM
To: 9(2)(a)
Subject: RE: RE: CDHB saline issue [EXTERNAL SENDER]

9(2) do you have a phone number?
Or can you call me on 027 531 4796

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:36 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: FW: RE: CDHB saline issue [EXTERNAL SENDER]

Hi Karalyn,
It might be best if I contact you as external emails to me seem to be bouncing back at this stage and my phone details are not yet fully established. Regards, 9(2)

9(2)(a) **I Senior Communications & Engagement Advisor I COVID-19 Vaccine and Immunisation Programme**
Ministry of Health I www.moh.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 1:26 pm
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; van Deursen, Karalyn <karalyn.vandeursen@cdhb.health.nz>
Subject: RE: CDHB saline issue

Hi 9(2)

The best person to discuss this with is Karalyn van Deursen so I've cced her into this.

Ngā mihi
9(2)(a)

9(2)(a) I Senior Communications Advisor I COVID-19 Vaccine and Immunisation Programme I Ministry of Health
p 9(2)(a) I e 9(2)(a) @health.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 10:30 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi both,
Let me know who you want to proceed In getting the info from CDHB? Regards, 9(2)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:14 am
To: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline issue

Lets catch up after the stand up

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:10 am
To: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline issue

Thanks, will do. The incident review meeting is at 12.30-1 today (I'm trying to work out how to save emails so I can forward them), do you want me to go?

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 9:08 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>; 9(2)(a) @health.govt.nz>; 9(2)(a) 9(2)(a) @health.govt.nz>
Subject: FW: CDHB saline issue

Hi 9(2)(a)

See below. This is the issue (one of two vaccine delivery incidents) we discussed earlier in the week – email from 9(2)(a) refers and I think you met with her also.

CDHB has completed its safety assessment of the issue now, and will draft comms about it. Can you please pull together some reactive lines both for the programme and for the minister's office.

You will need an introduction to CDHB comms via 9(2)(a) (from our stakeholder engagement team). 9(2)(a) can you please introduce 9(2) to the right person - KvD?

Any questions please get in touch. Deadline is asap today.

Thanks very much
9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:58 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline

Absolutely – good idea.

9(2)(a) CDHB will draft all the comms – we just need to be across and happy, and to have reactive lines both for on behalf of the programme and for MO.

Ngā mihi

9(2)(a)) | **GM Communications and Engagement | COVID-19 Vaccine and Immunisation Programme**
Ministry of Health | **Mobile** 9(2)(a) | 9(2)(a) @health.govt.nz | www.health.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:56 am
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: CDHB saline

Hi there
I spoke to 9(2)(a) about this earlier this week to give her a heads-up. She was going to assign a comms advisor to get lines together on this.
Ok if I pass this onto her for her staff to action, and we'll deal with them?
Cheers

Ngā mihi

9(2)(a) | **Media Lead | COVID-19 Vaccine and Immunisation Programme**
9(2)(a)
Ministry of Health | www.moh.govt.nz

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 8:51 am
To: 9(2)(a) @health.govt.nz>
Subject: CDHB saline

Hi 9(2)(a)

9(2) has advised that the safety assessment on the saline issue at CDHB will be completed this morning – can you assign someone to touch base with KvD on the patient comms and reactive lines?

Thanks,

Ngā mihi

9(2)(a)) | **GM Communications and Engagement | COVID-19 Vaccine and Immunisation Programme**
Ministry of Health | **Mobile** 9(2)(a) | 9(2)(a) @health.govt.nz | www.health.govt.nz

Kathleen Smitheram

From: 9(2)(a)
Sent: Wednesday, 28 July 2021 10:16 AM
To: 9(2)(a) ECC Controller (CDHB)
Subject: Patient contact number[EXTERNAL SENDER]

Kia ora 9(2)(a)

One of the patients from 9(2)(a) only had an email address for them to use to contact and they haven't had a response from him. Could you possibly have a look to see if there is a phone number in the system?

If not, I'll phone his GP practice manager to see if I can get a contact number.

Ngā mihi nui
9(2)(a)

9(2)(a)

CPRG GP Clinical Lead

Out of Scope

[redacted]

Out of Scope

Kathleen Smitheram

From: 9(2)(a)
Sent: Thursday, 5 August 2021 1:40 PM
To: 9(2)(a)
Subject: Re: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Thx heaps

Sent from my iPhone

On 5/08/2021, at 1:34 PM, 9(2)(a) @pegasus.org.nz> wrote:

Yes I can do this.

Get Outlook for Android

From: 9(2)(a) @gmail.com>
Sent: Thursday, August 5, 2021 12:24:10 PM
To: 9(2)(a)
Cc: 9(2)(a) @pegasus.org.nz>
Subject: Re: FW: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

I think 9(Has the most detailed information about this. I'm assuming this is a virtual meeting. 9(, are you amenable to supporting this process? MoH looking for a rep to contribute to a Q&S debrief, which will include the 9(2)(a) incident. If yes, we can make contact with 9(2)(a) to set up an invite.

9(2)(a)
CPRG GP Clinical Lead

On Wed, Aug 4, 2021 at 5:10 PM 9(2)(a) .nz> wrote:

> Would you please be able to do this please
>
> Thank you

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 4 August 2021 5:03 PM
To: 9(2)(a)
Cc: 9(2)(a) @gmail.com>; Erin Wilmshurst <Erin.Wilmshurst@cdhb.health.nz>; 9(2)(a) @health.govt.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

HI there 9(2)

Yes that's sounds great, if agreeable we'll be in touch on timing and mtg arrangements etc

Keep in touch.

Kind regards 9(2)(a)

From: 9(2)(a)
Sent: Wednesday, 4 August 2021 4:59 pm
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @gmail.com>; Erin Wilmshurst <Erin.Wilmshurst@cdhb.health.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Thank you

Alas I have a Board mtg that day and could not attend

I suggest we approach 9(2)(a) who was one of the team who worked with the 9(2)(a) Team on the investigation and /or 9(2)(a) . Both are very involved in the rollout of clinic' in Primary care. Would that be suitable

Thank you

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 4 August 2021 4:52 PM
To: 9(2)(a)
Cc: 9(2)(a) @health.govt.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Good afternoon [redacted]

I'm approaching you to consider joining the forum for a 10 minute talk/ presentation on the Wigram incident. The next NCQSF is Thursday 12 August.

The membership is regional representatives from DHB Clinical and Quality leads

The forum is chaired by [redacted].

The mtg is usually 60 mins and the agenda includes lessons from provider incidents amongst other quality and safety matters.

The next mtg is a catch up and scheduled for 90 minutes so there are some choice of times that day.

Talk is the operative word and a powerpoint isn't necessary – it's about sharing the experience and your improvements.

Thoughts please?

Kind regards [redacted]

[redacted] | *Noho ora mai* | Quality Manager Operations | COVID Vaccine and Immunisation Programme | [redacted]

<image001.jpg>
<image002.png>

From: [redacted]@health.govt.nz>
Sent: Wednesday, 21 July 2021 7:34 am
To: [redacted]@health.govt.nz>; [redacted]
Subject: RE: Vaccine error report from [redacted] Wigram July 2021

[redacted]

I'm not aware that any comms has been had yet and we will need to coordinate that.

In my discussions on Friday we took the decision to gat all the information first

9(2)(a) may have an update

Regards

9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 7:29 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a)
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

Morena 9(2)(a)

Many thanks for the incident reports

May I ask if there has been contact with the affected people as open communication?

Nga mihi nui

9(2)(a)

9(2)(a) | *Noho ora mai* | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 9

<image001.jpg>
<image002.png>

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 20 July 2021 3:25 pm
To: 9(2)(a) @health.govt.nz>
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

FYI

9(2)(a)

From: 9(2)(a) **On Behalf Of** ECC Controller (CDHB)
Sent: Tuesday, 20 July 2021 3:16 pm
To: 9(2)(a) t@auckland.ac.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: Vaccine error report from 9(2)(a) Wigram July 2021

Please advise if you need further details and next steps

Thank you

9(2)(a)

ECC Controller

9(2)(a)

Kathleen Smitheram

From: 9(2)(a)
Sent: Thursday, 5 August 2021 2:03 PM
To: 9(2)(a)
Subject: FW: FW: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Pls note that 9(will do this for you

Pls contact her direct

Thank you

From: 9(2)(a)@pegasus.org.nz>
Sent: Thursday, 5 August 2021 1:34 PM
To: 9(2)(a) 9(2)(a)@gmail.com>
Subject: Re: FW: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Yes I can do this.

Get Outlook for Android

From: 9(2)(a)@health.govt.nz>
Sent: Wednesday, 4 August 2021 5:03 PM
To: 9(2)(a)
Cc: 9(2)(a)@gmail.com>; Erin Wilmshurst <Erin.Wilmshurst@cdhb.health.nz>; 9(2)(a)@health.govt.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

HI there 9(2)

Yes that's sounds great, if agreeable we'll be in touch on timing and mtg arrangements etc

Keep in touch.

Kind regards 9(2)(a)

From: 9(2)(a)
Sent: Wednesday, 4 August 2021 4:59 pm
To: 9(2)(a)@health.govt.nz>
Cc: 9(2)(a)@gmail.com>; Erin Wilmshurst <Erin.Wilmshurst@cdhb.health.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Thank you

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Thank you

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Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Good afternoon 9(2)

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The forum is chaired by 9(2)(a) .

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Talk is the operative word and a powerpoint isn't necessary – it's about sharing the experience and your improvements.

Thoughts please?

Kind regards 9(2)(a)

9(2)(a) | *Noho ora mai* | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 9(2)(a)

9(2)(a)

MINISTRY OF HEALTH
MANATŪ HAUORA

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 7:34 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a)
Subject: RE: Vaccine error report from 9(2)(a) Wigram July 2021

9(2)(a)

I'm not aware that any comms has been had yet and we will need to coordinate that.

In my discussions on Friday we took the decision to gat all the information first

9(2) may have an update

Regards

9(2)(a)

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 21 July 2021 7:29 am
To: 9(2)(a) @health.govt.nz>; 9(2)(a)
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

Morena 9(2)(a)

Many thanks for the incident reports

May I ask if there has been contact with the affected people as open communication?

Nga mihi nui

9(2)(a)

9(2)(a) [redacted] | Noho ora mai | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 9(2)(a) [redacted]

From: 9(2)(a) [redacted]@health.govt.nz>
Sent: Tuesday, 20 July 2021 3:25 pm
To: 9(2)(a) [redacted]@health.govt.nz>
Subject: FW: Vaccine error report from 9(2)(a) [redacted] Wigram July 2021

FYI

9(2)(a) [redacted]

From: 9(2)(a) [redacted] **On Behalf Of** ECC Controller (CDHB)
Sent: Tuesday, 20 July 2021 3:16 pm
To: 9(2)(a) [redacted]@auckland.ac.nz>
Cc: 9 [redacted]@health.govt.nz>
Subject: Vaccine error report from 9(2)(a) [redacted] Wigram July 2021

Please advise if you need further details and next steps

Thank you

9(2)(a) [redacted]

ECC Controller

9(2)(a) [redacted]

Kathleen Smitheram

From: 9(2)(a) @health.govt.nz>
Sent: Thursday, 5 August 2021 3:56 PM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: FW: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Hi there 9(2)(a)
Many thanks and we've pencilled you in for 10 minutes from 1015 and the mtg arrangements will be sent to you this week. The next NCQSF is Thursday 12 August.
Kind regards C

9(2)(a) | Noho ora mai | Quality Manager Operations | COVID Vaccine and Immunisation Programme | 09(2)(a)

From: 9(2)(a) @gmail.com>
Sent: Thursday, 5 August 2021 2:06 pm
To: 9(2)(a) @health.govt.nz>; 9(2)(a) @pegasus.org.nz>; 9(2)(a)
Subject: Re: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Kia ora 9(2)(a)

9(2)(a) is happy to contribute to this meeting. Could you contact her with details?

Ngā mihi nui
9(2)(a)

9(2)(a)
CPRG GP Clinical Lead

On Wed, Aug 4, 2021 at 5:03 PM 9(2)(a) @health.govt.nz> wrote:

> HI there 9(2)
>
> Yes that's sounds great, if agreeable we'll be in touch on timing and mtg arrangements etc
>
> Keep in touch.

Kind regards 9(2)(a)

From: 9(2)(a)
Sent: Wednesday, 4 August 2021 4:59 pm
To: 9(2)(a) @health.govt.nz>
Cc: 9(2)(a) @gmail.com>; Erin Wilmshurst <Erin.Wilmshurst@cdhb.health.nz>
Subject: RE: Wigram Incident and National Clinical Quality Safety Forum NQCSF [EXTERNAL SENDER]

Thank you

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I suggest we approach 9(2)(a) who was one of the team who worked with the 9(2)(a) Team on the investigation and /or 9(2)(a) . Both are very involved in the rollout of clinic' in Primary care. Would that be suitable

Thank you

Double Up

Double Up

[redacted]

MINISTRY OF HEALTH
MANATŪ HAUORA

Double Up

[redacted]

Double Up

[redacted]

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 20 July 2021 3:25 pm
To: 9(2)(a) @health.govt.nz>
Subject: FW: Vaccine error report from 9(2)(a) Wigram July 2021

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Sent: Tuesday, 20 July 2021 3:16 pm
To: 9(2)(a) @auckland.ac.nz>
Cc: 9(2)(a) @health.govt.nz>
Subject: Vaccine error report from 9(2)(a) Wigram July 2021

Please advise if you need further details and next steps

Thank you

9(2)(a)

ECC Controller

9(2)(a)

Kathleen Smitheram

From: 9(2)(a) @health.govt.nz>
Sent: Tuesday, 10 August 2021 4:40 PM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: Question on the follow up action for the people affected by the missed dose

Morena 9(
Please remind where the team got to with the five people in the Wigram incident please?
What was their circumstances regarding another dose: if missed first then had first and booked for second... and if missed the second then had another/ final dose?

9(2)(a)
| Noho ora mai | Quality Manager Operations | COVID Vaccine and Immunisation Programme |
9(2)(a)

Kathleen Smitheram

From: 9(2)(a)@health.govt.nz>
Sent: Tuesday, 10 August 2021 5:02 PM
To: 9(2)(a)
Cc: 9(2)(a)
Subject: RE: Question on the follow up action for the people affected by the missed dose

Many thx for the update and an update on the 6th person will be appreciated as possible .. were they are first or second dose person please?

Kind

From: 9(2)(a)@pegasus.org.nz>
Sent: Tuesday, 10 August 2021 4:45 pm
To: 9(2)(a)@health.govt.nz>
Cc: 9(2)(a)@health.govt.nz>
Subject: RE: Question on the follow up action for the people affected by the missed dose

Sorry should have read your email better. There were four first doses affected and 2 second doses.

I'll contact the practice and get outcomes for everyone.

From: 9(2)(a)@health.govt.nz>
Sent: Tuesday, 10 August 2021 4:40 pm
To 9(2)(a)@pegasus.org.nz>
Cc: 9(2)(a)@health.govt.nz>
Subject: Question on the follow up action for the people affected by the missed dose

Morena 9(2)(a)
Please remind where the team got to with the five people in the Wigram incident please?
What was their circumstances regarding another dose: if missed first then had first and booked for second... and if missed the second then had another/ final dose?

9(2)(a)
| Noho ora mai | Quality Manager Operations | COVID Vaccine and Immunisation Programme |
9(2)(a)

Karalyn van Deursen

From: Karalyn van Deursen
Sent: Wednesday, 25 August 2021 6:31 PM
To: 9(2)(a) Haidee Scott; COVID Vacc Controller
Cc: 9(2)(a) Alex Taylor (Communications)
Subject: media query re wigram 'saline' incident
Attachments: FW: 210723 media statement_saline injection.docx

Kia ora team – please see below query from the MoH – can you check the highlighted statement – is this accurate. Our standby statement is attached. I thought it was just saline that was given.

From: 9(2)(a)@health.govt.nz>
Sent: Wednesday, 25 August 2021 6:26 PM
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Subject: RE: West Coast DHB Media Heads Up - Wednesday 25 August 2021 [EXTERNAL SENDER]

Kia ora Karalyn
We've received queries about an incident in Wigram last month, after the Minister alluded to it at select committee today. Here's our response FYI

- We are aware of an incident at the Wigram, Christchurch, vaccination clinic on 14 July where the end of day reconciliation of vaccine doses in stock didn't match the doses administered.
- During the full-day clinic, six vaccinations were administered with a very low dose of vaccine.
- As a result of the investigation into this event, we know the affected cohort in this case is only six people because records show it occurred between 1.20pm and 1.40pm that day.
- All six people have been contacted by the DHB and a clinical plan was developed for each person – four people were receiving dose 1 and two people receiving dose 2 on 14 July. They have since been given another dose of vaccine.
- This incident occurred as a result of a vaccinator picking up a tray of six syringes that hadn't had the correct vaccine drawn into them.

From: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Sent: Wednesday, 25 August 2021 6:23 pm
To: 9(2)(a)@parliament.govt.nz>; 9(2)(a) 9(2)(a)@parliament.govt.nz>; 9(2)(a)@parliament.govt.nz>; 9(2)(a)@parliament.govt.nz>; Ministry of Health Comms Team (media@moh.govt.nz) <media@moh.govt.nz>; 9(2)(a).trow@parliament.govt.nz>; T9(2)(a)@parliament.govt.nz>
Subject: Fyi: West Coast DHB Media Heads Up - Wednesday 25 August 2021

Kia ora koutou

FYI – please see below for today's media activity.

1. We issued the following media release.

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

MEDIA RELEASE

25 August 2021

Out of Scope

Karalyn van Deursen

From: 9(2)(a) @health.govt.nz>
Sent: Wednesday, 25 August 2021 6:39 PM
To: Haidee Scott; Karalyn van Deursen
Cc: 9(2)(a))
Subject: RE: media query re wigram 'saline' incident

Our position is to call these low dose vaccines. The response has gone so it's moot anyway. Our clinical leads signed this off.

From: Haidee Scott <Haidee.Scott@cdhb.health.nz>
Sent: Wednesday, 25 August 2021 6:37 pm
To: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Cc: 9(2)(a) @health.govt.nz>; 9(2)(a) @ccn.health.nz>; COVID Vacc Controller <covidvacccontroller@cdhb.health.nz>; 9(2)(a) @health.govt.nz>; Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Subject: Re: media query re wigram 'saline' incident

Hi KVD, yes, just saline - although I suppose there would be trace amounts of the vaccine left in the vial...?

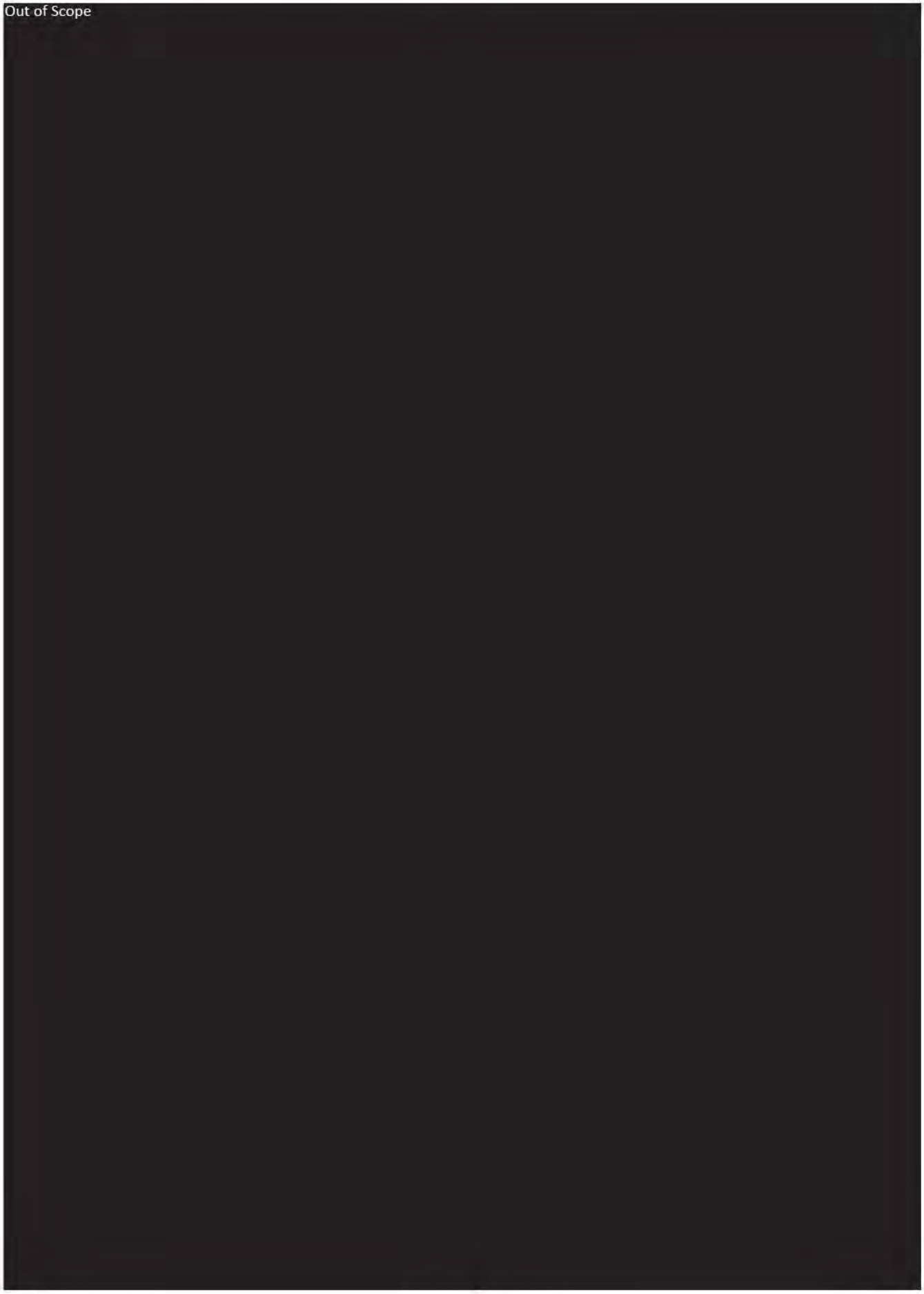
Sent from my iPhone

On 25/08/2021, at 6:31 PM, Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz> wrote:

> Kia ora team – please see below query from the MoH – can you check the highlighted statement – is this accurate.
> Our standby statement is attached. I thought it was just saline that was given.
>
> **From:** 9(2)(a) @health.govt.nz>
> **Sent:** Wednesday, 25 August 2021 6:26 PM
> **To:** Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
> **Subject:** RE: West Coast DHB Media Heads Up - Wednesday 25 August 2021 [EXTERNAL SENDER]
>
> Kia ora Karalyn
> We've received queries about an incident in Wigram last month, after the Minister alluded to it at select committee today. Here's our response FYI
>
> - We are aware of an incident at the Wigram, Christchurch, vaccination clinic on 14 July where the end of day reconciliation of vaccine doses in stock didn't match the doses administered.
> - During the full-day clinic, six vaccinations were administered with a very low dose of vaccine.
> - As a result of the investigation into this event, we know the affected cohort in this case is only six people because records show it occurred between 1.20pm and 1.40pm that day.
> - All six people have been contacted by the DHB and a clinical plan was developed for each person – four people were receiving dose 1 and two people receiving dose 2 on 14 July. They have since been given another dose of vaccine.

- This incident occurred as a result of a vaccinator picking up a tray of six syringes that hadn't had the correct vaccine drawn into them.

Out of Scope



Double Up

[redacted]

Out of Scope

[redacted]

Kathleen Smitheram

From: 9(2)(a) @pegasus.org.nz>
Sent: Thursday, 26 August 2021 12:03 PM
To: COVID Comms; Alex Taylor (Communications)
Cc: 9(2)(a)
Subject: RE: 9(2)(a) [EXTERNAL SENDER]

Can someone tell Wigram that the Minister will be doing that. Out of respect for the Wigram team it would be good if they had the heads up – they aren't feeling especially good at the moment.
Regards, 9(2)(a)

Primary Care Covid-19 Vaccination team
Pegasus House
Madras Street, Christchurch

Cellphone 9(2)(a)

From: Haidee Scott <Haidee.Scott@cdhb.health.nz> **On Behalf Of** COVID Comms
Sent: Thursday, 26 August 2021 11:54 am
To: Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Cc: 9(2)(a) @pegasus.org.nz>; 9(2)(a) @pegasus.org.nz>
Subject: FW: 9(2)(a) [EXTERNAL SENDER]

Hi Alex, 9(2)(g)(i) . We know the Minister will stand up at 1pm and defend Wigram – there's no need to do it themselves. What are your thoughts and advice?

what are your thoughts around this?
Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

From: 9(2)(a) @pegasus.org.nz>
Sent: Thursday, 26 August 2021 11:49 AM
To: COVID Vacc Ops <covidvaccops@cdhb.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>
Cc: 9(2)(a) @pegasus.org.nz>
Subject: FW 9(2)(a) [EXTERNAL SENDER]

Primary Care Covid-19 Vaccination team
Pegasus House
Madras Street, Christchurch

Cellphone 9(2)(a)

From: 9(2)(a) 9(2)(a)
Sent: Thursday, 26 August 2021 11:44 am
To: 9(2)(a) @pegasus.org.nz>
Subject: 9(2)(a)
Importance: High

Hi 9(2)(a)

Just to update you. It appears the news crews have left however three of them they spent a good hour filming the vaccinations. They also interviewed and filmed patients in their cars as they left the car park. One of my RN's has advised me it has already been on 9(2) news this morning.

Can we get the Primary Care Covid Team to put out a statement on our behalf regarding the situation? Or are we able to write a statement and run it past you?

Essentially we would like to put something out stating that we actually followed correct procedure and MoH guidelines and dealt with it well (9(2)(g)(i)).

Let me know your thoughts

Kind regards

9(2)(a)

9(2)(a)

Kathleen Smitheram

From: Haidee Scott <Haidee.Scott@cdhb.health.nz> on behalf of COVID Comms <covidcomms@cdhb.health.nz>
Sent: Thursday, 26 August 2021 10:52 AM
To: 9(2)(a) [redacted]
Cc: Shannon Beynon; 9(2)(a) [redacted]; COVID Vacc Ops; Communications
Subject: RE: 9(2) [redacted] News has joined 9(2)(a) [redacted] at 9(2)(a) [redacted] Wigram [EXTERNAL SENDER]

9(2)(a) [redacted] please would you make sure staff know to direct any media queries to our communications team? The email address is: Communications@cdhb.health.nz

Hang in there Wigram team…!

Ngā mihi nui

Haidee Scott
Senior Communications Advisor – COVID-19 Lead
Canterbury District Health Board
www.vaccinateCanterburyWestCoast.nz

From: Shannon Beynon <Shannon.Beynon@cdhb.health.nz>
Sent: Thursday, 26 August 2021 10:43 AM
To: Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>
Cc: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>; Haidee Scott <Haidee.Scott@cdhb.health.nz>; COVID Comms <covidcomms@cdhb.health.nz>
Subject: FW: 9(2) [redacted] News has joined NewsHub at 9(2)(a) [redacted] Wigram [EXTERNAL SENDER]

FYI

From: 9(2)(a) [redacted]@pegasus.org.nz>
Sent: Thursday, 26 August 2021 10:42 AM
To: COVID Vacc Ops <covidvaccops@cdhb.health.nz>; 9(2)(a) [redacted]@pegasus.org.nz>; Shannon Beynon <Shannon.Beynon@cdhb.health.nz>
Subject: 9(2) [redacted] News has joined 9(2)(a) [redacted] at 9(2)(a) [redacted] Wigram [EXTERNAL SENDER]

They are filming from the road and have been told they can't come into the carpark. They do have good views though of people coming and going. Vaccinations are continuing and they have been advised to bring on security if needed.
The staff are finding the situation quite unpleasant.
Regards, 9(2)(a) [redacted]

Primary Care Covid-19 Vaccination team
Pegasus House
Madras Street, Christchurch

Cellphone 9(2)(a) [redacted]