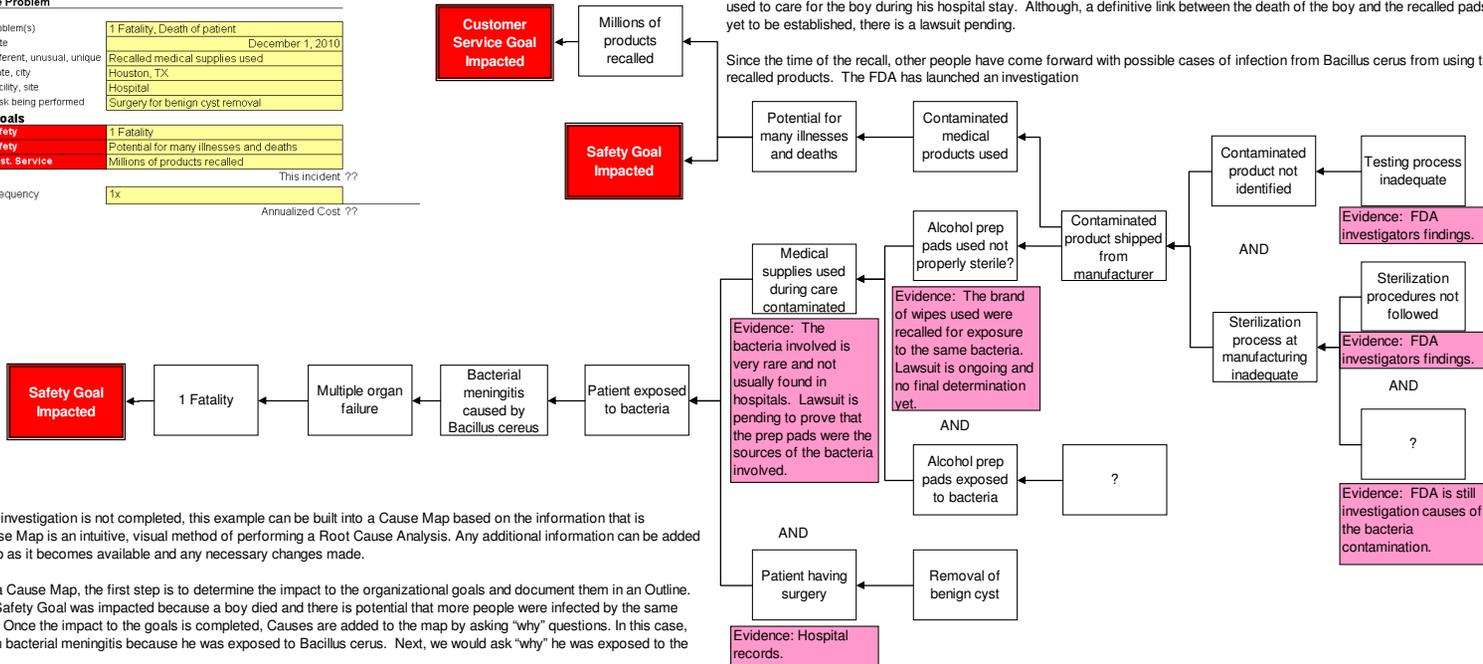


# Toddler Dies From Contaminated Wipes

Houston, Texas  
December 1, 2010

## Step 1. Define the Problem

<b>What</b>	Problem(s)	1 Fatality, Death of patient
<b>When</b>	Date	December 1, 2010
<b>Where</b>	Different, unusual, unique	Recalled medical supplies used
	State, city	Houston, TX
	Facility, site	Hospital
	Task being performed	Surgery for benign cyst removal
<b>Impact to the Goals</b>	<b>Safety</b>	1 Fatality
	<b>Safety</b>	Potential for many illnesses and deaths
	<b>Cust. Service</b>	Millions of products recalled
	Frequency	This incident ??
	Annualized Cost ??	



Even though the investigation is not completed, this example can be built into a Cause Map based on the information that is available. A Cause Map is an intuitive, visual method of performing a Root Cause Analysis. Any additional information can be added to the Cause Map as it becomes available and any necessary changes made.

When beginning a Cause Map, the first step is to determine the impact to the organizational goals and document them in an Outline. In this case, the Safety Goal was impacted because a boy died and there is potential that more people were infected by the same harmful bacteria. Once the impact to the goals is completed, Causes are added to the map by asking "why" questions. In this case, the boy died from bacterial meningitis because he was exposed to Bacillus cereus. Next, we would ask "why" he was exposed to the bacteria.

Because the link between the recalled wipes and the death of the patient has not been officially determined, a question mark is included with that information when it's added. It's important that all evidence or lack of evidence is documented on the Cause Map so that it is clear which Causes are agreed upon, known facts and which still need to be proven.

A 2 year old boy died December 1, 2010 following a routine surgery to remove a benign cyst from near his spinal cord and brain. He appeared to be recovering well when he contracted bacterial meningitis and quickly succumbed to the infection. Tests revealed the bacteria were a rare strain, Bacillus cereus, which is typically associated with food poisoning and not hospital infections. How the patient was exposed to the bacteria was initially unknown, but now a potential source has been identified.

On January 5, 2011, The Triad Group, one of the nation's largest medical product suppliers, announced a massive recall of alcohol wipes, swabs and pads because of contamination from the same rare bacteria, Bacillus cereus. Products by this manufacturer were used to care for the boy during his hospital stay. Although, a definitive link between the death of the boy and the recalled pads has yet to be established, there is a lawsuit pending.

Since the time of the recall, other people have come forward with possible cases of infection from Bacillus cereus from using the recalled products. The FDA has launched an investigation

The recall is a short term solution to this problem, but at least all products known to be contaminated should be removed from shelves and hospital storerooms. It isn't clear yet what steps are needed at the manufacturer to ensure safety of consumers, but the affected products will not be sold again until they are tested and deemed safe.

## Cause Map High Level



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