NHS Improvement

Never Events reported as occurring between 1 April 2016 and 31March 2017 – final update

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support collaborate challenge improve inspire

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

Never Events reported as occurring between 1 April 2016 and 31 March 2017 – final update

Now that sufficient time has elapsed to allow for local incident investigation and national analysis of data following the end of the 2016/17 reporting year, this report provides a final update of Never Events reported as occurring between 1 April 2016 and 31 March 2017. It replaces and supersedes the previously published provisional data report for 2016/17.

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The current Never Events Policy and Framework suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes. Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing existing safety advice/alerts may not be robust.

The concept of Never Events is not about apportioning blame to organisations when these incidents occur but rather to learn from what happened. The foreword to the Never Events Policy and Framework states: "Never Events are key indicators that there have been failures to put in place the required systemic barriers to error and their occurrence can tell commissioners something fundamental about the quality, care and safety processes in an organisation." Identifying and addressing the reasons behind this can potentially improve safety in ways that extend far beyond the department where the Never Event occurred or the type of procedure involved.

Please note that because the definitions and designated list of Never Events were revised from April 2015, direct comparison of the number of Never Events with earlier periods would be misleading.

The revised 2015 Never Events Policy and Framework requires commissioners and providers to agree and report Never Events via the Strategic Executive Information System (StEIS). Where a Serious Incident is logged as a Never Event but does not appear to fit any definition on the Never Events List 2015/16, commissioners are asked to discuss this with the provider organisation and either add extra detail to StEIS to confirm it is a Never Event or remove its Never Event designation from the StEIS system.

Supporting healthcare providers to prevent Never Events

To help prevent Never Events a set of new National Safety Standards for Invasive Procedures (NatSSIPs) was published in September 2015, and all relevant NHS organisations in England have now been instructed to develop and implement their own local standards based on the national principles of the NatSSIPs.

These new standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice: for example, through a series of

standardised safety checks and education and training. The standards also support NHS providers to work with staff to develop and maintain their own, more detailed, local standards and encourage organisations to share best practice.

To help prevent nasogastric Never Events an Alert *Nasogastric tube misplacement: continuing risk of death and severe harm* and resource set were published by NHS Improvement in July 2016. These provide materials to help trust boards, or their equivalents, assess whether previous alerts and guidance about nasogastric tubes have been implemented and embedded in their organisations.

Investigating and learning from Never Events

NHS providers are encouraged to learn from mistakes and any organisation that reports a Never Event is expected to conduct its own investigation so it can learn and take action on the underlying causes.

The fact that more and more NHS staff take the time to report incidents is good evidence that this learning is happening locally. We continue to encourage NHS staff to report Never Events and Serious Incidents to StEIS and all patient safety incidents to the National Reporting and Learning System (NRLS), to help us identify any risks so that necessary action can be taken.

Summary

When data for this report was extracted on 9 January 2018, 451 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2016 and 31 March 2017. Of these 451 incidents:

- 445 Serious Incidents appeared to meet the definition of a Never Event in the Never Events List 2015/16 and had an incident date between 1 April 2016 and 31 March 2017
- 3 Serious Incidents did not appear to meet the definition of a Never Event
- 3 Serious Incidents occurred before April 2016

More detail is provided in the tables below:

Table 1: Never Events 1 April 2016 to 31 March 2017 by month of incident

Month in which Never Event occurred	Number
April 2016	32
May 2016	32
June 2016	42
July 2016	45
August 2016	33
September 2016	33
October 2016	42
November 2016	49
December 2016	31
January 2017	41
February 2017	31
March 2017	34
Total	**445**

Note: As described above, three Serious Incidents did not appear to meet the definition of a Never Event and three occurred prior to April 2016

Table 2: Never Events 1 April 2016 to 31 March 2017 by type of incident with additional detail

Type and brief description of Never Event	Number
Wrong site surgery	**189**
Additional procedure to surgical plan	3
Biopsy of cervix rather than biopsy of colon/rectum	3
Central line wrongly sited into carotid artery	1
Convergent squint surgery rather than divergent squint surgery	1
Incision to wrong side of leg	1
Ovaries removed when the plan was to conserve them	1
Patient had a biopsy intended for another patient	1
Patient had a colposcopy intended for another patient	1
Patient had a coronary angiography intended for another patient	1
Patient had a gynae procedure intended for another patient	1
Patient had a subcutaneous device that monitors heart rhythm intended for another patient	1
Patient had eye injections intended for another patient	2
Patient had laser treatment intended for another patient	1
Two procedures part of the surgical plan - only one undertaken	1
Unnecessary supra pubic incision for vaginal surgery	1
Wrong area of breast	2
Wrong breast injection	1
Wrong clavicle incision	1
Wrong eye	1
Wrong eye injection	4
Wrong finger	3
Wrong finger incision	1
Wrong finger injection	2
Wrong foot incision	2
Wrong heel injection	1
Wrong hip incision	2
Wrong incision - carpal tunnel rather than trigger thumb	2
Wrong knee arthroscopy	1
Wrong level spinal incision	1
Wrong level spinal surgery	16
Wrong patient had a cystoscopy intended for another patient	1
Wrong patient had a loop biopsy intended for another patient	1
Wrong patient had a lumbar puncture	2
Wrong patient received an eye injection intended for another patient	1
Wrong patient received laser treatment intended for another patient	1
Wrong procedure - colonoscopy instead of flexible cystoscopy	1

Wrong side angiogram	1
Wrong side angioplasty	3
Wrong side arthrogram	1
Wrong side axillary clearance	1
Wrong side brain biopsy	1
Wrong side contraceptive implant	1
Wrong side hip injection	1
Wrong side of elbow	1
Wrong side of nose	1
Wrong side of toe nail removed	2
Wrong side pleuritic aspiration	1
Wrong side shunt	1
Wrong side stent	2
Wrong side sublingual gland removed	1
Wrong side thyroid lobectomy	1
Wrong side ureteroscopy and lithotripsy	2
Wrong side vein surgery	1
Wrong site block	30
Wrong site percutaneous biopsy	1
Wrong skin lesion biopsy	2
Wrong skin lesion removed	14
Wrong stent removed	1
Wrong toe	4
Wrong tooth root exploration	1
Wrong tooth/teeth incision	1
Wrong tooth/teeth removed	46
Retained foreign object post procedure	**114**
Cap from giving set	1
Corneal shield	1
Cotton bud applicator	1
Dappens dish	1
Drill guide	2
Endo file	1
Guide wire - central line	13
Guide wire - chest drain	4
Guide wire - femoral line	1
Guide wire - pacemaker	1
Guide wire - PICC line	2
Guide wire - urethrotomy	1
K wire	2
Nerve vessel retractor	1

Ophthalmology sponge	1
Ophthalmology trocar	1
Part of a drill bit	2
Part of a pair of forceps	1
Part of surgical drain	1
PICC line	1
Piece of shoulder instrumentation	1
Ribbon gauze	1
Screw tabs from spinal instrumentation	1
Specimen retrieval bag	5
Spring from suction device	1
Stem protector	1
Stylet from a Naso gastric tube	1
Surgical drain inserter cover	2
Surgical needle	1
Surgical swab	23
Swab tag	1
Throat pack	3
Vaginal occluder	1
Vaginal swab	32
Vasectomy clamps	1
Wrong implant/prosthesis	**53**
Contraceptive implant	2
Fracture fixation plate	1
Hip	5
Intra uterine device	1
Knee	20
Lens	21
Stent	1
Stent used instead of a balloon catheter	1
Wrong type of pacemaker	1
Wrong route administration of medication	**40**
Epidural medication given intravenously	12
Intravenous medication given via an epidural catheter and epidural medication given intravenously	1
Oral medication given intramuscularly	1
Oral medication given intravenously	19
Oral medication given subcutaneously	6
Oral medication given via a peritoneal dialysis line	1
Misplaced naso or oro gastric tubes	**26**
Naso gastric tube in respiratory tract and feed administered	26

Overdose of insulin due to abbreviations or incorrect device	**8**
Wrong syringe used	8
Overdose of methotrexate for non-cancer treatment	**5**
Overdose of methotrexate for non-cancer treatment	5
Falls from poorly restricted windows	**3**
Window restrictor not fitted correctly or failed	3
Chest or neck entrapment in bedrails	**2**
Neck entrapment	1
Redness of skin from entrapment in bedrails	1
Failure to install functional collapsible shower or curtain rails	**2**
Curtain rail failed to collapse	2
Scalding of patients	**1**
Burns to feet from soaking in a bowl of water	1
Misselection of a strong potassium containing solution	**1**
Potassium administered instead of antibiotic	1
Transfusion or transplantation of ABO incompatible blood components or organs	**1**
Wrong blood transfused	1
Total	**445**

Note: As described above, three Serious Incidents did not appear to meet the definition of a Never Event and three occurred prior to April 2016

Table 3: Never Events 1 April 2016 to 31 March 2017 by healthcare provider

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
7-day chemist, Welling, reported by Bexley CCG							1							1
Aintree University Hospital NHS Foundation Trust	2													2
Airedale NHS Foundation Trust	1													1
Alder Hey Children's NHS Foundation Trust		1												1
Ashford and St. Peters Hospitals NHS Foundation Trust		1		1										2
Barking Havering and Redbridge University Hospitals NHS Trust		2		1										3
Barnet,Enfield and Haringey Mental Health NHS Trust						1								1
Barts Health NHS Trust	3	5		2	1									11
Basildon and Thurrock University Hospitals NHS Foundation Trust		1		1										2
Bedford Hospital NHS Trust		1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Birmingham Community Healthcare NHS Foundation Trust		1												1
Birmingham Women's and Children's NHS Foundation Trust	2	2												4
Blackpool Teaching Hospitals NHS Foundation Trust	1		3		1									5
BMI The Chaucer private hospital, reported by NHS Canterbury and Coastal CCG	1													1
Bolton NHS Foundation Trust				1										1
BPAS Banbury, reported by NHS Oxfordshire CCG			1											1
BPAS Doncaster, reported by NHS Leeds West CCG			1											1
BPAS Portsmouth, reported by NHS Wiltshire CCG			1											1
BPAS Richmond, reported by NHS South Kent Coast CCG	1													1

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Bradford Hospitals NHS Foundation Trust	1			1										2
Brighton and Sussex University Hospitals NHS Trust		4										1		5
Bristol Community Health Social Enterprise, reported by NHS Bristol CCG							1							1
Buckinghamshire Healthcare NHS Trust	2		1	1										4
Burton Hospitals Foundation Trust	1		3	1										5
Calderdale and Huddersfield NHS Foundation Trust		1			1									2
Cambridge University Hospitals NHS Foundation Trust	2	1	1		1									5
Cambridgeshire Community Services NHS Trust	1	1												2
Central Manchester University Hospitals NHS Foundation Trust		1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Chelsea and Westminster Healthcare NHS Foundation Trust	1													1
City Hospital Sunderland NHS Foundation Trust	1	1		1										3
Colchester Hospital University NHS Foundation Trust	1		1		1									3
Community Dental Services, reported by NHS Bedfordshire CCG	1													1
Countess Of Chester Hospital NHS Foundation Trust	3	2												5
County Durham and Darlington NHS Foundation Trust	7		1											8
Croydon Health Services NHS Trust	1													1
Cumbria Partnership NHS Foundation Trust		1												1
Dartford and Gravesham NHS Trust		1	1											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Dental surgery, reported by NHS England North (Lancashire)	1													1
Derby Teaching Hospitals NHS Foundation Trust	2			1										3
Derbyshire Community Health Services NHS Trust		1												1
Devizes Treatment Centre, reported by NHS Wiltshire CCG	1													1
Devon Villa Dental Surgery, Newton Abbot, South West Provider	1													1
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		1												1
Dorset County Hospital NHS Foundation Trust	2													2
Dorset Healthcare University NHS Foundation Trust	1													1
Dudley Group NHS Foundation Trust			1											1

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East and North Hertfordshire NHS Trust		1	1					1						3
East Cheshire NHS Trust	1					1								2
East Kent Hospitals University NHS Foundation Trust	3													3
East Lancashire Hospitals NHS Trust		1												1
East Sussex Healthcare NHS Trust	1			1										2
Epsom and St Helier NHS Trust	1		1											2
Frimley Health NHS Foundation Trust	2			1										3
Gateshead Health NHS Foundation Trust	2	1												3
George Eliot Hospital NHS Trust	1		1		2									4
Gloucestershire Hospitals NHS Foundation Trust	1	1	1											3

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Great Ormond Street Hospital for Children NHS Foundation Trust					1									1
Great Western Hospitals NHS Foundation Trust	1													1
Guy's and St Thomas' NHS Foundation Trust	2	3		1										6
Hampshire Hospitals NHS Foundation Trust	2		1											3
Heart of England NHS Foundation Trust	1		1		1									3
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1													1
Hillingdon Hospital NHS Foundation Trust				1										1
Hinchingbrooke Health Care NHS Trust	1													1
Homerton Hospital NHS Foundation Trust					1									1
Hull and East Yorkshire Hospitals NHS Trust					1									1

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Imperial College Healthcare NHS Trust		3		1										4
Ipswich Hospital NHS Foundation Trust		1	1				1							3
Isle of Wight NHS Trust	1	2		1										4
James Paget University Hospitals NHS Foundation Trust				1										1
Kent Community Health NHS Foundation Trust	1													1
Kettering General Hospital NHS Foundation Trust	1	1												2
KIMS private hospital, reported by NHS Medway CCG	1													1
King's College Hospital NHS Foundation Trust	3	2		1	1									7
Kingston Hospital NHS Foundation Trust		2		1										3
Lancashire Teaching Hospitals NHS Foundation Trust	2				1									3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Leeds Teaching Hospitals NHS Trust	4	1												5
Lewisham and Greenwich NHS Trust				2										2
Liverpool Community Health NHS Trust				1										1
Liverpool Heart and Chest NHS Foundation Trust	1		1											2
Liverpool Women's Hospital NHS Foundation Trust	2	1												3
London North West Healthcare NHS Trust		3												3
Luton and Dunstable University Hospital NHS Foundation Trust	1		1											2
Maidstone and Tunbridge Wells NHS Trust	2		1		1									4
Medway NHS Foundation Trust	1													1
Mid Cheshire Hospitals NHS Foundation Trust	1		1											2

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Mid Essex Hospital Services NHS Trust	3	1	1											5
Mid Yorkshire Hospitals NHS Trust	2	1		1										4
Milton Keynes Community Health Services	1													1
Milton Keynes University Hospital NHS Foundation Trust	1							1						2
Moorfields Eye Hospital NHS Foundation Trust		1	3											4
Newcastle Upon Tyne Hospitals NHS Foundation Trust	5	2		1										8
Norfolk and Norwich University Hospitals NHS Foundation Trust	2	1	1											4
North Bristol NHS Trust	2	1	1		1									5
North Cumbria University Hospitals Trust				1										1
North Middlesex Hospital NHS Trust	1	1			1									3

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North Tees and Hartlepool NHS Foundation Trust	1													1
North West Anglia NHS Foundation Trust			1											1
Northamptonshire Healthcare NHS Foundation Trust	1						1		1					3
Northern Devon Healthcare NHS Trust	1			2										3
Northern Lincolnshire and Goole NHS Foundation Trust		1												1
Northumbria Healthcare NHS Foundation Trust		1												1
Nottingham University Hospitals NHS Trust	1	2		2	1	1								7
Nuffield Chester private healthcare, reported by NHS West Cheshire CCG			1											1
Nuffield Leeds private hospital, reported by NHS Leeds West CCG						1								1

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Nuffield Tees private hospital, reported by NHS Hartlepool and Stockton CCG	1													1
Nuffield Woking private hospital, reported by NHS North West Surrey CCG	1													1
Oldbury Court Dental Services, reported by South West Area Team		1												1
Oxford University Hospitals NHS Foundation Trust	1		1											2
Papworth Hospital NHS Foundation Trust					1									1
Patients home, reported by NHS Herts Valleys CCG										1				1
Pennine Acute Hospitals NHS Trust	2	2	2											6
Pharmacy, reported by NHS England Yorkshire and the Humber area team							1							1

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Plymouth Community Dental Services, reported by NHS North, East, West Devon CCG	1													1
Plymouth Hospitals NHS Trust	1	3												4
Poole Hospital NHS Foundation Trust		4												4
Portsmouth Hospitals NHS Trust	2	1				1								4
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust		1												1
Queen Victoria Hospital NHS Foundation Trust	1	1												2
Ramsay Fitzwilliam private hospital, reported by NHS Cambridgeshire and Peterborough CCG	1													1
Ramsay Horton private hospital, reported by NHS Oxfordshire CCG		1	1											2
Ramsay Renacres private hospital, reported by NHS Greater	1													1

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Peston CCG														
Ramsay The Yorkshire Clinic private hospital, reported by NHS Bradford Districts CCG	1													1
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	3													3
Rotherham NHS Foundation Trust		1		1		1								3
Royal Berkshire NHS Foundation Trust	1													1
Royal Cornwall Hospitals NHS Trust	2	1	1											4
Royal Devon and Exeter NHS Foundation Trust	2	1												3
Royal Free London NHS Foundation Trust	1		1		2									4
Royal Orthopaedic Hospital NHS Foundation Trust	2		1											3

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Royal Surrey County Hospital NHS Foundation Trust		1												1
Royal Wolverhampton NHS Trust	2	2	1											5
Salford Royal NHS Foundation Trust	3													3
Salisbury NHS Foundation Trust	1					1								2
Sandal Castle Medical Centre, reported by NHS Greater Huddersfield CCG		1												1
Sandwell and West Birmingham Hospitals NHS Trust	1	2												3
Sheffield Children's NHS Foundation Trust	1													1
Sheffield Health and Social Care NHS Foundation Trust									1					1
Sheffield Teaching Hospitals NHS Foundation Trust	4	1												5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Sherwood Forest Hospitals NHS Foundation Trust		1	1		1									3
Shrewsbury and Telford Hospitals NHS Trust	1	3												4
South London and Maudsley NHS Foundation Trust								1						1
South Tees Hospitals NHS Foundation Trust	3	1			1									5
South Tyneside NHS Foundation Trust				1		1								2
Southampton Treatment Centre, reported by NHS Southampton CCG	2		1											3
Southend University Hospital NHS Foundation Trust		1	1										1	3
Southern Health NHS Foundation Trust		1												1
Southport and Ormskirk Hospital NHS Trust	2		1											3

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Southwick Dental Practice, reported by NHS Sunderland CCG	1													1
SpaMedica reported by NHS Central Manchester CCG			1											1
Spire Cambridge Lea private hospital, reported by NHS Cambridgeshire and Peterborough CCG	1													1
Spire Liverpool private hospital, reported by NHS Liverpool CCG			1											1
Spire Parkway private healthcare, reported by Solihul CCG	1													1
Spire Roding private healthcare, reported by NHS Waltham Forest CCG	1													1
Spire Southampton private hospital, reported by NHS Southampton CCG		1												1
Spire St Anthony's private hospital, reported by NHS Surrey Downs CCG	1													1

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Spire Wellesley private hospital, reported by NHS Southend CCG	1													1
St George's University Hospitals NHS Foundation Trust	2	1												3
St Helens and Knowsley Hospitals NHS Trust		2												2
Stockport NHS Foundation Trust				1										1
Surrey and Sussex Healthcare NHS Trust	1													1
Taunton and Somerset NHS Foundation Trust	4	1	1											6
Tees Valley Treatment Centre, reported by NHS South Tees CCG	1													1
Torbay and South Devon NHS Foundation Trust				1										1
United Lincolnshire Hospitals NHS Trust	1													1
University College London Hospitals NHS Foundation Trust	3				1									4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
University Hospital of South Manchester NHS Foundation Trust	1				1									2
University Hospital Southampton NHS Foundation Trust	1		2											3
University Hospitals Birmingham NHS Foundation Trust		1												1
University Hospitals Bristol NHS Foundation Trust		2												2
University Hospitals Coventry and Warwickshire NHS Trust		1		1										2
University Hospitals of Leicester NHS Trust	2	1									1			4
University Hospitals of Morecambe Bay NHS Foundation Trust			1	1										2
University Hospitals of North Midlands NHS Trust		2		1	1									4
Walton Centre NHS Foundation Trust	2				1									3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Warrington and Halton Hospitals NHS Foundation Trust	2	1												3
West Hertfordshire Hospitals NHS Trust	1	1												2
West Suffolk NHS Foundation Trust	1	1		1										3
Western Sussex Hospitals NHS Foundation Trust	2			1										3
Weston Area Health NHS Trust		1												1
Whittington Health NHS Trust		1												1
Wirral Community NHS Foundation Trust	1													1
Wirral University Teaching Hospital NHS Foundation Trust	1	1	1											3
Woodburn Cottage Dental Services, South West area provider	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Chest on neck entrapment in bedrails	Total
Worcestershire Acute Hospitals NHS Trust	1	1												2
Wrightington, Wigan and Leigh NHS Foundation Trust										1				1
Wye Valley NHS Trust	2													2
Yeovil District Hospital NHS Foundation Trust	2													2
York Teaching Hospital NHS Foundation Trust	4			1										5
Total	**189**	**114**	**53**	**40**	**26**	**8**	**5**	**3**	**2**	**2**	**1**	**1**	**1**	**445**

Note: As described above, three Serious Incidents did not appear to meet the definition of a Never Event and three occurred prior to April 2016

Table 4: Never Events occurring before 1 April 2016 that have not been identified in previous reports

Provider organisation where Never Event occurred	Date	Retained foreign object post procedure
Ipswich Hospital NHS Foundation Trust	05/01/2016	1
Pennine Acute Hospitals NHS Trust	29/11/2012	1
West Midlands private hospital reported by Dudley CCG	Unspecified date 2012	1
Total		**3**

Note: As described above, three Serious Incidents did not appear to meet the definition of a Never Event and three occurred prior to April 2016

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