Provisional publication of Never Events reported as occurring between 1 April 2017 and 31 January 2018

Published 27 February 2018

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 4
Supporting healthcare providers to prevent Never Events..4
Investigating and learning from Never Events 5
Important notes on the provisional nature of this data 5
Summary 6
Table 1: Never Events 1 April 2017 to 31 January 2018 by month of incident …….….…….6
Table 2: Never Events 1 April 2017 to 31 January 2018 by type of incident with additional detail ……………………………………………………………………………………….7
Table 3: Never Events 1 April 2017 to 31 January 2018 by healthcare provider …..…..…12
Table 4: Never Events occurring before 1 April 2017…………………………………………32

Never Events

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 2015 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 2015 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.

NB: A revised Never Events Policy and Framework and Never Events List became active on 1 February 2018 but all Never Events in the period covered by this publication were reported against the 2015 Never Events Policy and Framework and the 2015/16 Never Events list.

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.

Important notes on the provisional nature of this data

To support learning from Never Events we are committed to publishing this data as early as possible. However, because reports of apparent Never Events are submitted by healthcare providers as soon as possible, often before local investigation is complete, all data is provisional and subject to change.

Because of the complex combination of incidents identified as Never Events when first reported, Serious Incidents designated as Never Events at a later date, and incidents initially reported as Never Events that on investigation are found not to meet the criteria, our monthly provisional Never Event reports provide cumulative totals for the current financial year. This is to ensure the information provided is as consistent and as accurate as possible.

This provisional report is drawn from the StEIS system, and includes all Serious Incidents with a reported incident date between 1 April 2017 and 31 January 2018 and which on 16 February 2018 were designated by their reporters as Never Events.

Data on Never Events for 2016/17 and previous years can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2017/18 reporting year for local incident investigation and national analysis of data, NHS Improvement will produce a final whole-year report of Never Events, which will replace this provisional data.

Summary

When data for this report was extracted on 16 February 2018, 405 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April and 31 January 2018. Of these 405 incidents:

- 393 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 2017 and 31 January 2018; this number is subject to change as local investigations are completed
- 12 Serious Incidents did not appear to meet the definition of a Never Event.

More detail is provided in the tables below:

Table 1: Never Events 1 April 2017 to 31 January 2018 by month of incident*

Month in which Never Event occurred	Number
Apr 2017	38
May 2017	38
Jun 2017	42
Jul 2017	49
Aug 2017	39
Sep 2017	27
Oct 2017	58
Nov 2017	43
Dec 2017	27
Jan 2018	32
Total	**393**

Note: As described above, another twelve Serious Incidents did not appear to meet the definition of a Never Event
***Numbers are subject to change as local investigations are completed.**

Table 2: Never Events 1 April 2017 to 31 January 2018 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**172**
Additional procedure undertaken which was not identified on the surgical plan	1
Ascites drained instead of a seroma	1
Banding of haemorrhoids rather than incision of pilonidal sinus	1
Both ovaries removed when surgical plan was to preserve left ovary	1
Botulinum injection to wrong leg	1
Carpal tunnel release instead of trigger finger	1
Cervical biopsy instead of rectal biopsy	1
Colposcopy rather than routine smear test	1
Contraceptive implant to wrong arm	1
Incision to elbow rather than finger	1
Insertion of PICC line intended for another patient	1
K wire to wrong finger	1
Oesophago Gastro Duodenoscopy instead of Flexible Sigmoidoscopy	1
Ovaries removed in error during a hysterectomy when plan was to conserve them	3
Perianal abscess excised instead of gluteal abscess	1
Perianal abscess excised instead of pilonidal abscess	1
Plan was for a wider excision of squamous cell carcinoma	1
Radio frequency ablation to wrong leg	1
Sigmoidoscopy rather than a cystoscopy	1
Suprascapular nerve injection instead of facet joint injection	1
Umbilical venous catheter incorrectly sited into the left portal vein of the liver	1
Unnecessary procedure - coronary angiogram	1
Unnecessary urodynamics test	1
Unnecessary procedure in addition to planned procedure	1
Urethral catheter rather than supra pubic catheter	1
Vocal cord injection to wrong side	1
Wrong area of breast biopsied	2
Wrong area of breast excised	2
Wrong area of ear	1
Wrong breast lesion removed	1
Wrong eye	3
Wrong eye injection	4
Wrong finger	1
Wrong finger incision	2
Wrong finger joint	1
Wrong groin	1

Wrong hand tendon	1
Wrong hernia repair	1
Wrong hip	1
Wrong hip bursa removed	1
Wrong kidney biopsy	1
Wrong leg	1
Wrong level spinal surgery	8
Wrong lung biopsy	1
Wrong patient - wrong skin lesion removed	1
Wrong patient had a cheek biopsy	1
Wrong patient had a CVP line	1
Wrong patient had a cystoscopy	2
Wrong patient had a gastroscopy	1
Wrong patient had a lumbar puncture	1
Wrong patient had a ultrasound guided biopsy	1
Wrong procedure - cystoscopy instead of vaginoscopy	1
Wrong rib removed	1
Wrong shoulder injection	1
Wrong side angioplasty	2
Wrong side angioplasty incision	1
Wrong side chest drain	3
Wrong side hernia repair	1
Wrong side lithotripsy	1
Wrong side nephrostomy	1
Wrong side of arm	1
Wrong side of elbow	1
Wrong side of face	1
Wrong side removal of stent	2
Wrong side sacroiliac joint injection	1
Wrong side spinal injection	4
Wrong side spinal surgery	1
Wrong side stent	4
Wrong side ureteroscopy	1
Wrong side ureteroscopy and insertion of stent	1
Wrong site block	26
Wrong skin lesion biopsy	3
Wrong skin lesion removed	9
Wrong spinal level	6
Wrong squint surgery - convergent rather than divergent	1
Wrong thumb injection	1
Wrong toe incision	1

Wrong tooth/ teeth removed	27
Retained foreign object post procedure	**97**
Armature from cardiac valve insertion	1
Black insulation material	1
Cap from arthroscopic washout tubing	1
Dental pack	1
End piece of a pulse lavage system	1
Finger tourniquet	1
Guide wire - bladder sensor	1
Guide wire - central line	9
Guide wire - chest drain	3
Guide wire - femoral line	1
Guide wire - naso gastric tube	1
Guide wire - Vascath	1
Hip lag screw	1
Instrument screw	1
K wire	2
Microvascular clamp	1
Ophthalmic trocar	1
Part of a drill bit	1
Part of a screw	1
Part of a specimen retrieval bag	1
Part of a surgical drain	1
Part of a surgical needle	1
Part of a surgical swab	1
Part of a tracheostomy swab	1
Part of an amplatz wire	1
Part of an umbilical venous catheter	1
Part of hawkins wire	1
Piece of laparosopic port tubing	1
Plastic sheath from ablation device	1
Plastic tubing	1
Raney surgical clip	1
Ribbon gauze	1
Screw 'ears' that should have been removed	1
Screw from cable system for hip surgery	1
Screw from instrumentation	1
Small piece of metal	1
Specimen retrieval bag	3
Surgical clamp	1
Surgical glove	1

Surgical instrument	1
Surgical needle	4
Surgical swab	14
Throat pack	5
Vaginal swab	20
Vascular sling	1
Wrong implant/ prosthesis	**60**
Cranial plate	1
Femoral nail instead of a tibial nail	1
Hip	13
Knee	12
Left ovary preserved when surgical plan was to remove both ovaries	1
Lens	22
Wring intrauterine device	1
Wrong Intra uterine device	3
Wrong stent	2
Wrong type of oesophageal stent (non removable rather than removable)	1
Wrong type of stent	3
Misplaced naso- or oro-gastric tubes	**21**
Naso gastric tube in respiratory tract and feed administered	21
Administration of medication by the wrong route	**20**
Enteral medication given intravenously	1
Epidural medication given intravenously	10
Oral medication given by parenteral route	1
Oral medication given intravenously	6
Oral medication given subcutaneously	2
Overdose of methotrexate for non cancer treatment	**5**
Incorrectly dispensed	1
Overdose of methotrexate for non cancer treatment	4
Overdose of insulin due to abbreviations or incorrect device	**5**
Wrong syringe used	5
Transfusion or transplantation of ABO-incompatible blood components or organs	**4**
Wrong blood transfused	4
Falls from poorly restricted windows	**3**
Window restrictor removed	1
Window retainer failed	1
Window retainer missing	1
Failure to install functional collapsible shower or curtain rails	**2**
Curtain rail failed to collapse	2
Scalding of patients	**2**

Patient lowered into bath water that was too hot	1
Water temperature increased unexpectedly	1
Chest on neck entrapment in bed rails	**1**
Chest on neck entrapment in bedrails	1
Mis-selection of a strong potassium solution	**1**
Potassium selected and administered instead of Fentanyl	1
Total	**393**

Note: As described above, another twelve Serious Incidents did not appear to meet the definition of a Never Event
*__Numbers are subject to change as local investigations are completed.__

Table 3: Never Events 1 April to 31 January 2017 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Abbey Field Medical Centre, reported by NHS North East Essex CCG	1													1
Aintree University Hospital NHS Foundation Trust	4		1											5
Airedale NHS Foundation Trust		1												1
Alder Hey Children's NHS Foundation Trust	1													1
Barking Havering and Redbridge University Hospitals NHS Trust		4												4
Barnsley Hospital NHS Foundation Trust			2											2
Barts Health NHS Trust	3	3												6
Basildon and Thurrock University Hospitals NHS Foundation Trust	2													2
Bedford Hospital NHS Trust		3												3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Birmingham Community Healthcare NHS Foundation Trust	2													2
Birmingham Women's and Children's Hospital NHS Foundation Trust		2												2
Blackpool Teaching Hospitals NHS Foundation Trust	1	1												2
BMI Chiltern private hospital, reported by NHS Aylesbury Vale CCG		1												1
BMI Edgbaston private hospital, reported by NHS Birmingham Cross City CCG	1													1
BMI The Hampshire private clinic, reported by NHS North Hampshire CCG	1													1
BMI Woodlands private hospital, reported by NHS Nene CCG			1											1
Bolton NHS Foundation Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
BPAS Doncaster, reported by NHS Nene CCG	1													1
BPAS Liverpool, reported by NHS Halton CCG			1											1
Bradford Hospitals NHS Foundation Trust			1											1
Brighton and Sussex University Hospitals NHS Trust	3													3
Buckinghamshire Healthcare NHS Trust	1	1	2											4
Burton Hospitals Foundation Trust			2											2
Calderdale and Huddersfield NHS Foundation Trust	1													1
Cambridge University Hospitals NHS Foundation Trust	2	1	1											4
Cambridgeshire Community Services NHS Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Care UK Peninsula Treatment Centre, reported by NHS North, East, West Devon CCG			1											1
Central and North West London Mental Health NHS Foundation Trust			1											1
Central Manchester University Hospitals NHS Foundation Trust	1				1									2
Chelsea and Westminster Healthcare NHS Foundation Trust		1			1			1						3
City Hospital Sunderland NHS Foundation Trust	1													1
Colchester Hospital University NHS Foundation Trust	2			1										3
Countess of Chester Hospital NHS Foundation Trust	1													1
County Durham and Darlington NHS Foundation Trust	1	2			1									4
Croydon Health Services NHS Trust					1									1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Dartford and Gravesham NHS Trust	1		1											2
Derby Teaching Hospitals NHS Foundation Trust	1				1									2
Derbyshire Healthcare NHS Foundation Trust					1									1
Dorset County Hospital NHS Foundation Trust		1												1
Dudley Group NHS Foundation Trust		1			1					1				3
East and North Hertfordshire NHS Trust	1	1												2
East Cheshire NHS Trust	1													1
East Kent Hospitals University NHS Foundation Trust	1	2	2											5
East Lancashire Hospitals NHS Trust	4	1		1										6
East Sussex Healthcare NHS Trust			2	1										3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Epsom and St Helier NHS Trust	1	1												2
Euxton Hall private hospital, reported by NHS Greater Preston CCG			1											1
Frimley Health NHS Foundation Trust	2		1											3
Gateshead Health NHS Foundation Trust	1													1
George Eliot Hospital NHS Trust	2													2
Gloucestershire Care Services NHS Trust	1													1
Gloucestershire Hospitals NHS Foundation Trust	1		1		1									3
Great Ormond Street Hospital for Children NHS Foundation Trust	1	1												2
Guy's and St Thomas' NHS Foundation Trust	3	4	1	1				1						10

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Haddenham Dental Centre, reported by NHS South Central CCG	1													1
Hampshire Hospitals NHS Foundation Trust	1			1										2
Heart of England NHS Foundation Trust	1	1	1	2										5
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	4	1			1									6
Hillingdon Hospital NHS Foundation Trust		1	1											2
HMT St Hugh's, reported by NHS North East Lincolnshire CCG			2											2
Homerton Hospital NHS Foundation Trust		1												1
Hull and East Yorkshire Hospitals NHS Trust	2		1		1									4
Imperial College Healthcare NHS Trust					1									1
James Paget University Hospitals NHS Foundation Trust		1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Kettering General Hospital NHS Foundation Trust		1												1
King's College Hospital NHS Foundation Trust		1				1			1					3
Lancashire Care NHS Foundation Trust							1							1
Lancashire Teaching Hospitals NHS Foundation Trust	1	1												2
Leeds Community Healthcare NHS Trust	1													1
Leeds Teaching Hospitals NHS Trust	2	1	1											4
Lewisham and Greenwich NHS Trust								1						1
Lincoln County Hospital, reported by NHS Lincolnshire West CCG		1												1
Liverpool Community Health NHS Trust	1													1
Liverpool Women's Hospital NHS Foundation Trust			1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
London North West Healthcare NHS Trust		1												1
Luton and Dunstable University Hospital NHS Foundation Trust	1		1	1		1								4
Maidstone and Tunbridge Wells NHS Trust	2				1									3
Manchester University NHS Foundation Trust	1													1
Medway NHS Foundation Trust	1	1		1		1								4
Mid Essex Hospital Services NHS Trust	2	1												3
Mid Yorkshire Hospitals NHS Trust	1													1
Middleton St George Dental Care, reported by NHS Darlington CCG	1													1
Milton Keynes University Hospital NHS Foundation Trust	1	1	1											3
Moorfields Eye Hospital NHS Foundation Trust			2											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Mount Stuart Private Hospital, reported by NHS South Devon and Torbay CCG			1											1
mydentist Shepton Mallet, reported by NHS England South	1													1
New Hayesbank Surgery Cataract Clinic, reported by NHS South Kent Coast CCG			1											1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	1	1	1		2									5
Norfolk and Norwich University Hospitals NHS Foundation Trust	1	1	1											3
North Bristol NHS Trust	1		1											2
North East London NHS Treatment Centre reported by NHS Barking and Dagenham CCG		1												1
North Middlesex Hospital NHS Trust	3	2												5
North Tees and Hartlepool NHS Foundation Trust		1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
North West Anglia NHS Foundation Trust		2												2
Northampton General Hospital NHS Trust	2		1											3
Northern Lincolnshire and Goole NHS Foundation Trust		1	1											2
Nottingham Healthcare NHS Foundation Trust	1													1
Nottingham University Hospitals NHS Trust	1													1
Nuffield Health Plymouth Private Healthcare, reported by NHS North, East, West Devon CCG			1											1
Nuffield Health Wolverhampton private hospital, reported by NHS Wolverhampton CCG	1													1
Oxford Health NHS Foundation Trust												1		1
Oxford University Hospitals NHS Foundation Trust	2					1								3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Papworth Hospital NHS Foundation Trust		1												1
Pennine Acute Hospitals NHS Trust	2													2
Pennine Acute Hospitals NHS Trust	1													1
Plymouth Hospitals NHS Trust	1	1											1	3
Poole Hospital NHS Foundation Trust	1													1
Portsmouth Hospitals NHS Trust	2	3	1											6
Priory Chelmsford Private Hospital, reported by East of England SCG											1			1
Queen Elizabeth Kings Lynn NHS Foundation Trust	2													2
Queen Victoria Hospital NHS Foundation Trust	2	1												3
Ramsay Health, Fitzwilliam private hospital, reported by Lincolnshire South CCG	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Ramsay Health, Fulwood Hall private hospital, reported by NHS Greater Preston CCG	1													1
Ramsay Health, New Hall private hospital, reported by NHS Dorset CCG	1													1
Ramsay Health, Springfield private hospital, reported by Mid Essex CCG	1													1
Ramsay Health, The Yorkshire Clinic private hospital, reported by NHS Greater Huddersfield CCG			1											1
Ramsay Health, Woodland private hospital, reported by NHS Nene CCG	1													1
Ramsay Health, Woodthorpe private hospital, reported by NHS Nottingham West CCG	1													1
Riverside Medical Practice, reported by Lambeth CCG							1							1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Riverside Medical Practice, reported by NHS Medway CCG			1											1
Rodericks Dental Practice, reported by NHS Gloucestershire CCG	1													1
Royal Berkshire NHS Foundation Trust		2												2
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	4	1	1	1										7
Royal Brompton and Harefield NHS Foundation Trust		1												1
Royal Cornwall Hospitals NHS Trust	1	1	5											7
Royal Devon and Exeter NHS Foundation Trust	1	2												3
Royal Free London NHS Foundation Trust	3	4				1								8
Royal Liverpool and Broadgreen NHS Trust	1	1												2
Royal National Orthopaedic Hospital NHS Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Royal Surrey County Hospital NHS Foundation Trust			2											2
Royal Wolverhampton NHS Trust	4	1												5
Salford Royal NHS Foundation Trust	6			1										7
Salisbury NHS Foundation Trust			1											1
Sandwell and West Birmingham Hospitals NHS Trust	3													3
Sheffield Teaching Hospitals NHS Foundation Trust	1	1	1	1										4
Sherwood Forest Hospitals NHS Foundation Trust	1													1
Shrewsbury and Telford Hospital NHS Trust			1											1
Shropshire Community Health NHS Trust	2													2
Somerset Partnership NHS Foundation Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
Somerset Surgical Services, reported by NHS North Somerset CCG		1												1
South Tees Hospitals NHS Foundation Trust	1													1
Southend University Hospital NHS Foundation Trust	2		1											3
Southport and Ormskirk Hospital NHS Trust	1													1
Spencer Private Hospital, reported by NHS Thanet CCG			1											1
Spire Leeds Private Hospital, reported by NHS Leeds West CCG	1		1											2
Spire Wellesley Private Healthcare, reported by NHS Southend CCG			1											1
St George's University Hospitals NHS Trust		3												3
St Helens and Knowsley Hospitals NHS Trust				2										2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
St John's Care Home, reported by NHS Croydon CCG									1					1
Superdrug Pharmacy, reported by NHS Bedfordshire CCG							1							1
Surrey and Sussex Healthcare NHS Trust		1												1
Tameside and Glossop Integrated Care NHS Foundation Trust	1	1												2
Taunton and Somerset NHS Foundation Trust		1						1						2
Tyne House, Percy Headly Foundation, reported by NHS Newcastle Gateshead CCG										1				1
United Lincolnshire Hospitals NHS Trust	2	1		1										4
University Hospital of South Manchester NHS Foundation Trust	1													1
University Hospital Southampton NHS Foundation Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
University Hospitals Birmingham NHS Foundation Trust	4			2										6
University Hospitals Bristol NHS Foundation Trust	3	1		1										5
University Hospitals Coventry and Warwickshire NHS Trust	2	2			1									5
University Hospitals of Leicester NHS Trust	1	3		1	1									6
University Hospitals of Morecambe Bay NHS Foundation Trust	2													2
University Hospitals of North Midlands NHS Trust		1												1
Unknown, reported by NHS Rotherham CCG							1							1
Walsall Healthcare NHS Trust		1			1									2
Walton Centre NHS Foundation Trust	1													1
Warrington and Halton Hospitals NHS Foundation Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
West Hertfordshire Hospitals NHS Trust	1				2									3
West London Mental Health NHS Trust											1			1
West Suffolk NHS Foundation Trust							1							1
Western Sussex Hospitals NHS Foundation Trust									1					1
Weston Area Health NHS Trust	1				1									2
Whittington Health NHS Trust		1												1
Wirral University Teaching Hospital NHS Foundation Trust	2	2												4
Worcestershire Acute Hospitals NHS Trust	1			1										2
Wrightington, Wigan and Leigh NHS Foundation Trust	2			1										3
Wye Valley NHS Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Misplaced naso or oro-gastric tubes	Administration of medication by the wrong route	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO-incompatible blood components or organs	Falls from poorly restricted windows	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Chest on neck entrapment in bed rails	Misselection of a strong potassium solution	Total
York Teaching Hospital NHS Foundation Trust	2		1											3
Total	**172**	**97**	**60**	**21**	**20**	**5**	**5**	**4**	**3**	**2**	**2**	**1**	**1**	**393**

Note: As described above, another twelve Serious Incidents did not appear to meet the definition of a Never Event

***Numbers are subject to change as local investigations are completed.**

Table 4: Never Events occurring before 1 April 2017*

None reported

* Numbers are subject to change as local investigations are completed.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

Follow us on Twitter @NHSImprovement

This publication can be made available in a number of other formats on request.

© NHS Improvement 2018 Publication code: TD 09/18