NHS Improvement

Provisional publication of Never Events reported as occurring between 1 April 2018 and 31 January 2019

Published 27th February 2019

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

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 Never Events policy and framework – revised January 2018 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. This is why, following consultation, in the revised *Never Events policy and framework* (published January 2018) we removed the option for commissioners to impose financial sanctions when Never Events were reported. The foreword to the framework states: "……allowing commissioners to impose financial sanctions following Never Events reinforced the perception of a 'blame culture'. Our removal of financial sanctions should not be interpreted as a weakening of effort to prevent Never Events. It is about emphasising the importance of learning from their occurrence, not blaming." 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 February 2018, direct comparison of the number of Never Events since that date with earlier periods is not appropriate.

The revised 2018 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 2018* (published 31 January 2018), 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.

The Care Quality Commission has undertaken a recent thematic review in collaboration with NHS Improvement to get a better understanding of what can be done to prevent the occurrence of Never Events. The report 'Opening the door to change' was published in December 2018.

The report found that: "Never Events continue to happen despite the hard work and efforts of frontline staff. Staff are struggling to cope with large volumes of safety guidance, they have little time and space to implement guidance effectively, and the systems and processes around them are not always supportive. Where staff are trying to implement guidance, they are often doing this on top of a demanding and busy role that makes it difficult to give the work the time it requires."

The report includes a recommendation that "NHS Improvement should review the Never Events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes;

and those that could be designed out entirely such as through the removal equipment or fitting/using physical barriers to risks). This review should focus on the leadership and culture needed to underpin safety. It should take into account the different settings in which Never Events occur, including acute, mental health and community settings" This work may involve changes to the approach of the Never Events framework and the list of Never Events in the future.

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 2018 and 31 January 2019 and which on 7 February 2019 were designated by their reporters as Never Events.

Data on Never Events for 2017/18 and previous years can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2018/19 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 7 February 2019, 430 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2018 and 31 January 2019. Of these 430:

- 423 Serious Incidents appeared to meet the definition of a Never Event in the *Never Events list 2018* (published 31 January 2018) and had an incident date between 1 April 2018 and 31 January 2019; this number is subject to change as local investigations are completed
- A further six Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations
- One was a duplicate entry.

More detail is provided in the tables below.

Table 1: Never Events 1 April 2018 to 31 January 2019 by month of incident*

Month in which Never Event occurred	Number
April 2018	39
May 2018	52
June 2018	63
July 2018	32
August 2018	57
September 2018	30
October 2018	46
November 2018	38
December 2018	32
January 2019	34
Total	**423**

Note: A further six Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 2: Never Events 1 April 2018 to 31 January 2019 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**165**
Adenoids removed in error during a tonsillectomy when plan was to conserve them	1
Biopsy of wrong breast	1
Botox injection instead of nerve block	1
Circumcision rather than a flexible cystoscopy	1
Cystoscopy undertaken that was intended for another patient	1
Exploration of wrong oral cyst	1

Grommet inserted to wrong ear	1
Incision to wrong part of ear	1
Incision to wrong side of elbow	1
Incision to wrong side of head	1
Incision to wrong side of knee	1
Incision to wrong side of toe nail	1
Injection to both eyes rather than just one	1
Injection to wrong area of foot	1
Injection to wrong eye	6
Injection to wrong hip	1
Injection to wrong toe	1
K wire to wrong thumb joint	1
Knee aspiration performed instead of joint injection	1
Laser surgery to wrong eye	1
Lumbar puncture performed on wrong patient	1
Myometrial biopsy performed on the wrong patient	1
Ovaries removed in error when plan was to preserve them	3
Ovary removed in error when plan was to conserve it	1
Perianal abscess incised instead of pilonidal abscess	1
Tonsillectomy performed when not consented for	2
Unnecessary shoulder injection as patient had already had it	1
Wrong breast lump removed	1
Wrong ear lesion removed	1
Wrong eye muscle resected as part of squint surgery procedure	1
Wrong finger incision	2

Wrong hip procedure	1
Wrong injection to eye	1
Wrong joint arthrogram and injection	1
Wrong laparoscopic port site re-explored	1
Wrong patient - central line inserted that was intended for another patient	1
Wrong patient had a colonoscopy intended for another patient	1
Wrong patient had laser eye surgery intended for another patient	1
Wrong side angiogram	2
Wrong side angioplasty	3
Wrong side Bartholins cyst	1
Wrong side chest drain	2
Wrong side excision of vas and testicular vessels	1
Wrong side hernia incision	1
Wrong side lung biopsy	1
Wrong side of colon removed	1
Wrong side of elbow	1
Wrong side of toe nail removed	1
Wrong side spinal injection	9
Wrong side spinal surgery	1
Wrong side ureteric stent	2
Wrong side ureteric stent removed	2
Wrong side ureteroscopy	2
Wrong site block	31
Wrong skin lesion biopsy	2
Wrong skin lesion removed	16

Wrong squint surgery esotropia rather than exotropia	1
Wrong thyroid lobe removed	1
Wrong toe incision	1
Wrong toe nail removed	1
Wrong toe removed	1
Wrong tooth/teeth removed	34
Retained foreign object post procedure	**91**
Acetabular sizing trial	1
Filshie bung	1
Gauze roll	1
Guide wire - central line	7
Guide wire - chest drain	2
Guide wire - coronary artery stent	2
Guide wire - femoral line	1
Guide wire - Hickman line	1
Guide wire - nasogastric tube	1
Guide wire - PICC line	2
Guide wire - vascath	1
Guide wire from pelvic facture repair	1
Guide wire tip - PICC line	1
Guide wire tip - urinary catheter	1
Haemostatic material	1
K wire	1
Knee replacement pin	2
Loop electrode from uterine resectoscope	1

Metallic object	1
Mouth props	1
Part of a catheter from a trans jugular intrahepatic portosystemic shunt	1
Part of a drill bit	1
Plastic tubing	1
Screw caps	1
Specimen retrieval bag	1
Surgical drain	2
Surgical forcep	1
Surgical needle	2
Surgical swab	10
Throat pack	1
Tonsil swab	1
Trocar protector	1
Vaginal swab	37
Vein cannula	1
Wrong implant/prosthesis	**58**
Breast implant	1
Femoral nail	1
Hip	22
Knee	9
Lens	8
Wrong bone cement	1
Wrong fracture fixation plate	4
Wrong intra uterine device	6

Wrong k wires	1
Wrong neuro stimulator	1
Wrong spinal cord stimulator	1
Wrong stent	1
Wrong type of corneal graft	1
Wrong vascular graft	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	**43**
Patient connected to air flowmeter rather than oxygen	43
Misplaced naso- or orogastric tubes	**26**
Nasogastric tube in the respiratory tract and feed administered	26
Overdose of insulin due to abbreviations or incorrect device	**12**
Insulin withdrawn from a Kwik pen device	1
Wrong syringe used	11
Administration of medication by the wrong route	**10**
Bladder irrigation given intravenously	1
Intravenous medication administered via PICC line	1
Oral medication given intravenously	7
Oral medication given via endotracheal tube	1
Failure to install functional collapsible shower or curtain rails	**7**
Curtain rail failed to collapse	3
Shower curtain rail failed to collapse	4
Transfusion or transplantation of ABO incompatible blood components or organs	**4**
Blood transfused that was intended for another patient	1
Wrong blood transfused	3

Mis-selection of high strength midazolam during conscious sedation	**3**
Overdose of midazolam	3
Overdose of methotrexate for non-cancer treatment	**3**
Higher dose prescribed	1
Overdose of methotrexate for non-cancer treatment	2
Falls from poorly restricted windows	**1**
Window restrictors damaged	1
Total	**423**

Note: A further six Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 3: Never Events 1 April 2018 to 31 January 2019 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Abbeyfield Medical Centre, reported by NHS North East Essex CCG	1												1
Aintree University Hospital NHS Foundation Trust			1										1
Airedale NHS Foundation Trust	2												2
Alder Hey Children's NHS Foundation Trust	1		1			1							3
Ashford and St. Peter's Hospitals NHS Foundation Trust		1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Barking, Havering and Redbridge University Hospitals NHS Trust		1		2									3
Barnsley Hospital NHS Foundation Trust	1					1							2
Barts Health NHS Trust	4	5	1	1	1								12
Basildon and Thurrock University Hospitals NHS Foundation Trust	1	1		1		1	1						5
Bedford Hospital NHS Trust	4	1											5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Birmingham Community Healthcare NHS Foundation Trust	2												2
Birmingham Women's and Children's Hospital NHS Foundation Trust	1	1			2								4
Blackpool Teaching Hospitals NHS Foundation Trust	1												1
Bolton NHS Foundation Trust	2												2
Bradford Teaching Hospitals NHS Foundation Trust	1	2				1							4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Bridgewater Community Healthcare NHS Foundation Trust	1	1											2
Brighton and Sussex University Hospitals NHS Trust	1	1											2
Buckinghamshire Healthcare NHS Trust	1	1		1									3
Calderdale and Huddersfield NHS Foundation Trust		1		3									4
Cambridgeshire Community Services NHS Trust	1		2										3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Cambridge University Hospitals NHS Foundation Trust	1				2								3
Chelsea and Westminster Hospital NHS Foundation Trust		1		1									2
Chesterfield Royal Hospital NHS Foundation Trust	1	1											2
Circle Nottingham NHS Treatment Centre	1												1
City Healthcare Dental Services, Goole Hospital - reported by NHS Hull CCG	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
City Healthcare Dental Services, Highlands Health Centre - reported by NHS Hull CCG	1												1
City Hospitals Sunderland NHS Foundation Trust	3												3
Community Dental Services, Dental Access Centre, Peterborough reported by NHS Luton CCG	1												1
Countess of Chester Hospital NHS Foundation Trust	1												1

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County Durham and Darlington NHS Foundation Trust	1		1				1		1				4
Dartford and Gravesham NHS Trust				2									2
Dental Services, reported by NHS South West regional team	1												1
Derbyshire Community Health Services NHS Foundation Trust		1											1
Devizes NHS Treatment Centre (Care UK), reported by NHS England	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	1												1
Dorset County Hospital NHS Foundation Trust		1											1
East and North Hertfordshire NHS Trust	4				1								5
East Cheshire NHS Trust			1										1
East Kent Hospitals University NHS Foundation Trust	2	1	1								1		5
East Lancashire Hospitals NHS Trust				1			1						2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
East Suffolk and North Essex NHS Foundation Trust	1	1	2			1							5
East Sussex Healthcare NHS Trust		1											1
Epsom and St Helier University Hospitals NHS Trust							1		1				2
Essex Partnership University NHS Foundation Trust										2			2
Frimley Health NHS Foundation Trust	1												1

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Gateshead Health NHS Foundation Trust	1												1
Gentle Dental Care, reported by NHS Croydon CCG	1												1
George Eliot Hospital NHS Trust				1									1
Gibraltar House Dental Clinic, Reported by NHS South East CCG	1												1
Gloucestershire Hospitals NHS Foundation Trust	1												1

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Great Western Hospitals NHS Foundation Trust	1		3										4
Guy's and St Thomas' NHS Foundation Trust	5			1			1						7
Hampshire Hospitals NHS Foundation Trust			1										1
Hillingdon Hospital NHS Foundation Trust	2		1										3
Homerton University Hospital NHS Foundation Trust		1	1										2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Hull City Health Care Partnership, reported by NHS Hull CCG	1												1
Imperial College Healthcare NHS Trust	3	3											6
Kettering General Hospital NHS Foundation Trust		1											1
King's College Hospital NHS Foundation Trust	3	2		2		1	1						9
Kingston Hospital NHS Foundation Trust							1						1
Lancashire Care NHS Foundation Trust	1												1

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Lancashire Teaching Hospitals NHS Foundation Trust	2	1			2								5
Leeds Teaching Hospitals NHS Trust	1		1	2	1								5
Leicestershire Partnership NHS Trust										1			1
Liverpool Heart and Chest Hospital NHS Foundation Trust				1									1
Liverpool Women's Hospital NHS Foundation Trust		1	1										2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Locala Community Partnerships CIC, reported by NHS Greater Huddersfield CCG			1										1
London North West University Healthcare NHS Trust	2	1	1	1									5
Luton and Dunstable University Hospital NHS Foundation Trust	1												1
Maidstone and Tunbridge Wells NHS Trust		1											1
Manchester University NHS Foundation Trust	1		1		2								4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Medway Community Healthcare	1												1
Medway NHS Foundation Trust		1											1
Mersey Care NHS Foundation Trust										1			1
Mid Cheshire Hospitals NHS Foundation Trust		1											1
Mid Essex Hospital Services NHS Trust	3												3
Mid Yorkshire Hospitals NHS Trust	1				1								2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Milton Keynes University Hospital NHS Foundation Trust	1	1					1						3
Moorfields Eye Hospital NHS Foundation Trust	2												2
My dentist Leigh, reported by Greater Manchester Direct Commissioning	1												1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	1				1	1						5
Norfolk and Norwich University Hospitals NHS Foundation Trust	1	2	2										5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
North Bristol NHS Trust		1		4									5
North Cumbria University Hospitals Trust		1					1						2
North Middlesex University Hospital NHS Trust		1	2										3
North Staffordshire Combined Healthcare NHS Trust										1			1
North West Anglia NHS Foundation Trust	1	1											2
Northampton General Hospital NHS Trust	1												1

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Northamptonshire Healthcare NHS Foundation Trust								1					1
Northern Devon Healthcare NHS Trust	1												1
Northern Lincolnshire and Goole NHS Foundation Trust	2	1											3
Northumbria Healthcare NHS Foundation Trust	2												2
Nuffield Health North Staffordshire private hospital, reported by NHS North Staffordshire CCG		1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Oxford Health NHS Foundation Trust	1									1			2
Oxford University Hospitals NHS Foundation Trust	3	4											7
Parkside private hospital, reported by NHS Wandsworth CCG			1										1
Pennine Acute Hospitals NHS Trust				1									1
Pinehill private hospital, reported by NHS East and North Hertfordshire CCG			1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Poole Hospital NHS Foundation Trust	2	1											3
Portsmouth Hospitals NHS Trust	2				2								4
Priory Hospital Southampton, reported by NHS England										1			1
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	1												1
Queen Victoria Hospital NHS Foundation Trust		1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Ramsay Rivers Hospital, reported by NHS West Essex CCG	1												1
Rotherham NHS Foundation Trust	1				1								2
Rowley Hall Hospital, reported by Stafford and surrounds CCG	1												1
Royal Berkshire NHS Foundation Trust		3		3									6
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1		2										3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Royal Brompton and Harefield NHS Foundation Trust					1								1
Royal Cornwall Hospitals NHS Trust		1				1							2
Royal Devon and Exeter NHS Foundation Trust	3	1			1								5
Royal Free London NHS Foundation Trust	4	2	1	2									9
Royal Liverpool and Broadgreen University Hospitals NHS Trust			1		1			1					3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Royal Surrey County Hospital NHS Foundation Trust		1											1
Royal United Hospitals Bath NHS Foundation Trust	2												2
Royal Wolverhampton NHS Trust	2	2											4
Salisbury NHS Foundation Trust	1			1									2
Sandwell and West Birmingham Hospitals NHS Trust	1	2											3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Sheffield Children's NHS Foundation Trust	2												2
Sheffield Teaching Hospitals NHS Foundation Trust		2											2
Sherwood Forest Hospitals NHS Foundation Trust	1												1
Shrewsbury and Telford Hospitals NHS Trust	1	2											3
Somerset Partnership NHS Foundation Trust	1												1
South Tees Hospitals NHS Foundation Trust	1	3											4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
South Warwickshire NHS Foundation Trust	2												2
Southampton General Hospital, reported by NHS Southampton CCG	1												1
Southampton NHS Treatment Centre (Care UK), reported by NHS Southampton CCG	1												1
Southend University Hospital NHS Foundation Trust	1												1
Southport and Ormskirk Hospital NHS Trust		2											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Spire London East private hospital, reported by NHS Redbridge CCG	1												1
Spire Manchester private hospital, reported by NHS Manchester CCG		1											1
Spire Regency private hospital, reported by NHS Eastern Cheshire CCG	1												1
St Catherine's Hospital, reported by NHS Wirral CCG			1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
St George's University Hospitals NHS Foundation Trust			1		1	1			1				4
St Helens and Knowsley Teaching Hospitals NHS Trust		1											1
Stockport NHS Foundation Trust		1											1
Surrey and Sussex Healthcare NHS Trust	1		1										2
Tameside and Glossop Integrated Care NHS Foundation Trust		1			1								2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Taunton and Somerset NHS Foundation Trust	2		1										3
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust			1										1
Torbay and South Devon NHS Foundation Trust	1	1											2
United Lincolnshire Hospitals NHS Trust	2				1							2	5
University College London Hospitals NHS Foundation Trust	1	3											4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
University Hospital Southampton NHS Foundation Trust	1	1	1										3
University Hospitals Birmingham NHS Foundation Trust	1	2	1	2	2		1						9
University Hospitals Bristol NHS Foundation Trust	2	2											4
University Hospitals of Derby and Burton NHS Foundation NHS Trust	3	1		3		1							8
University Hospitals of Leicester NHS Trust	4		1	1									6

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
University Hospitals of Morecambe Bay NHS Foundation Trust	1		1		1								3
University Hospitals of North Midlands NHS Trust		2	1						1				4
University Hospitals Plymouth NHS Trust	5		1				1						7
Wallace House Surgery, reported by NHS South West regional team	1												1
Walsall Healthcare NHS Trust			12	1									13

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Walton Centre NHS Foundation Trust			1										1
Warrington and Halton Hospitals NHS Foundation Trust					1								1
West Hertfordshire Hospitals NHS Trust			2										2
West Suffolk NHS Foundation Trust	1												1
Western Sussex Hospitals NHS Foundation Trust	1	1		1									3
Weston Area Health NHS Trust												1	1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Whittington Health NHS Trust	1												1
Wirral University Teaching Hospital NHS Foundation Trust					1								1
Woodland Hospital, reported by NHS Nene CCG	1												1
Worcestershire Acute Hospitals NHS Trust	2												2
Wrightington, Wigan and Leigh NHS Foundation Trust	2	1	1	1									5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric 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	Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of high strength midazolam	Total
Wye Valley NHS Trust				2									2
York Teaching Hospital NHS Foundation Trust				1				1					2
Total	**165**	**91**	**58**	**43**	**26**	**10**	**12**	**3**	**4**	**7**	**1**	**3**	**423**

Note: A further six Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 4: Never Events occurring before 1 April 2018 not previously reported

Provider organisation where Never Event occurred	Month in which Never Event occurred	Incident Type
Great Western Hospitals NHS Foundation Trust	January 2011	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	March 2013	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	February 2016	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	November 2016	Wrong implant/prosthesis
Total		**4**

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 Publication code: TD 05/19