

Provisional publication of Never Events reported as occurring between 1 April and 30 June 2019

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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 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.

To help prevent the use of curtain or shower rails being used as a ligature point, an Estates and Facilities Alert *Anti-ligature' type curtain rail systems: Risks from incorrect installation or modification* has been published in March 2019. The alert is not accessible publicly but can be accessed via log in to the [Central Alerting System](#).

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 of 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 and 30 June 2019, and which on 15 July 2019 were designated by their reporters as Never Events.

Data on [Never Events for 2018/19 and previous years](#) can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2019/20 reporting year for local incident investigation and national analysis of data, we 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 15 July 2019, 100 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April and 30 June 2019. Of these 100 incidents:

- 90 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 and 30 June 2019; this number is subject to change as local investigations are completed
- 10 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April and 30 June 2019.

More detail is provided in the tables below:

Table 1: Never Events 1 April to 30 June 2019 by month of incident*

Month in which Never Event occurred	Number
Apr	25
May	34
Jun	31
Total	90

Note: As described above, a total of ten 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 to 30 June 2019 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	45
Cervical biopsy instead of colon/rectal biopsy	1
Contrast injection to wrong breast	1
Cystoscopy instead of sigmoidoscopy	1
Incision to wrong eye lid	1
Injection to wrong eye	2
Injections to both eyes rather than one	1
Misplaced central line	1
Needle aspiration of wrong lung	1
Perineal fistulotomy instead of incision and drainage of pilonidal abscess	1
Pilonidal sinus excised instead of groin abscess	1
Wrong breast lesion removed	1
Wrong side chest drain	1
Wrong side spinal injection	4
Wrong site block	19
Wrong site pleural aspiration	1
Wrong skin lesion removed	2
Wrong tooth/teeth removed	6
Retained foreign object post procedure	18
Bladder loop	1
Guide wire - central line	4
Guide wire - renal dialysis line	1
Ophthalmic pars plana vitrectomy (PPV) port	1
Part of dental instrument	1
Part of a uterine manipulator	1
Percutaneous Endoscopic Gastrostomy (PEG) insertion device	1
Surgical forcep	1
Surgical needle	1
Surgical swab	4
Vaginal swab	2
Wrong implant/prosthesis	12
Femoral nail	1
Fracture fixation plate - right instead of left	1
Intra uterine device	1
Knee	5
Lens	2
Wrong intrauterine device	2
Misplaced naso or oro gastric tube	7
Naso gastric tube in the respiratory tract and feed administered	7

Unintentional connection of a patient requiring oxygen to an air flowmeter	3
Patient connected to air flowmeter rather than oxygen	3
Misselection of high strength midazolam during conscious sedation	1
Wrong strength midazolam administered	1
Misselection of a strong potassium solution	1
Wrong strength potassium administered	1
Overdose of methotrexate for non-cancer treatment	1
Methotrexate overdose prescribed and administered	1
Administration of medication by the wrong route	1
Oral medication given intravenously	1
Failure to install functional collapsible shower or curtain rails	1
Curtain rail failed to collapse	1
Total	90

Note: As described above, another ten 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 30 June 2019 by healthcare provider*

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Airedale NHS Foundation Trust										1	1
Alexandra Group Medical Practice reported by NHS Oldham CCG						1					1
Barking Havering and Redbridge University Hospitals NHS Trust							1				1
Barnet, Enfield and Haringey Mental Health NHS Trust		1									1
Barts Health NHS Trust								1	3		4
BPAS Merseyside reported by NHS Halton CCG								1			1
Cambridge University Hospitals NHS Foundation Trust							1			1	2

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Chesterfield Royal Hospital NHS Foundation Trust										1	1
City Hospital Sunderland NHS Foundation Trust								1			1
County Durham and Darlington NHS Foundation Trust				1				1			2
Croydon Health Services NHS Trust										1	1
Cumbria Partnership NHS Foundation Trust										1	1
Derbyshire Community Health Services NHS Foundation Trust							1				1
East Kent Hospitals University NHS Foundation Trust							2				2
East Lancashire Hospitals NHS Trust							1				1

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
East Suffolk and North Essex NHS Foundation Trust										1	1
East Sussex Healthcare NHS Trust										1	1
Epsom and St Helier NHS Trust								1			1
Epsom and St Helier University Hospitals NHS Trust										1	1
Frimley Health NHS Foundation Trust					1						1
George Eliot Hospital NHS Trust										1	1
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					1		1			1	3

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Homerton Hospital NHS Foundation Trust									1		1
Hull and East Yorkshire Hospitals NHS Trust					1		1			1	3
Imperial College Healthcare NHS Trust							1				1
King's College Hospital NHS Foundation Trust										1	1
Leeds Teaching Hospitals NHS Trust										1	1
Lewisham and Greenwich NHS Trust										2	2
Luton and Dunstable University Hospital NHS Foundation Trust										1	1
Medway NHS Foundation Trust							1				1
Mid Essex Hospital Services NHS Trust					1						1
Mid Yorkshire Hospitals NHS Trust			1				1				2

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
North Tees and Hartlepool NHS Foundation Trust										1	1
North West Anglia NHS Foundation Trust									1		1
Northern Devon Healthcare NHS Trust										1	1
Northumbria Healthcare NHS Foundation Trust							1				1
Nottingham University Hospitals NHS Trust									1		1
Rowley Hall Hospital reported by NHS Stafford and Surrounds CCG									1		1
Royal Free London NHS Foundation Trust					1						1
Royal Liverpool and Broadgreen NHS Trust										2	2
Royal Orthopaedic Hospital NHS Foundation Trust										1	1

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Royal Papworth Hospital NHS Foundation Trust							1				1
Royal United Hospital Bath NHS Trust								1			1
Salisbury NHS Foundation Trust								1			1
Sandwell and West Birmingham Hospitals NHS Trust							1			1	2
Sheffield Teaching Hospitals NHS Foundation Trust									1	1	2
Smiles Orthodontics Dental Practice reported by NHS East and North Hertfordshire CCG										1	1
South Tees Hospitals NHS Foundation Trust										1	1
South Warwickshire NHS Foundation Trust										1	1

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Southport and Ormskirk Hospital NHS Trust										1	1
Spire London East Hospital, reported by NHS Redbridge CCG										1	1
Springfield Hospital - Ramsay Health Care reported by NHS Mid Essex CCG								1			1
Surrey and Sussex Healthcare NHS Trust										2	2
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1										1
The Royal Wolverhampton NHS Trust										1	1
Torbay and South Devon NHS Foundation Trust										1	1
United Lincolnshire Hospitals NHS Trust							1				1

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
University College London Hospitals NHS Foundation Trust								1			1
University Hospital Southampton NHS Foundation Trust					1					1	2
University Hospitals Bristol NHS Foundation Trust									1		1
University Hospitals of Derby and Burton NHS Foundation Trust										1	1
University Hospitals of Leicester NHS Trust										2	2
University Hospitals of North Midlands NHS Trust										1	1
Weston Area Health NHS Trust										1	1
Whittington Health NHS Trust										1	1
Worcestershire Acute Hospitals NHS Trust							1				1

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
Wrightington, Wigan and Leigh NHS Foundation Trust					1						1
Wye Valley NHS Trust							1				1
Yeovil District Hospital NHS Foundation Trust										2	2
Total	1	1	1	1	7	1	18	3	12	45	90

Note: As described above, another ten 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 2019 not previously reported*

. None reported.

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

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