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

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NHS England and NHS Improvement

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 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 A*nti-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 31 July 2019, and which on 8 August 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 8 August 2019, 138 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 July 2019. Of these 138 incidents:

- 125 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 31 July 2019; this number is subject to change as local investigations are completed
- 13 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April and 31 July 2019.

More detail is provided in the tables below:

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

Month in which Never Event occurred	Number
Apr	25
May	34
Jun	31
Jul	35
Total	**125**

Note: As described above, a further 13 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

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

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

Type and brief description of Never Event	Number
Wrong site surgery	**63**
Cervical biopsy instead of colon/rectal biopsy	1
Circumcision instead of planned frenuloplasty	1
Contrast injection to wrong breast	1
Cystoscopy instead of sigmoidoscopy	1
Gastroscopy intended for another patient	1
Incision to wrong eye lid	1
Injection to wrong eye	3
Injection to wrong eye muscle	1
Injection to wrong leg	1
Injections to both eyes rather than one	1
Knee injection instead of elbow aspiration	1
Laser treatment intended for another patient	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 finger incision	1
Wrong finger injection	1
Wrong side chest drain	1
Wrong side spinal injection	5
Wrong site block	22

Wrong site pleural aspiration	1
Wrong skin lesion removed	3
Wrong tooth/teeth removed	10
Retained foreign object post procedure	**23**
Bladder loop	1
Bladder resectoscope tip	1
Corneal guard	1
Guide wire - central line	4
Guide wire - PICC line	1
Guide wire - renal dialysis line	1
Ophthalmic pars plana vitrectomy (PPV) port	1
Part of dental instrument	1
Part of a uterine manipulator	1
PEG insertion device	1
Surgical forceps	1
Surgical needle	1
Surgical swab	5
Vaginal swab	3
Wrong implant/prosthesis	**15**
Femoral nail	1
Fracture fixation plate - right instead of left	1
Hip	1
Intra uterine device	3
Knee	6
Lens	2
Naso jejunal feeding tube rather than a palliative stent	1

Misplaced naso or oro gastric tube	**9**
Naso gastric tube in the respiratory tract and feed administered	9
Unintentional connection of a patient requiring oxygen to an air flowmeter	**8**
Patient connected to air flowmeter rather than oxygen	8
Administration of medication by the wrong route	**2**
Oral medication given intravenously	2
Transfusion or transplantation of ABO incompatible blood components or organs	**1**
Wrong blood transfused	1
Mis selection of high strength midazolam during conscious sedation	**1**
Wrong strength midazolam administered	1
Failure to install functional collapsible shower or curtain rails	**1**
Curtain rail failed to collapse	1
Mis selection of a strong potassium solution	**1**
Wrong strength potassium given	1
Overdose of methotrexate for non-cancer treatment	**1**
Methotrexate overdose prescribed and administered	1
Total	**125**

Note: As described above, a further 13 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

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

Table 3: Never Events 1 April to 31 July 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	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**
Ashford and St. Peters Hospitals NHS Foundation Trust											2	**2**
Barking, Havering and Redbridge University Hospitals NHS Trust							1					**1**
Barnet, Enfield and Haringey Mental Health 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Barts Health NHS Trust										1	3	**4**
BMI - The Chiltern Hospital reported by NHS Aylesbury Vale CCG										1		**1**
BPAS Merseyside reported by NHS Halton CCG										1		**1**
Bradford District Care NHS Foundation Trust											1	**1**
Cambridge University Hospitals NHS Foundation Trust							1				1	**2**
Chesterfield Royal 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
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 and North Hertfordshire 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
East Kent Hospitals University NHS Foundation Trust							2					**2**
East Lancashire Hospitals NHS Trust							1					**1**
East Suffolk and North Essex NHS Foundation Trust							1				2	**3**
East Sussex Healthcare NHS Trust											1	**1**
Epsom and St Helier University Hospitals NHS Trust										1	1	**2**
Frimley Health 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
George Eliot Hospital NHS Trust											1	**1**
Gloucestershire Hospitals NHS Foundation 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				1	**4**
Hampshire Hospitals 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	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		1	**4**
iSIGHT Private Eye Care, Southport reported by NHS South Sefton CCG											1	**1**
Imperial College Healthcare NHS Trust							1					**1**
King's College Hospital NHS Foundation Trust											1	**1**
Leeds Teaching 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Lewisham and Greenwich NHS Trust											2	**2**
Luton and Dunstable University Hospital NHS Foundation Trust											1	**1**
Manchester University NHS Foundation Trust					1		1					**2**
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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Moorfields Eye Hospital NHS Foundation Trust											1	**1**
Norfolk and Norwich University Hospitals NHS Foundation Trust									1			**1**
Norfolk Community Health and Care NHS Trust											1	**1**
North East Ambulance Service NHS Foundation Trust **									1			**1**
North Tees and Hartlepool NHS Foundation Trust											1	**1**
North West Anglia 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Northern Devon Healthcare NHS Trust											1	**1**
Northumbria Healthcare NHS Foundation Trust							1					**1**
Nottingham University Hospitals NHS Trust							1			1		**2**
Rowley Hall Hospital reported by Stafford and Surrounds CCG										1		**1**
Royal Free London NHS Foundation Trust					1							**1**
Royal Liverpool and Broadgreen NHS Trust											2	**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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Royal Orthopaedic Hospital NHS Foundation Trust											1	**1**
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	2	**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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Sherwood Forest Hospitals NHS Foundation Trust											1	**1**
Smiles Orthodontics Dental Practice, reported by NHS East and North Hertfordshire CCG											1	**1**
South Tees Hospitals NHS Foundation Trust					1						1	**2**
South Warwickshire NHS Foundation Trust											1	**1**
Southend University Hospital NHS Foundation Trust										1		**1**
Southport and Ormskirk Hospital 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Spire London East Hospital, reported by NHS Redbridge CCG											1	**1**
Spire Manchester reported by NHS Manchester CCG											1	**1**
Springfield Hospital, Ramsay Health Care, reported by NHS Mid Essex CCG										1		**1**
St George's University Hospitals NHS Foundation Trust							1					**1**
Surrey and Sussex Healthcare NHS Trust											2	**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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
The McIndoe Centre reported by NHS High Weald Lewes Havens CCG											1	**1**
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1						1					**2**
The Royal Free NHS Foundation Trust								1				**1**
The Royal Wolverhampton NHS Trust											1	**1**
The 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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Torbay and South Devon NHS Foundation Trust											1	**1**
United Lincolnshire Hospitals NHS Trust							1					**1**
University College London Hospitals NHS Foundation Trust									1			**1**
University Hospital Southampton NHS Foundation Trust					1						2	**3**
University Hospitals Birmingham NHS Foundation Trust											2	**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 or oro gastric tube	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
University Hospitals Bristol NHS Foundation Trust										1	1	**2**
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**

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Worcestershire Acute Hospitals NHS Trust							1					**1**
Wrightington, Wigan and Leigh NHS Foundation Trust					1					1		**2**
Wye Valley NHS Trust							1				1	**2**
Yeovil District Hospital NHS Foundation Trust											2	**2**
Total	**2**	**1**	**1**	**1**	**9**	**1**	**23**	**1**	**8**	**15**	**63**	**125**

Note: As described above, a further 13 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

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

** Reported by North East Ambulance Service NHS Foundation Trust but appears related to an air flowmeter left in situ in University Hospital of North Durham.

Table 4: Never Events reported as occurring after 1 April 2019 but actually occurring prior to this

. None reported.

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

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