NHS Improvement

Provisional publication of Never Events reported as occurring between 1 April 2016 and 31 January 2017

Published 27 February 2017

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

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers. The current Never Events Policy and Framework suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes. Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing existing safety advice/ alerts might not be robust. For more detail on Never Events, see: www.england.nhs.uk/ourwork/patientsafety/never-events/

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

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

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

Supporting healthcare providers to prevent Never Events

To support the prevention of 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 the sharing of best practice between organisations.

To support the prevention of 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 a range of materials designed to help trust boards, or their equivalents, assess whether previous alerts and guidance around 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 also 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 and 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 now 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 where the date of the incident was between 1 April 2016 and 31 January 2017 and where on 10 February 2017 they were designated by their reporters as Never Events.

Data on Never Events for 2015/16 and previous years can be found on the NHS England website.

After the 2016/17 period has ended and sufficient time has elapsed for local incident investigation and national analysis of data, NHS Improvement will produce a final whole-year report of Never Events, which will replace the provisional data.

Summary

When data for this report was extracted on 10 February 2017, 365 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2016 and 31 January 2017. Of these 365 incidents:

- 351 Serious Incidents appeared to meet the definition of a Never Event in the Never Events List 2015/16 and had an incident date between 1 April 2016 and 31 January 2017; this number is subject to change as local investigations take place
- 7 Serious Incidents did not appear to meet the definition of a Never Event
- 1 Serious Incident was still in draft form
- 6 Serious Incidents occurred or were likely to have occurred before the reporting year from April 2016.

More detail is provided in the tables below:

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

Month in which Never Event occurred	Number
Apr 2016	31
May 2016	30
Jun 2016	41
Jul 2016	42
Aug 2016	35
Sep 2016	29
Oct 2016	41
Nov 2016	43
Dec 2016	29
Jan 2017	30
Total	**351**

Note: As described above, an extra seven Serious Incidents did not appear to meet the definition of a Never Event, one was still in draft form and six occurred before April 2016.
***Numbers are subject to change as local investigations are completed.**

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

Type and brief description of Never Event	Number
Wrong site surgery	**143**
Angiogram to wrong side	1
Axillary biopsy instead of chest wall biopsy	1
Central line placed into carotid artery	1
Cervical biopsy rather than rectal biopsy	2
Patient had a procedure intended for another patient	1
Procedure undertaken that was in addition to the consented procedure	1
Saphenous vein harvested from wrong leg	1
Ventriculoperitoneal shunt externalisation to wrong side	1
Wrong area of the breast excised	2
Wrong breast injection	1
Wrong buttock	1
Wrong eye - squint surgery	1
Wrong eye injection	2
Wrong finger	4
Wrong finger incision	1
Wrong heel injection	1
Wrong hip aspiration	1
Wrong incision - wrist instead of finger	1
Wrong incision - wrist instead of thumb	1
Wrong incision to remove tooth/teeth	1
Wrong patient - received a subcutanous device to monitor heart rhythm that was intended for another patient	1
Wrong patient - cystoscopy rather than outpatient consultation	1
Wrong patient - eye injections rather than outpatient consultation	2
Wrong patient - laser eye treatment instead of eyelid procedure	1
Wrong patient - wrong eye injection	1
Wrong patient had a lumbar puncture intended for another patient	1
Wrong patient identification - unnecessary procedure	4
Wrong procedure - polypectomy rather than coil insertion	1
Wrong rib	1
Wrong scar excised	1

Wrong shoulder	1
Wrong side angioplasty	2
Wrong side axillary node clearance	1
Wrong side block	3
Wrong side contraceptive implant	1
Wrong side hip incision	1
Wrong side hip injection	1
Wrong side kidney stent	1
Wrong side knee arthroscopy	1
Wrong side of brain	1
Wrong side of elbow	2
Wrong side of leg	1
Wrong side of toenails	1
Wrong side pleural aspiration	1
Wrong side sublingual gland removed	1
Wrong side surgical intervention	1
Wrong side varicose vein surgery	1
Wrong site block	23
Wrong skin lesion removed	11
Wrong spinal level	10
Wrong thyroid lobe removed	1
Wrong toe	4
Wrong tooth/teeth	33
Retained foreign object post procedure	**89**
Broken drill bit not identified at the time of the procedure	1
Cap from drain inserter	1
Corneal shield	1
Cotton bud	1
Drill guide used for internal fixation of a fracture	1
Endo file	1
Guide wire - central line	10
Guide wire - chest drain	4
Guide wire - femoral line	1
Guide wire - PICC line	1
Guide wire - urethrotomy catheter	1
Guide wire - vascath	2
K wire	2

Nerve/vessel retractor (elastic)	1
Ophthalmology sponge	1
Part of a drill bit not identified as missing at the time of the procedure	1
Part of surgical forceps	1
Partial PICC catheter	1
Piece of shoulder instrumentation	1
Ribbon gauze	1
Screw guide	1
Screw tabs	1
Small Dappens dish used as a mouth prop	1
Specimen retrieval bag	4
Stem protector	1
Surgical drain	1
Surgical needle	1
Surgical swab	13
Swab tag	1
Throat pack	2
Ureteric stent	1
Vaginal swab	28
Wrong implant/prosthesis	**44**
Contraceptive implant	3
Hip	6
Knee	16
Lens	18
Wrong side fixation plate	1
Wrong route administration of medication	**36**
Epidural and intravenous medication mixed up and both given via the wrong route	1
Epidural medication administered intravenously	10
Intravenous medication administered via epidural catherter	1
Oral medication given intravenously	17
Oral medication given subcutaneously	5
Oral medication given via peritoneal dialysis line	1
Route not known – further details being requested	1
Misplaced naso or oro gastric tubes	**23**
Naso gastric tube in respiratory tract and feed administered	23
Overdose of insulin due to abbreviations or incorrect device	**3**

Abbreviations used	1
Wrong syringe used	2
Chest or neck entrapment in bedrails	**3**
Chest or neck entrapment in bedrails	3
Overdose of methotrexate for non-cancer treatment	**3**
Overdose of methotrexate for non-cancer treatment	3
Failure to install functional collapsible shower or curtain rails	**2**
Collapsible curtain rail failed to collapse	1
Curtain rail failed to collapse	1
Falls from poorly restricted windows	**2**
Failure of window restrictor	1
Window restrictor failed or not fitted correctly	1
Scalding of patients	**1**
Burns to feet from soaking in a bowl of water	1
Transfusion or transplantation of ABO incompatible blood components or organs	**1**
Wrong blood transfused	1
Misselection of a strong potassium containing solution	**1**
Potassium administered instead of saline	1
Total	**351**

Note: As described above, an extra seven Serious Incidents did not appear to meet the definition of a Never Event, one was still in draft form and six occurred before April 2016.
***Numbers are subject to change as local investigations are completed.**

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

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Aintree University Hospital NHS Foundation Trust	1													1
Airedale NHS Foundation Trust	1													1
Alder Hey Children's NHS Foundation Trust		1												1
Ashford and St. Peters Hospitals NHS Foundation Trust		1		1										2
Barking Havering and Redbridge University Hospitals NHS Trust		1		1										2
Barts Health NHS Trust	3	4		2	1									10
Basildon and Thurrock University Hospitals NHS Foundation Trust		1	1	1										3

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

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Brighton and Sussex University Hospitals NHS Trust		4										1		5
Bristol Community Health Social Enterprise, reported by NHS Bristol CCG							1							1
Buckinghamshire Healthcare NHS Trust	2		1	1										4
Burton Hospitals Foundation Trust	1		3	1										5
Calderdale and Huddersfield NHS Foundation Trust		1			1									2
Cambridge University Hospitals NHS Foundation Trust	1	1	1		1									4
Central Manchester University Hospitals NHS Foundation Trust		1												1
Chelsea and Westminster Healthcare NHS Foundation Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Colchester Hospital University NHS Foundation Trust	1		1		1									3
Countess of Chester Hospital NHS Foundation Trust	3	1												4
County Durham and Darlington NHS Foundation Trust	6		1											7
Croydon Health Services NHS Trust	1													1
Cumbria Partnership NHS Foundation Trust		1												1
Darley Dale Medical Centre, reported by Sheffield CCG	1													1
Dartford and Gravesham NHS Trust		1	1											2
Derby Teaching Hospitals NHS Foundation Trust	2			1										3
Derbyshire Community Health Services NHS Trust		1												1

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

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Epsom and St Helier NHS Trust			1											1
Frimley Health NHS Foundation Trust	1			1										2
Gateshead Health NHS Foundation Trust	2	1												3
George Eliot Hospital NHS Trust	1				1									2
Gloucestershire Hospitals NHS Foundation Trust		1	1											2
Great Ormond Street Hospital for Children NHS Foundation Trust					1									1
Gretton Court Nursing Home, reported by NHS Hartlepool and Stockton CCG								1						1
Guy's and St Thomas' NHS Foundation Trust	2	3		1										6
Hampshire Hospitals NHS Foundation Trust	2		1											3

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Heart of England NHS Foundation Trust					1									1
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1													1
Hinchingbrooke Health Care NHS Trust	1													1
Homerton Hospital NHS Foundation Trust					1									1
Hull and East Yorkshire Hospitals NHS Trust					1									1
Imperial College Healthcare NHS Trust		3		1										4
Ipswich Hospital NHS Trust		1	1				1							3
Isle of Wight NHS Trust	1	2		1										4
James Paget University Hospitals NHS Foundation Trust				1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Kent Community Health NHS Foundation Trust	1													1
Kettering General Hospital NHS Foundation Trust	1	1												2
KIMS private hospital, reported by NHS Medway CCG	1													1
King's College Hospital NHS Foundation Trust	3	1			1									5
Kingston Hospital NHS Foundation Trust		2		1										3
Lancashire Teaching Hospitals NHS Foundation Trust	2				1									3
Leeds Teaching Hospitals NHS Trust	4													4
Lewisham and Greenwich NHS Trust				2										2
Liverpool Community Health NHS Trust				1										1

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Liverpool Heart and Chest NHS Foundation Trust	1													1
Liverpool Women's Hospital NHS Foundation Trust	1													1
London North West Healthcare NHS Trust		2												2
Luton and Dunstable University Hospital NHS Foundation Trust	1		1											2
Maidstone and Tunbridge Wells NHS Trust	2		1											3
Medway NHS Foundation Trust	1	1												2
Mid Cheshire Hospitals NHS Foundation Trust	1		1											2
Mid Essex Hospital Services NHS Trust	3	1	1											5
Mid Yorkshire Hospitals NHS Trust	1	1		1										3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Moorfields Eye Hospital NHS Foundation Trust		1	2											3
Newcastle Upon Tyne Hospitals NHS Foundation Trust	4	2		1										7
Norfolk and Norwich University Hospitals NHS Foundation Trust	2	1	1											4
North Bristol NHS Trust	2	1	1		1									5
North Middlesex Hospital NHS Trust	1	1												2
North Tees and Hartlepool NHS Foundation Trust	1													1
Northamptonshire Healthcare NHS Foundation Trust	1								1					2
Northern Devon Healthcare NHS Trust	1			2										3
Northern Lincolnshire and Goole NHS Foundation Trust		1												1

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Northumbria Healthcare NHS Foundation Trust		1												1
Nottingham University Hospitals NHS Trust	1	1		1	1	1								5
Nuffield Clinic Dental Access Centre, reported by Plymouth Community Healthcare	1													1
Nuffield Health Tees private hospital, reported by NHS Hartlepool and Stockton CCG	1													1
Nuffield Private Healthcare Chester, reported by NHS West Cheshire CCG			1											1
Oldbury Court Dental Services, reported by South West Area Team		1												1
Oxford University Hospitals NHS Foundation Trust	1		1											2
Papworth Hospital NHS Foundation Trust					1									1

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Pennine Acute Hospitals NHS Trust	2	1	2											5
Peterborough and Stamford NHS Foundation Trust			1											1
Swillington Pharmacy reported by Yorkshire and the Humber area team							1							1
Plymouth Hospitals NHS Trust	1	2												3
Poole Hospital NHS Foundation Trust		3												3
Portsmouth Hospitals NHS Trust	1	1				1								3
Queen Victoria Hospital NHS Foundation Trust	1	1												2
Ramsey Horton Independent Sector Treatment Centre, reported by NHS Oxfordshire CCG			1											1

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Ramsey private healthcare reported by NHS Oxfordshire CCG		1												1
Ramsey The Yorkshire Clinic private hospital, reported by NHS Bradford District CCG	1													1
Reported by NHS Herts Valleys CCG								1						1
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2													2
Royal Berkshire NHS Foundation Trust	1													1
Royal Cornwall Hospitals NHS Trust	1													1
Royal Devon and Exeter NHS Foundation Trust	1	1												2
Royal Free London NHS Foundation Trust					2									2

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Royal Orthopaedic Hospital NHS Foundation Trust	2		1											3
Salford Royal NHS Foundation Trust	3													3
Salisbury NHS Foundation Trust	1					1								2
Sandwell and West Birmingham Hospitals NHS Trust	1	2												3
Sheffield Health and Social Care NHS Foundation Trust									1					1
Sheffield Teaching Hospitals NHS Foundation Trust	1	1												2
Sherwood Forest Hospitals NHS Foundation Trust		1			1									2
Shrewsbury and Telford Hospitals NHS Trust	1	3												4
South Tees Hospitals NHS Foundation Trust	2				1									3

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South Tyneside NHS Foundation Trust				1										1
Southampton Treatment Centre reported by NHS Southampton CCG	1													1
Southend University Hospital NHS Foundation Trust		1	1										1	3
Southport and Ormskirk Hospital NHS Trust	1	1	1											3
Southwick Dental Practice, reported by NHS Sunderland CCG	1													1
Spire Cambridge Lea private hospital, reported by NHS Cambridgeshire and Peterborough CCG	1													1
Spire Liverpool private hospital, reported by NHS Liverpool CCG			1											1

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Spire Parkway private healthcare, reported by Solihull CCG	1													1
Spire Roding private healthcare, reported by NHS Waltham Forest CCG	1													1
Spire Southampton private hospital, reported by NHS West Hampshire CCG		1												1
Spire Wellesley private hospital, reported by NHS Southend CCG	1													1
St Anthony's private hospital , reported by NHS Surrey Downs CCG	1													1
St George's Healthcare NHS Trust	2													2
St Helens and Knowsley Hospitals NHS Trust		2												2
Stockport NHS Foundation Trust				1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Surrey and Sussex Healthcare NHS Trust	1													1
Taunton and Somerset NHS Foundation Trust	4		1											5
Tees Valley Treatment Centre, reported by NHS South Tees CCG	1													1
The Dudley Group NHS Foundation Trust			1											1
The Hillingdon Hospital NHS Foundation Trust				1										1
The Rotherham NHS Foundation Trust		1		1										2
The Royal Wolverhampton NHS Trust	2	2												4
The Wirral Community NHS Foundation Trust	1													1
Torbay and South Devon NHS Foundation Trust				1										1

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

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

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong route administration of medication	Misplaced naso or oro gastric tubes	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non cancer treatment	Chest or neck entrapment in bedrails	Failure to install collapsible shower or curtain rails	Falls from poorly restricted windows	Misselection of a strong potassium containing solution	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Total
Woodburn Cottage Dental Services - South West Area Provider	1													1
Worcestershire Acute Hospitals NHS Trust	1	1												2
Wrightington, Wigan and Leigh NHS Foundation Trust								1						1
Wye Valley NHS Trust	2									1				3
Yeovil District Hospital NHS Foundation Trust	2													2
York Teaching Hospital NHS Foundation Trust	3			1										4
	143	**89**	**44**	**36**	**23**	**3**	**3**	**3**	**2**	**2**	**1**	**1**	**1**	**351**

Note: As described above, an additional seven serious incidents did not appear to meet the definition of a Never Event, one was still in draft from and six occurred prior to April 2016.

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

Table 4: Never Events occurring before 1 April 2016*

Provider organisation where Never Event occurred	Date	Retained foreign object post procedure
Countess of Chester Hospital NHS Foundation Trust	Likely to predate April 2016 but date unknown (multiple procedures)	1
Ipswich Hospital NHS Trust	Early 2016	1
Pennine Acute Hospitals NHS Trust	Likely to predate April 2016 but date unknown	1
Pennine Acute Hospitals NHS Trust	2012	1
South Tees Hospitals NHS Foundation Trust	Likely to have been left in during a previous procedure 2014	1
Ramsey Healtcare West Midlands private hospital, reported by Dudley CCG	2012	1
South Tees Hospitals NHS Foundation Trust	Likely to have been left in during a previous procedure in 2014	1
		7

*Numbers are subject to change as local investigation is 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

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