

# **Provisional publication of Never Events reported as occurring between 1 and 31 July 2015**



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## **Provisional publication of Never Events reported as occurring between 1 and 31 July 2015**

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## Provisional publication of Never Events reported as occurring between 1 and 31 July 2015

This report provides a provisional summary of Never Events that have been reported as occurring between 1 and 31 July 2015.

### Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on Never Events, see:

[www.england.nhs.uk/ourwork/patientsafety/never-events/](http://www.england.nhs.uk/ourwork/patientsafety/never-events/)

Please note that because the definitions and designated list of Never Events was revised from April 2015, direct comparison of numbers with periods prior to 1 April 2015 would be misleading.

The revision of the [Never Events Policy and Framework](#) 2015 requires commissioners and providers to agree and report Never Events via 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 the StEIS system to confirm it is a Never Event or to remove its Never Event designation from the StEIS system.

### IMPORTANT NOTES on the provisional nature of these data

To support learning from Never Events, NHS England is committed to early publication. However, because reports of apparent Never Events are made as soon as possible before local investigation is complete all data are subject to change.

This provisional report is drawn from the StEIS system, and includes all Serious Incidents where the date of the incident was between 1 and 31 July 2015 and where on 7 August 2015 they were designated by their reporters as Never Events.

This report is part of a series of reports based on provisional data that are made available throughout the year. Provisional data on Never Events for earlier periods of 2015/16 can be found at: <http://www.england.nhs.uk/ourwork/patientsafety/never-events/ne-data/>

After the 2015/16 period has ended and sufficient time has elapsed for local incident investigation and national analysis of data to take place, a final whole-year report of Never Events reported as occurring in 2015/16 will be produced and will replace these provisional reports.

## Summary

At the time data for this report were extracted on 7 August 2015, 29 Serious Incidents on the STEIS system were designated by their reporters as Never Events with a reported incident date between 1 and 31 July 2015. Of these 29 incidents:

- There were 27 Serious Incidents that appeared to meet the definitions of a Never Event in the [Never Events List 2015/16](#) and the actual date of incident fell between 1 and 31 July 2015. This number is subject to change as local investigation takes place.
- Two other Serious Incidents were reported in July 2015 but the date of the incidents was before 1 April 2015

More detail is provided in the tables below.

**TABLE ONE: Never Events 1 to 31 July 2015 by month**

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Month in which Never Event occurred	Number
July	27
<b>Total</b>	<b>27</b>
<b>Note:</b> As described above, two other Serious Incidents were reported in July 2015 but the date of the incidents was before 1 April 2015	

**TABLE TWO: Never Events 1 to 31 July 2015 by type of incident**

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type of Never Event	Number
Wrong site surgery	11
Misplaced naso- or oro gastric tubes	7
Retained foreign object post procedure	3
Wrong implant/ prosthesis	2
Mis selection of high strength midazolam during conscious sedation	1
Wrong route administration of medication	1
Transfusion or transplantation of ABO incompatible blood components or organs	1
Failure to install collapsible shower or curtain rails	1
<b>Total</b>	<b>27</b>
<b>Note:</b> As described above, two other Serious Incidents were reported in July 2015 but the date of the incidents was before 1 April 2015	

**TABLE THREE: Never Events 1 to 31 July 2015 by type of incident with additional detail**

<b>PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED</b>	
<b>Type and brief description of Never Event</b>	<b>Number</b>
<b>Wrong site surgery</b>	<b>11</b>
Wrong side block	2
Wrong skin lesion removed	1
Wrong tooth/ teeth removed	1
Laser treatment to wrong eye	1
Wrong side chest drain insertion	1
Wrong aspect of wrist explored	1
Wrong spinal level	1
Wrong Bartholin's cyst removed	1
Botox injection to stomach rather than oesophagus	1
Wrong elbow procedure carried out	1
<b>Misplaced naso- or oro-gastric tubes</b>	<b>7</b>
Naso gastric tube in respiratory tract	7
<b>Retained foreign object post procedure</b>	<b>3</b>
Part of a chisel	1
Vaginal swab	1
Surgical swab	1
<b>Wrong implant/ prosthesis</b>	<b>2</b>
Knee prosthesis	2
<b>Mis selection of high strength midazolam during conscious sedation</b>	<b>1</b>
Wrong strength midazolam administered	1
<b>Wrong route administration of medication</b>	<b>1</b>
Oral medication given IV	1
<b>Transfusion or transplantation of ABO incompatible blood components or organs</b>	<b>1</b>
Incorrect blood transfused	1
<b>Failure to install collapsible shower or curtain rails</b>	<b>1</b>
Attempted suicide using a curtain rail	1
<b>Total</b>	<b>27</b>
<b>Note:</b> As described above, two other Serious Incidents were reported in July 2015 but the date of the incidents was before 1 April 2015	

**TABLE FOUR: Never Events 1 to 31 July 2015 by healthcare provider**

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED						
Provider organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong site surgery	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Sub-total SI reported as NE that can be matched to NE list type 1-14
Bedford Hospital NHS Trust						1
Brighton and Sussex University Hospitals NHS Trust		1				1
Central Manchester University Hospitals NHS Foundation Trust			1			1
City Hospital Sunderland NHS Foundation Trust				1		1
Colchester Hospital University NHS Foundation Trust				1		1
Derby Hospitals NHS Foundation Trust			1			1
East Kent Hospitals University NHS Foundation Trust				1		1
East Lancashire Hospitals NHS Trust				1		1
Frimley Park Hospital NHS Foundation Trust			1			1
Gloucestershire Hospitals NHS Foundation Trust		1				1
Hinchingbrooke Health Care NHS Trust			1			1
Luton and Dunstable University Hospital NHS Foundation Trust					1	1
Milton Keynes General NHS Foundation Trust			1			1
North Bristol NHS Trust			1			1



PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED						
Provider organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/prosthesis	Wrong site surgery	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Sub-total SI reported as NE that can be matched to NE list type 1-14
North Cumbria University Hospitals Trust			1			1
Private clinic: Queens Square, University Hospitals Bristol NHS Foundation Trust			1			1
Sheffield Children's NHS Foundation Trust				1		1
South Devon Healthcare NHS Foundation Trust	1					1
Southend University Hospital NHS Foundation Trust						1
St George's Healthcare NHS Trust				1		1
Stockport NHS Foundation Trust			1			1
The Royal Wolverhampton NHS Trust	1					1
The Wirral Community NHS Trust			1			1
University Hospitals Coventry and Warwickshire NHS Trust	1					1
University Hospitals of Morecambe Bay NHS Foundation Trust			1			1
University Hospitals of North Midlands NHS Trust				1		1
West London Mental Health NHS Trust						1
	3	2	11	7	1	27