NHS England

Never Events reported as occurring between 1 April 2013 and 31 March 2014

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Publications Gateway Reference:	**02824**
Document Purpose	Resources
Document Name	Never Events reported as occurring between 1 April 2013 and 31 March 2014
Author	NHS England, Patient Safety Domain
Publication Date	30 December 2014
Target Audience	Published on NHS England website for public access
Additional Circulation List	All NHS England Employees
Description	This report provides a summary of never events reported as occuring between 1 April 2013 and 31 March 2014
Cross Reference	N/A
Superseded Docs (if applicable)	Provisional publication of never events reported as occurring between 1 April 2013 and 31 March 2014
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
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Document Status

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Never Events reported as occurring between 1 April 2013 and 31 March 2014

Version number: 1

First published: 30 December 2014

Prepared by: Patient Safety Domain, NHS England

Classification: Official

Contents

Never Events reported as occurring between 1 April 2013 and 31 March 2014

This report provides a summary of Never Events reported as occurring between 1 April 2013 and 31 March 2014.

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/

Reconciliation of Never Events reported through different routes

In April 2013, NHS England became responsible for the Never Events policy framework. Never Events data for 2013/14 to date have been collected from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) by the NHS England Patient Safety Domain.

In prior years, although efforts were made at each year's end to identify any duplicates in the number of Never Events reported via both the NRLS and STEIS, an accurate assessment of overlap (and therefore the total number of Never Events reported to either or both systems) was difficult.

To avoid this, any possible Never Events reported via NRLS since April 2013 have been passed by NHS England to commissioners, who are asked to discuss with the relevant provider organisations and either confirm this is not a Never Event or to ensure the incident is reported as a Never Event on the STEIS system. This process means that (once this confirmation has been received) STEIS can be considered as the reliable and complete data source.

Additionally, the quality of reporting of Never Events made to the STEIS system is routinely reviewed. 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 2013/14 update*, 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.

The detail of this reconciliation process is shown in the Appendix.

Summary

There are 340 Serious Incidents on the STEIS system that have been designated by their reporters as Never Events with a reported incident date between 1 April 2013 and 31 March 2014. Of these 340 incidents:

- There were 338 Serious Incidents that appeared to meet the definitions of a Never Event in The *Never Events list 2013/14 update* and the actual date of incident fell between 1 April 2013 and 31 March 2014.

- Two of the reported Serious Incidents appeared to meet the definitions of a Never Event but the actual dates of incidents were clearly prior to April 2013. These were both an apparent retained foreign object recently discovered when the patient underwent further surgery or x-ray examination.

This report updates the previous provisional 2013/14 never events data that was published in May 2014. This will be the final update of never events reported as occurring in the 2013/14 financial year.

More detail is provided in the tables below.

TABLE ONE: Never Events 1 April 2013 to 31 March 2014 by month of incident

Month in which Never Event occurred	Number
April	28
May	30
June	32
July	26
August	30
September	21
October	25
November	31
December	19
January	36
February	21
March	39
Total	**338**
Note as described above, two additional reported incidents occurred prior to 1 April 2013	

TABLE TWO: Never Events 1 April 2013 to 31 March 2014 by type of incident

Type of Never Event	Number
Retained foreign object post procedure	134
Wrong site surgery	98
Wrong implant/ prosthesis	54
Inappropriate administration of daily oral methotrexate	16
Misplaced naso or oro gastric tubes	16
Wrong gas administered	3
Transfusion of ABO incompatible blood components	3
Air embolism	3
Maladministration of a potassium containing solution	2
Maladministration of insulin	2
Overdose of midazolam during conscious sedation	2
Falls from unrestricted window	1
Failure to monitor and respond to oxygen saturation	1
Opioid overdose of an opioid naïve patient	1
Escape of a transferred prisoner	1
Maternal death due to post partum haemorrhage after elective caesarian section	1
Total	**338**
Note as described above, two additional reported incidents occurred prior to 1 April 2013	

TABLE THREE: Never Events 1 April 2013 to 31 March 2014 by type of incident with additional detail

Type *and brief description* **of Never Event**	**Number**
Retained foreign object post procedure	**134**
Vaginal swab	30
Surgical swab	22
Vaginal tampon	16
Throat pack	4
Central line guide wire	4
Throat swab	4
Surgical needle	3
Arterial line guide wire	3
Surgical forceps	2
Retrieval bag	2
Pedicle screw tab	2
Drill bit	2
Femoral guide wire	2
Surgical glove	2
Retained specimen	1
Dressing used during surgical procedure	1
Drill guide block	1
Fragment of blue plastic	1
Pledget	1
Guide plate for internal fixation	1
Feeding tube that was used to dilate a vessel	1
Guide wire - central line	1
Tracheostomy guide wire	1
Guide wire - PICC line	1
Eye swab (German strip)	1
Humeral disc	1
Renal dialysis trocar	1
Eye conformer	1
Retrieval bag and specimen	1
Chest drain guide wire	1
Suction guard	1
Teeth from Charnley retractor	1
Diathermy cleaning patch	1
Irrigation bulb syringe tip	1
Cochlear implant template	1
Laparoscopic port	1
CVH guide wire	1
Urethral introducer fragment	1
Tip of hypodermic needle	1

Type *and brief description* **of Never Event**	**Number**
Vaginal cotton wool ball	1
Trial acetabular head	1
Vascular clamp	1
Part of a porta cath	1
Central line introducer	1
Vas cath guidewire	1
Laser sheath tip	1
Vas cath guidewire introducer	1
Microvascular clamp	1
ACL guide wire	1
Not known	1
Wrong site surgery	**98**
Wrong procedure	41
Wrong tooth removed	22
Unnecessary procedure	5
Wrong incision	4
Wrong spinal level	3
Wrong eye	3
Wrong skin lesion excised	2
Wrong side chest drain	2
Injection in wrong eye	2
Wrong side spinal surgery	1
Carpal Tunnel release not required	1
Wrong side thoracoscopy	1
Wrong foot	1
Acute inflammatory disease – adipose tissue removed instead of appendix	1
Wrong side stent	1
Complications at time of surgery – fallopian tube removed instead of appendix	1
Wrong side thoracostomy	1
Incorrect area of pilonidal sinus excised	1
Clinical decision during surgery was to remove left fallopian tube rather than right but right fallopian tube subsequently developed ectopic	1
Wrong scar excised	1
Wrong femoral artery	1
Vein harvesting commenced on wrong leg	1
Complications with procedure and wrong ovary removed	1
Wrong implant/ prosthesis	**54**
Lens	29
Knee prosthesis	10
Hip prosthesis	9
Pacemaker	1
Metal stent	1
Incorrect right ventricular lead	1
Wrong fixation plate	1
Cochlear implant	1

Type *and brief description* **of Never Event**	**Number**
Grommet	1
Inappropriate administration of daily oral methotrexate	**16**
Inappropriate administration of daily oral methotrexate	16
Misplaced naso or oro gastric tubes	**16**
NG tube in lung	15
Nasojejunal tube in lung	1
Wrong gas administered	**3**
Air instead of oxygen	2
Oxygen instead of air	1
Transfusion of ABO incompatible blood components	**3**
Wrong unit of blood	3
Air embolism	**3**
Air injected into coronary artery	2
Radial arterial line flushed	1
Maladministration of a potassium containing solution	**2**
Maladministration of a potassium containing solution	2
Maladministration of insulin	**2**
Insulin not given	2
Overdose of midazolam during conscious sedation	**2**
Overdose of midazolam during conscious sedation	2
Falls from unrestricted window	**1**
Falls from unrestricted window	1
Failure to monitor and respond to oxygen saturation	**1**
Volatile agent and ventilator not set correctly	1
Opioid overdose of an opioid naïve patient	**1**
Fentanyl patches	1
Escape of a transferred prisoner	**1**
Escaped during transfer from one area of hospital to another	1
Maternal death due to post partum haemorrhage after elective caesarian section	**1**
Maternal death due to post partum haemorrhage after elective caesarian section	1
Total	**338**

Note as described above, two additional reported incidents occurred prior to 1 April 2013

TABLE FOUR: Never Events 1 April 2013 – 31 March 2014 by healthcare provider

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
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	
Barking Havering & Redbridge University Hospitals NHS Trust			1	1	2	
Barnet & Chase Farm Hospitals NHS Trust				1	1	
Barts Health NHS Trust	1		4	1	6	
Basildon and Thurrock University Hospitals NHS Foundation Trust	1			1	2	
Birmingham Children's Hospital NHS Foundation Trust	1				1	
Birmingham Midland Eye Centre		1			1	
Birmingham Women's NHS Foundation Trust	1				1	
Blackpool Fylde & Wyre Hospitals NHS Foundation Trust (Victoria site)			1	1	2	
BMI Highfield Hospital		1			1	
BMI Saxon Clinic	1				1	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
BMI Thornbury Hospital	1				1	
BMI Woodlands Hospital			1		1	
Bolton NHS Foundation Trust			1		1	
Bradford Hospitals NHS Foundation Trust			2		2	
Brighton and Sussex University Hospitals NHS Trust	1			1	2	
Buckinghamshire Healthcare NHS Trust	1		1		2	
Burton Hospitals Foundation Trust				1	1	
Cambridge University Hospitals NHS Foundation Trust	1				1	
Central Manchester University Hospitals NHS Foundation Trust	3				3	
Chelsea & Westminster Healthcare NHS Foundation Trust	2	1			3	
Chesterfield Royal Hospital NHS Foundation Trust	1				1	
City Hospital Sunderland NHS Foundation Trust			1		1	
Colchester Hospital University NHS Foundation Trust		1			1	
Co-operative Pharmacy,Chaddlewood District Shopping Centre, Plympton				1	1	
County Durham & Darlington NHS Foundation Trust					0	1
Croydon Health Services NHS Trust	1				1	
Dartford & Gravesham NHS Trust		1			1	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Derby Hospitals NHS Foundation Trust	1	1			2	
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	1		2		3	
Dorset County Hospital NHS Foundation Trust	1				1	
Dorset Healthcare University NHS Foundation Trust			1		1	
Ealing Hospital NHS Trust				1	1	
East and North Hertfordshire NHS Trust			1		1	
East Kent Hospitals University NHS Foundation Trust	1			1	2	
East Lancashire Hospitals NHS Trust	1				1	
East London NHS Foundation Trust				1	1	
Epsom & St Helier NHS Trust	1				1	
Essex Primary Care Team	1				1	
Frimley Park Hospital NHS Foundation Trust	1				1	
George Eliot Hospital NHS Trust			3		3	
Gloucestershire Care Services NHS Trust			1		1	
Gloucestershire Hospitals NHS Foundation Trust	1	1			2	
Great Ormond Street Hospital for Children NHS Foundation Trust			1		1	
Great Western Hospitals NHS Foundation Trust	4				4	
Hampshire Hospitals NHS Foundation	1				1	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Trust						
Harrogate and District NHS Foundation Trust		1			1	
Heart of England NHS Foundation Trust		1	1		2	
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1		1		2	
Homerton Hospital NHS Foundation Trust				1	1	
Horton Independent Sector Treatment Centre			1		1	
Hull & East Yorkshire Hospitals NHS Trust	2		1	1	4	
Imperial College Healthcare NHS Trust			1	1	2	
Ipswich Hospital NHS Trust	1		1		2	
Isle of Wight NHS Trust				1	1	
James Paget University Hospitals NHS Foundation Trust	2				2	
Kettering General Hospital NHS Foundation Trust	1				1	
King's College Hospital NHS Foundation Trust	3		3	1	7	
Kingston Hospital NHS Foundation Trust	1			1	2	
Lancashire Teaching Hospitals NHS Foundation Trust	1		1		2	
Leeds Teaching Hospitals NHS Trust	6	1	1	1	9	
Lewisham and Greenwich NHS Trust	3	1			4	
Liverpool Community Health NHS Trust			1		1	
Liverpool Heart and Chest NHS			2		2	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Foundation Trust						
Liverpool Women's Hospital NHS Foundation Trust				1	1	
Lloyds Pharmacy, 175 The Ridgeway, Sedgley				1	1	
Luton and Dunstable University Hospital NHS Foundation Trust			1	1	2	
Maidstone and Tunbridge Wells NHS Trust			1		1	
Medway NHS Foundation Trust				1	1	
Mid Cheshire Hospitals NHS Foundation Trust	3			1	4	
Mid Essex Hospital Services NHS Trust			2	1	3	
Mid Yorkshire Hospitals NHS Trust	1		1	1	3	
Moorfields Eye Hospital NHS Foundation Trust	1	3			4	
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	3	1		6	
NHS South West Commissioning Support Unit	1				1	
Norfolk & Norwich University Hospitals NHS Foundation Trust	3		1		4	
North Bristol NHS Trust	2		2		4	
North Cumbria University Hospitals Trust	2		1		3	
North Tees & Hartlepool NHS Foundation Trust			1		1	
North West London Hospitals NHS Trust	1		1	3	5	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Northern Devon Healthcare NHS Trust	1		1	1	3	
Northern Lincolnshire & Goole NHS Foundation Trust	1	1			2	
Northumbria Healthcare NHS Foundation Trust			1	1	2	
Nottingham University Hospital NHS Trust			1	1	2	
Nuffield Hospital Cambridge		1			1	
Oxford University Hospitals NHS Trust	1	1	1		3	
Papworth Hospital NHS Foundation Trust	1			1	2	
PCH Dental (Peninsula Community Health)			1		1	
Peterborough and Stamford NHS Foundation Trust			1		1	
Plymouth Hospitals NHS Trust	1		1		2	
Poole Hospital NHS Foundation Trust	1		2		3	
Portsmouth Hospitals NHS Trust			2	1	3	
Queen Elizabeth Hospital - King's Lynn - NHS Foundation Trust			1		1	
Queen Victoria Hospital NHS Foundation Trust			3		3	
Renacres Hospital		1			1	
Rochdale Ophthalmology Clinical Assessment and Treatment Service (CATS)		2			2	
Royal Berkshire NHS Foundation Trust	3	2	1	1	7	
Royal Brompton & Harefield NHS	1			1	2	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Foundation Trust						
Royal Cornwall Hospitals NHS Trust		2	2	1	5	
Royal Devon and Exeter NHS Foundation Trust			1	1	2	
Royal Free London NHS Foundation Trust		1			1	
Royal Liverpool & Broadgreen NHS Trust	1		2		3	
Royal Surrey County Hospital NHS Foundation Trust	1		2		3	
Salford Royal NHS Foundation Trust			2		2	
Sandwell and West Birmingham Hospitals NHS Trust	1	3	1		5	
Sedgeley House Hospital				1	1	
Sheffield Independent/Non NHS Providers			1		1	
Sheffield Teaching Hospitals NHS Foundation Trust	3			1	4	
Sherwood Forest Hospitals NHS Foundation Trust				1	1	
South Devon Healthcare NHS Foundation Trust		2			2	
South Tees Hospitals NHS Foundation Trust	2			1	3	
South Warwickshire NHS Foundation Trust	3	1			4	
Southampton NHS Treatment Centre	1		1		2	
Southend University Hospital NHS Foundation Trust				1	1	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Southport & Ormskirk Hospital NHS Trust	2				2	
Spire Cambridge Lea Hospital	1	1			2	
Spire Parkway Hospital		1			1	
Spire Tunbridge Wells Hospital	1				1	
Spire Wellesley Hospital		1			1	
St George's Healthcare NHS Trust	2		3	1	6	
St Helens & Knowsley Hospitals NHS Trust			1		1	
Staffordshire and Stoke on Trent Partnership Trust				1	1	
Stockport NHS Foundation Trust		1			1	
Surrey and Sussex Healthcare NHS Trust				1	1	
Tameside Hospital NHS Foundation Trust	1				1	
Taunton and Somerset NHS Foundation Trust			3		3	
The Dudley Group NHS Foundation Trust	1				1	
The Hillingdon Hospital NHS Foundation Trust	2				2	
The Princes Alexandra NHS Foundation Trust	2				2	
The Rotherham NHS Foundation Trust			1		1	
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust		1	1		2	
The Royal National Orthopaedic Hospital NHS Trust			2		2	
The Royal Wolverhampton NHS Trust	2		2		4	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
The Walton Centre NHS Foundation Trust				1	1	
United Lincolnshire Hospitals NHS Trust	2				2	
University College London Hospitals NHS Foundation Trust	2		1	1	4	
University Hospital North Staffordshire	1				1	
University Hospital of South Manchester NHS Foundation Trust	1	1			2	
University Hospital Southampton NHS Foundation Trust	2				2	
University Hospitals Birmingham NHS Foundation Trust	1		2		3	
University Hospitals Bristol NHS Foundation Trust	1		1		2	
University Hospitals Coventry and Warwickshire NHS Trust	2	1			3	
University Hospitals of Leicester NHS Trust	1	2			3	
University Hospitals of Morecambe Bay NHS Foundation Trust		2	1		3	
Walsall Healthcare NHS Trust	1			1	2	
Warrington and Halton Hospitals NHS Foundation Trust		1			1	
West Hertfordshire Hospitals NHS Trust	1		1		2	
West Middlesex University NHS Trust	3			1	4	
West Suffolk NHS Foundation Trust	1	1			2	
Western Sussex Hospitals NHS Foundation Trust		1			1	

Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional NEs detected since April 2013 but NE occurred at an earlier date
Weston Area Health NHS Trust	1		1		2	
Whittington Hospital	1				1	
Will Adams NHS Treatment Centre		1			1	
Wirral University Teaching Hospital NHS Foundation Trust	1	2			3	1
Worcestershire Acute Hospitals NHS Trust		2	1	1	4	
Wrightington, Wigan and Leigh NHS Foundation Trust	1			1	2	
Wye Valley NHS Trust	2			1	3	
Yeovil District Hospital NHS Foundation Trust	1				1	
York Hospitals NHS Foundation Trust	2		1		3	
Yorkshire Clinic		1			1	
Total	**134**	**54**	**98**	**52**	**338**	**2**

Appendix: technical process of reconciliation of NRLS and STEIS

The following steps are undertaken as incidents are reported and become available for review:

1. Ensuring all NRLS reports of Never Events are reported as Never Events via STEIS:

    a. Identifying possible or apparent Never Events in the NRLS:
        i. The NRLS is searched for all reports with the term 'Never Event' in the free text and reports where the field 'Never Event' has been reported as = Yes. These reports are reviewed by clinicians. Incidents that are clearly not Never Events are disregarded but all possible or apparent Never Events are flagged for reconciliation with STEIS.
        ii. All incidents reported to the NRLS with an outcome of death or severe harm are reviewed by clinicians, and regardless of whether or not the term 'Never Event' is used, all possible or apparent Never Events are flagged for reconciliation with STEIS.

    b. Matching apparent and possible Never Events reported via NRLS with STEIS:
        i. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) can be matched with a Never Event reported on STEIS no action is taken.
        ii. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) CANNOT be matched with a Never Event reported on STEIS, commissioners are contacted and asked to contact the relevant provider organisations and either confirm this is not a Never Event or to ensure the incident is not flagged in the Never Event field on the STEIS system.

2. Ensuring the quality and completeness of STEIS flagging of Never Events:

    a. Whilst the designation of an incident as a Never Event is the remit of the commissioning organisation, STEIS is routinely reviewed by clinicians with specialist expertise and where an incident does not appear to meet the definitions in The *Never Events list 2013/14 update* commissioners are asked to either add extra detail to confirm the type of Never Event, or to take its Never Event designation off the STEIS system.

    b. Some Never Events may only be detected at a later date (particularly retained objects found during further surgery). Where reports to STEIS

clearly describe Never Events occurring prior to the date they are reported as occurring on STEIS, commissioners are asked to ensure incident date on STEIS reflects when the Never Event occurred, not when it was detected. For the purpose of this provisional publication of Never Events, where date of actual incident is clear from free text, it is used in analysis.