NHS England

Never Events reported as occurring between 1 April 2014 and 31 March 2015 – final update

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Contents

Never Events reported as occurring between 1 April 2014 and 31 March 2015 – final update

This report provides a final update of Never Events reported as occurring between 1 April and 31 March 2015 and supersedes the previously published provisional data.

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/

The data in this report relates to Never Events as defined in The *Never Events list 2013/14 update*. The definitions of Never Events changed in April 2015.

Data collection and checking

In April 2013, NHS England became responsible for the Never Events policy framework. Never Events data for this report have been collected from the Strategic Executive Information System (STEIS) by the NHS England Patient Safety Domain.

The quality of reporting of Never Events made to the STEIS system is routinely reviewed. Where a Serious Incident that occurred in 2014/15 was logged as a Never Event but did not appear to fit any definition of a Never Event on The *Never Events list 2013/14 update*, commissioners were 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 checking process is shown in the Appendix.

Summary

There are 312 Serious Incidents on the STEIS system that have been designated by their reporters as Never Events with a reported incident date between 1 April 2014 and 31 March 2015. Of these 312 incidents:

- There were 306 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 2014 and 31 March 2015.
- One of the reported Serious Incidents appeared to meet the definitions of a Never Event but the actual date of the incident was clearly prior to April 2014. The incident was an apparent retained foreign object recently discovered when the patient underwent a CT scan.
- Five of the reported Serious Incidents did not appear to meet the definition of a Never Event.

More detail is provided in the tables below:

TABLE ONE: Never Events 1 April 2014 to 31 March 2015 by month of incident

Month in which Never Event occurred	Number
Apr	15
May	29
Jun	29
Jul	24
Aug	35
Sep	28
Oct	38
Nov	25
Dec	19
Jan	22
Feb	17
Mar	25
Total	**306**

Note as described above, one additional reported incident occurred prior to 1 April 2014 and another five incidents did not appear to meet the definition of a Never Event.

TABLE TWO: Never Events 1 April 2014 to 31 March 2015 by type of incident

Type of Never Event	Number
Wrong site surgery	124
Retained foreign object post procedure	102
Wrong implant/ prosthesis	40
Inappropriate administration of daily oral methotrexate	11
Misplaced naso or oro gastric tubes	10
Misidentification of patients	4
Wrong gas administered	2
Maladministration of a potassium containing solution	2
Escape of a transferred prisoner	2
Maladministration of insulin	2
Air embolism	2
Transfusion of ABO - incompatible blood components	2
Wrong route administration of oral / enteral treatment	1
Wrongly prepared high risk injectable medication	1
Wrong route administration of chemotherapy	1
Total	**306**

Note as described above, one additional reported incident occurred prior to 1 April 2014 and another five incidents did not appear to meet the definition of a Never Event.

TABLE THREE: Never Events 1 April 2014 to 31 March 2015 by type of incident with additional detail

Type of Never Event with additional detail	Number
Wrong site surgery	**124**
Additional procedure undertaken that was not required	1
Appendicitis diagnosed, fallopian tube removed instead of appendix (salpingitis found)	1
Biopsy of wrong skin lesion	1
Carpal Tunnel procedure undertaken instead of De Quervains procedure	1
Incision to wrong side of head	1
Incorrect procedure as biopsy mixed up with another specimen at the time of the procedure	1
Kidney removed instead of ovary - distorted anatomy and inconclusive pre op scans	1
Liver biopsied instead of pancreas	1
Ovary/ovaries removed when undertaking hysterectomy when they should have been conserved	2
Testicle removed instead of epididymal cyst on testicle	1
Wrong area of breast	3
Wrong area of ear	1
Wrong ear	1
Wrong eye	8
Wrong finger	2
Wrong finger incision	4
Wrong hernia repair	1
Wrong hip	1
Wrong incision to remove tooth	1
Wrong knee	1
Wrong leg	1
Wrong margins of breast lump excised	1
Wrong procedure - endoscopy instead of flexible sigmoidoscopy	1
Wrong procedure - femoral line	1
Wrong procedure - sigmoidoscopy instead of cystoscopy	1
Wrong procedure - wrong patient sent for	1
Wrong shoulder	1
Wrong side angiogram	3
Wrong side angioplasty incision	1
Wrong side chest drain	3
Wrong side chronic pain intervention	1
Wrong side iliac artery occlusion procedure	1
Wrong side JJ stent	1
Wrong side lithotripsy	1
Wrong side lung biopsy	1
Wrong side nail bed	1
Wrong side nephrostomy	1

Type of Never Event with additional detail	Number
Wrong side of scalp	1
Wrong side of thyroid gland removed	1
Wrong side pleural biopsy	1
Wrong side spinal root injection	3
Wrong side tonsillar cyst removed	1
Wrong side ureteric stent	1
Wrong site angioplasty	1
Wrong skin lesion removed	12
Wrong skin tag removed	2
Wrong spinal level	12
Wrong toes	5
Wrong tooth incision	1
Wrong tooth/ teeth removed	27
Wrong vulval lesion removed	1
Retained foreign object post procedure	**102**
Drill guide	1
Eye trocar	1
Guide pegs	1
Guide wire - balloon pump	1
Guide wire - chest drain	6
Guide wire - CVC line	1
Guide wire - external illiac vein line	1
Guide wire - femoral cooling catheter	1
Guide wire - internal jugular line	1
Guide wire - midline	1
Guide wire - naso gastric tube	1
Guide wire - peritoneal catheter	1
Guide wire - PICC line	1
Hypodermic needle	1
Microvascular clip	1
Pack around ET tube	1
Part of a stent graft	1
Part of breast expander	1
Part of surgical blade	1
Part of surgical needle	1
Part of uterine manipulator	1
Red tag from swab bundle	1
Screw from retractor	1
Specimen retrieval bag	3
Surgical needle	5
Surgical swab	19
Throat pack	8
Vaginal swab	36
Vaseline gauze	1

Type of Never Event with additional detail	Number
Vitrectomy trocar	1
Wound dressing	1
Wrong implant/ prosthesis	**40**
Aortic stent	1
Hip prosthesis	12
Knee prosthesis	8
Lens	18
Pacemaker	1
Inappropriate administration of daily oral methotrexate	**11**
Wrong dose	1
Wrong frequency	10
Misplaced naso or oro gastric tubes	**10**
Naso gastric tube in respiratory tract	10
Misidentification of patients	**4**
Case notes mixed up	1
Patients with similar surnames mixed up	1
Shared waiting area for two specialities	2
Wrong gas administered	**2**
Failure to administer oxygen	1
Medical air administered instead of oxygen	1
Maladministration of a potassium containing solution	**2**
Given at a greater rate than intended	1
Potassium infusion administered without an infusion pump to control the rate	1
Escape of a transferred prisoner	**2**
Prisoner escaped during ground leave	1
Prisoner escaped during unescorted leave	1
Maladministration of insulin	**2**
Insulin not given when prescribed	2
Air embolism	**2**
Central line disconnected	1
Result of changing and flushing an arterial line	1
Transfusion of ABO - incompatible blood components	**2**
Wrong blood transfused	2
Wrong route administration of oral/ enteral treatment	**1**
Oral medication given via PICC line	1
Wrongly prepared high risk injectable medication	**1**
Wrongly prepared chemotherapy	1
Wrong route administration of chemotherapy	**1**
Administered intravenously instead of intravesical	1
Total	**306**

Note as described above, one additional reported incident occurred prior to 1 April 2014 and another five incidents did not appear to meet the definition of a Never Event.

TABLE FOUR: Never Events 1 April 2014 – 31 March 2015 by healthcare provider

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Airedale NHS Foundation Trust		1														1		
Alder Hey Children's NHS Foundation Trust	1				1											2		
Ashford and St. Peters Hospitals NHS Foundation Trust	1	1	2				1									5		
Barking Havering & Redbridge University Hospitals NHS Trust		2														2		
Barlborough NHS Treatment Centre			1													1		
Barnsley Hospital NHS Foundation Trust	1															1		
Barts Health NHS Trust	1	1														2		
Basildon and Thurrock University Hospitals NHS Foundation Trust	1		1													2		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Birmingham Children's Hospital NHS Foundation Trust					1											1		
Birmingham Community Healthcare NHS Trust	1															1		
Birmingham Women's NHS Foundation Trust		1														1		
BMI Beaumont Private Hospital, reported by NHS Bolton CCG		1														1		
BMI The Chiltern Private Hospital, reported by NHS Aylesbury Vale CCG	1															1		
Bolton NHS Foundation Trust	2	1	2													5		
Bradford Hospitals NHS Foundation Trust	1	1														2		
Brighton and Sussex University Hospitals NHS Trust	2	2														4		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Broomfield Hospital, reported by Essex Primary Care team	2															2		
Buckinghamshire Healthcare NHS Trust	1															1		
Burton Hospitals NHS Foundation Trust		2														2		
Cambridge University Hospitals NHS Foundation Trust			3													3		
Central Manchester University Hospitals NHS Foundation Trust	2	1														3		
Circle Nottingham, NHS Treatment Centre	1															1		
City Hospital Sunderland NHS Foundation Trust	1															1		
Colchester Hospital University NHS Foundation Trust	3	5	1													9		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Countess Of Chester Hospital NHS Foundation Trust	2															2		
County Durham & Darlington NHS Foundation Trust		2	1													3		
Croydon Health Services NHS Trust	1											1				2		
Derby Teaching Hospitals NHS Foundation Trust	1	1					1	1								4		
Devonport Dental Facility, reported by Devon, Cornwall and Isles of Scilly Area Team	1															1		
Doncaster & Bassetlaw Hospitals NHS Foundation Trust		1														1		
Dudley Group NHS Foundation Trust		1														1		
East and North Hertfordshire NHS Trust	1															1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
East London NHS Foundation Trust															1	1		
Euxton Hall Private Hospital, reported by NHS Greater Preston CCG			1													1		
Frimley Park Hospital NHS Foundation Trust		1														1		
Fulwood Hall Private Hospital, reported by NHS Greater Preston CCG			1													1		
Gateshead Health NHS Foundation Trust	1	1														2		
George Eliot Hospital NHS Trust				1												1		
Gloucestershire Hospitals NHS Foundation Trust	1			1	1											3		
Great Ormond Street Hospital for Children NHS Foundation Trust		1														1		
Great Western Hospitals NHS Foundation Trust	1	1														2		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Guy's & St Thomas' NHS Foundation Trust	2	2	2	1												7		
Heart of England NHS Foundation Trust			1													1		
Herts & Essex Community Hospital	1															1		
Hillingdon Hospital NHS Foundation Trust	1									1						2		
Homerton Hospital NHS Foundation Trust		1	1													2		
Hull & East Yorkshire Hospitals NHS Trust	3	1														4		
Imperial College Healthcare NHS Trust		1			1											2		
Ipswich Hospital NHS Trust	2				1											3		
James Paget University Hospitals NHS Foundation Trust														1		1		
Kettering General Hospital NHS Foundation Trust					1											1		
King's College Hospital NHS Foundation Trust	2	2	2			1										7	1	

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Kingston Hospital NHS Foundation Trust	1		2													3		
Lancashire Teaching Hospitals NHS Foundation Trust	2		2													4		
Leeds Teaching Hospitals NHS Trust	3	2														5		
Leicestershire Partnership NHS Trust				1												1		
Lewisham and Greenwich NHS Trust		2														2		
Liverpool Community Health NHS Trust	1															1		
Liverpool Heart and Chest NHS Foundation Trust	1															1		
Maidstone and Tunbridge Wells NHS Trust	1		1													2		
Medway NHS Foundation Trust	2	1		1												4		
Mid Cheshire Hospitals NHS Foundation Trust											1					1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Mid Essex Hospital Services NHS Trust	4												1			5		
Mid Staffs NHS Foundation Trusts						1										1		
Mid Yorkshire Hospitals NHS Trust				1												1		
Milton Keynes University Hospital NHS Foundation Trust		1														1		
Moorfields Eye Hospital NHS Foundation Trust		1	3													4		
Niti Pharmacy, reported by Hertfordshire and South Midlands Area Team				1												1		
Norfolk & Norwich University Hospitals NHS Foundation Trust	2	1														3		
North Bristol NHS Trust	2	1														3		
North Cumbria University Hospitals Trust	1	1														2		
North Middlesex Hospital NHS Trust									1							1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
North Tees & Hartlepool NHS Foundation Trust	1															1		
North West London Hospitals NHS Trust	1				1											2		
Northampton General Hospital NHS Trust	1	1														2		
Northern Devon Healthcare NHS Trust	1	1														2		
Nottingham NHS Treatment Centre	1															1		
Nottingham University Hospitals NHS Trust			2	1												3		
Nuffield Health Brentwood Private Hospital, reported by NHS Basildon and Brentwood CCG			2													2		
Nuffield Health Taunton Private Hospital, reported by NHS Somerset CCG			1													1		
Oxford University Hospitals NHS Trust	3	2			1											6		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Peninsula Community Health	2															2		
Peterborough and Stamford NHS Foundation Trust	1	1														2		
Pilgrim Hospital Lincoln, reported by Lincolnshire Community Health Services		1														1		
Plymouth Hospitals NHS Trust		1	1													2		
Poole Hospital NHS Foundation Trust		1														1		
GP Surgery, Luton area (name not supplied), reported by Hertfordshire and South Midlands Area Team				1												1		
Princess Alexandra Hospital NHS Trust		2														2		
Priory Thornford Park Hospital, reported by Wessex Area Team															1	1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Queen Elizabeth Hospital - King's Lynn - NHS Foundation Trust	2	2						1						1		6		
Queen Victoria Hospital NHS Foundation Trust	1															1		
Ramsay Healthcare Ashtead Private Hospital reported by NHS Surrey Downs CCG	1															1		
Ramsay Healthcare, Yorkshire Clinic reported by NHS Bradford Districts CCG		1														1		
Ramsey Healthcare Rowley Hall Private Hospital, reported by Stafford and Surrounds CCG	1															1		
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1															1		
Rotherham NHS Foundation Trust		1														1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Royal Berkshire NHS Foundation Trust	2															2		
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	2	2														4		
Royal Brompton & Harefield NHS Foundation Trust		4														4		
Royal Cornwall Hospitals NHS Trust		1														1		
Royal Free London NHS Foundation Trust	2		1													3	1	
Royal Liverpool & Broadgreen NHS Trust	1					1										2		
Royal National Orthopaedic Hospital NHS Trust	3															3		
Royal Orthopaedic Hospital NHS Foundation Trust	1															1		
Royal Surrey County Hospital NHS Foundation Trust	2															2		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Royal United Hospital Bath NHS Trust		1														1		
Royal Wolverhampton NHS Trust	1															1		
Salford Royal NHS Foundation Trust	3															3		
Salisbury NHS Foundation Trust		2														2		
Sheffield Teaching Hospitals NHS Foundation Trust		2														2		
Shepton Mallet Treatment Centre, reported by NHS Somerset CCG		1														1		
South Devon Healthcare NHS Foundation Trust	1	1														2		
South Tees Hospitals NHS Foundation Trust			1													1		
South Warwickshire NHS Foundation Trust						1										1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Southampton NHS Treatment Centre reported by NHS Southampton CCG	1															1		
Southport & Ormskirk Hospital NHS Trust																	1	
Spire Hartswood, Private Hospital , reported by NHS Southend CCG	1															1		
Spire Methley Park Private Hospital		1														1		
Spire Sussex Private Hospital, reported by NHS Hastings and Rother CCG	1															1		
Spire Wellesley Private Hospital, reported by Southend CCG			1													1		
St George's Healthcare NHS Trust	1	3														4		
Stockport NHS Foundation Trust		1														1		1
Surrey and Sussex Healthcare NHS Trust	1			1												2		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Tameside Hospital NHS Foundation Trust		2														2		
United Lincolnshire Hospitals NHS Trust		1														1		
University College London Hospitals NHS Foundation Trust	2	2							1							5		
University Hospital of South Manchester NHS Foundation Trust	2															2		
University Hospital Southampton NHS Foundation Trust	2	1														3		
University Hospitals Birmingham NHS Foundation Trust	1	1														2		
University Hospitals Bristol NHS Foundation Trust	5									1						6		
University Hospitals Coventry and Warwickshire NHS Trust		1			1											2		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
University Hospitals of Leicester NHS Trust	1	1	1													3		
University Hospitals of North Midlands NHS Trust		1			1											2		
Walsall Healthcare NHS Trust		1														1		
Walton Centre NHS Foundation Trust	1															1		
West Hertfordshire Hospitals NHS Trust		2	1													3		
West London Mental Health NHS Trust				1												1		
West Middlesex University NHS Trust		1														1		
West Suffolk NHS Foundation Trust	2	1														3		
Weston Area Health NHS Trust	2															2		
Winfield Private Hospital, reported by NHS Gloucestershire CCG		1														1		

Provider organisation where Never Event (NE) occurred	Wrong Site Surgery	Retained Foreign Object Post Procedure	Wrong Implant/ Prosthesis	Inappropriate administration of daily oral methotrexate	Misplaced naso or oro gastric tubes	Misidentification of patients	Maladministration of a potassium containing solution	Maladministration of insulin	Transfusion of ABO - incompatible blood components	Wrong gas administered	Wrong route administration of chemotherapy	Wrong route administration of oral/ enteral treatment	Wrongly prepared high risk injectable medication	Air embolism	Escape of a transferred prisoner	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported that cannot be matched to NE list	Additional NEs detected 1 April 2014 – 31 March 2015 but NE occurred at an earlier date
Wirral Community NHS Trust	1															1		
Wirral University Teaching Hospital NHS Foundation Trust		2	1													3	1	
Worcestershire Acute Hospitals NHS Trust	1															1	1	
Wrightington, Wigan and Leigh NHS Foundation Trust	1	5														6		
Wye Valley NHS Trust		1	1													2		
Yeovil District Hospital NHS Foundation Trust	1															1		
Total	**124**	**102**	**40**	**11**	**10**	**4**	**2**	**2**	**2**	**2**	**1**	**1**	**1**	**2**	**2**	**306**	**5**	**1**

Appendix: 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 did not appear to meet the definitions in The Never Events list 2013/14 update commissioners were 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 publication of Never Events, where date of actual incident is clear from free text, it is used in analysis.