NHS England

Provisional publication of Never Events reported as occurring between 1 April 2014 and 31 March 2015

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Contact Details for further information	Patient Safety Domain NHS England Skipton House 80 London Road London SE1 6LH

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Provisional publication of Never Events reported as occurring between 1 April 2014 and 31 March 2015

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Contents

Provisional monthly publication of Never Events reported as occurring between 1 April 2014 and 31 March 2015

This report provides a provisional summary of Never Events that have occurred between 1 April and 31 March 2015.

Each monthly report updates the previous month's publication as incidents are locally investigated and more accurate information becomes available throughout the 2014/15 financial year.

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.

IMPORTANT NOTES on the provisional nature of these data

To support learning from Never Events, NHS England is committed to early publication. However, because of the process of reconciliation described above, and 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 April 2014 and 31 March 2015 and where on 14 April 2015 they were designated by their reporters as Never Events.

Summary

At the time data for this report were extracted on 14 April 2015, 311 Serious Incidents on the STEIS system were designated by their reporters as Never Events with a reported incident date between 1 April 2014 and 31 March 2015. Of these 311 incidents:

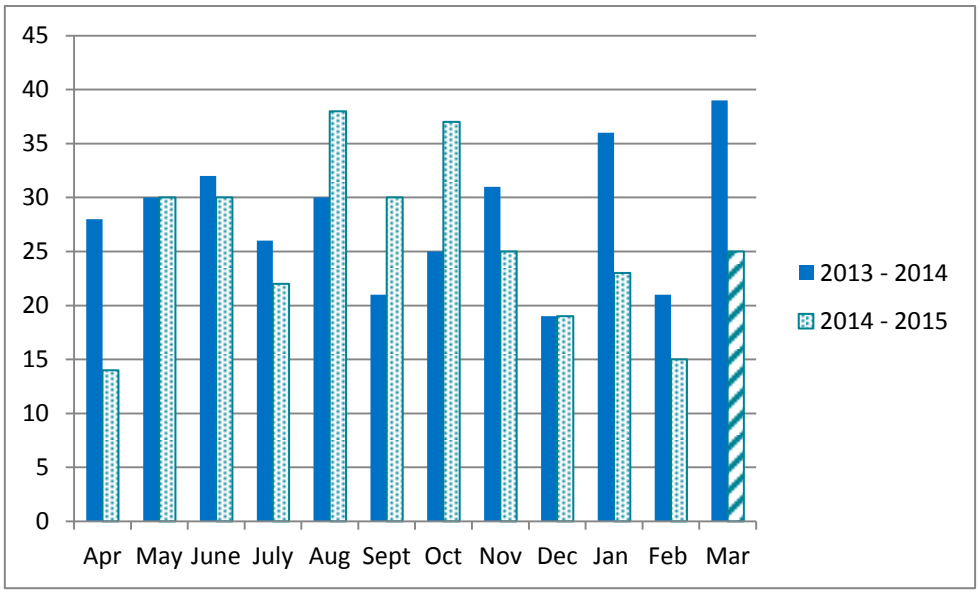
- There were 308 Serious Incidents that appeared to meet the definitions of a Never Event in The *Never Events list 2013/14 update* and the actual date of incident fell between 1 April 2014 and 31 March 2015. This number is subject to change as local investigation takes place.
- One of the reported Serious 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 further surgery or x-ray examination.
- Two 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

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Month in which Never Event occurred	**Number**
April	14
May	30
June	30
July	22
August	38
September	30
October	37
November	25
December	19
January	23
February	15
March	25
Total	**308**
Note as described above, one additional reported incident occurred prior to 1 April 2014 and another two incidents did not appear to meet the definition of a Never Event.	

Figure one: Never Events declared on STEIS (numbers per month from dataset for publication) since 1 April 2013*



* March 2015 data likely to be incomplete

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

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type of Never Event	**Number**
Wrong site surgery	126
Retained foreign object post procedure	102
Wrong implant/ prosthesis	38
Misplaced naso or oro gastric tubes	15
Inappropriate administration of daily oral methotrexate	11
Maladministration of a potassium containing solution	3
Air embolism	2
Escape of a transferred prisoner	2
Maladministration of insulin	2
Transfusion of ABO incompatible blood components	2
Wrong gas administered	1
Failure to monitor and respond to oxygen saturation	1
Wrongly prepared high risk injectable medication	1
Wrong route administration of chemotherapy	1
Wrong route administration of oral/ enteral treatment	1
Total	**308**
Note as described above, one additional reported incident occurred prior to 1 April 2014 and another two 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

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* of Never Event	**Number**
Wrong site surgery	**126**
Wrong tooth/ teeth removed	27
Wrong skin lesion excised	9
Wrong spinal level	8
Wrong eye	7
Wrong side chest drain	4
Wrong site angioplasty	4
Wrong level spinal surgery	3
Wrong patient - incorrect procedure carried out	3
Wrong toe	3
Wrong area of breast removed	2
Wrong eye - Ranibizumab	2
Wrong finger	2
Wrong side spinal injection	2
A unilateral orchidectomy undertaken in error while attempting to repair a hydrocele	1
Acute salpingitis apparently misdiagnosed as appendicitis; fallopian tube removed	1
Both ovaries removed when only left ovary planned for removal	1
Carpal tunnel procedure instead of DeQuervains	1
Consented for liver biopsy instead of pancreas biopsy; liver biopsy carried out	1
Endovenous laser treatment on wrong leg	1
Excision of wrong scar	1
Femoral line inserted on wrong patient	1
Hysterectomy with conservation of ovaries intended but hysterectomy and oophorectomy carried out	1
Incorrect breast lump margins excised	1
Injection under imaging on wrong patient	1
Laser treatment to wrong area	1
Medial instead of lateral toe nail resection	1
Ovary and fallopian tube removed instead of appendix	1
Pelvic kidney (congenital condition) apparently misidentified as ectopic pregnancy on ultrasound; kidney removed	1
Sigmoidoscopy instead of cyctoscopy	1
Stent inserted to wrong side	1
Surgery commenced but found unnecessary (relates to pre-operative investigation)	1
Unnecessary procedure - specimens mixed up resulted in further surgery	1
Wrong area of ear biopsied	1
Wrong area of scalp excised	1
Wrong breast lump removed	1
Wrong cyst excised	1

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of Never Event**	**Number**
Wrong eyelid lesion excised	1
Wrong finger - middle finger instead of ring finger	1
Wrong finger joint incision (correct finger)	1
Wrong hernia repaired	1
Wrong incision - hand web space	1
Wrong kidney lithotripsy	1
Wrong knee arthroscopy	1
Wrong labial skin tag removed	1
Wrong procedure undertaken	1
Wrong scalp lesion excised	1
Wrong side chronic pain intervention	1
Wrong side ear grommets	1
Wrong side femoral angiogram	1
Wrong side hip injection	1
Wrong side illiac artery	1
Wrong side lung biopsy	1
Wrong side nephrostomy	1
Wrong side of the head	1
Wrong side of thyroid excised	1
Wrong side spinal root block	1
Wrong side tonsillar cyst	1
Wrong side ureteric stent	1
Wrong skin lesion biopsied	1
Wrong toe nails removed	1
Wrong toes	1
Wrong tooth incision made	1
Wrong vulval lesion excised	1
Retained foreign object post procedure	**102**
Vaginal swab	31
Surgical swab	16
Throat pack	8
Guide wire - chest drain	6
Bert bag	3
Surgical needle	3
Vaginal pack /tampon/ sponge	8
Part of a surgical needle	2
Cap from connector tubing	1
Dressing used during surgical procedure	1
Drill guide	1
Epicardial pacing needle	1
Guide wire - CVC line	1
Guide wire - femoral artery	1

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of Never Event**	**Number**
Guide wire - femoral coolguard	1
Guide wire - iliac vein	1
Guide wire - jugular line	1
Guide wire - mid line	1
Guide wire - NG tube	1
Guide wire - peritoneal catheter	1
Guide wire - PICC line stylet	1
Hypodermic needle	1
Implant guide pegs	1
Microvascular clamp	1
Not known	1
Part of a stent graft	1
Part of instrument	1
Red tag from surgical swab bundle	1
Ribbon gauze	1
Screw from retractor	1
Trocar	1
Uterine manipulator spacer	1
Vitrectomy trocar	1
Wrong implant/ prosthesis	**38**
Lens	18
Hip prosthesis	12
Knee prosthesis	7
Wrong size stent	1
Misplaced naso or oro gastric tubes	**15**
Misplaced naso or oro gastric tubes	13
NG tube coiled in oesophagus	1
Perforated oesophagus	1
Inappropriate administration of daily oral methotrexate	**11**
Inappropriate administration of daily oral methotrexate	11
Maladministration of a potassium containing solution	**3**
Maladministration of a potassium containing solution	3
Air embolism	**2**
Air embolism	2
Escape of a transferred prisoner	**2**
Escaped during unescorted ground leave	2
Maladministration of insulin	**2**
Insulin not given	2
Transfusion of ABO incompatible blood components	**2**
Transfusion of ABO incompatible blood components	1
Wrong patient - incorrect blood transfused	1
Wrong gas administered	**1**

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of Never Event**	**Number**
Medical air instead of oxygen	1
Failure to monitor and respond to oxygen saturation	**1**
Failure to monitor and respond to oxygen saturation	1
Wrongly prepared high risk injectable medication	**1**
Wrongly prepared high risk injectable medication	1
Wrong route administration of chemotherapy	**1**
Wrong route administration of chemotherapy	1
Wrong route administration of oral/ enteral treatment	**1**
Medication administered through wrong route	1
Total	**308**
• **Note** as described above, one additional reported incident occurred prior to 1 April 2014 and another two 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

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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Airedale NHS Foundation Trust	1				1		
Alder Hey Children's NHS Foundation Trust			2	1	3		
Ashford and St. Peters Hospitals NHS Foundation Trust	1	2	1	1	5		
Ashtead Hospital (Ramsay Health Care UK)			1		1		
Barking Havering & Redbridge University Hospitals NHS Trust	2		1	1	4		
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		
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 Hospital	1				1		
BMI Chiltern			1		1		
BMI Healthcare Bath Clinic						1	
Bolton NHS Foundation Trust		2	1		3		
Bradford Hospitals NHS Foundation Trust	1		1		2		

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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Brighton and Sussex University Hospitals NHS Trust	2		2		4		
Buckinghamshire Healthcare NHS Trust			1		1		
Burton Hospitals Foundation Trust	2				2		
Cambridge University Hospitals NHS Foundation Trust		3			3		
Central Manchester University Hospitals NHS Foundation Trust	1		2		3		
City Hospital Sunderland NHS Foundation Trust			1		1		
Colchester Hospital University NHS Foundation Trust	5	1	3		9		
Countess Of Chester Hospital NHS Foundation Trust			1		1		
County Durham & Darlington NHS Foundation Trust	2	1			3		
Croydon Health Services NHS Trust			1	1	2		
Derby Hospitals NHS Foundation Trust	1		1	2	4		
Devonport Dental Facility			1		1		
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	1				1		
East and North Hertfordshire NHS Trust			1		1		
East London NHS Foundation Trust				1	1		
Euxton Hall Hospital (Ramsay Health Care UK)		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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Frimley Park Hospital NHS Foundation Trust	1				1		
Fulwood Hall Hospital (Ramsay Health Care UK)		1			1		
Gateshead Health NHS Foundation Trust	1		1		2		
George Eliot Hospital NHS Trust			1	1	2		
Gloucestershire Hospitals NHS Foundation Trust			1	2	3		
Great Ormond Street Hospital for Children NHS Foundation Trust	1				1		
Great Western Hospitals NHS Foundation Trust	1		1		2		
Guy's & St Thomas' NHS Foundation Trust	2	1	2	1	6		
Heart of England NHS Foundation Trust		1			1		
Herts & Essex Community Hospital			1		1		
Homerton Hospital NHS Foundation Trust	1	1			2		
Hull & East Yorkshire Hospitals NHS Trust	1		4		5		
Imperial College Healthcare NHS Trust	1			1	2		
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	3	1	8		
Kingston Hospital NHS Foundation Trust		2	1		3		
Lancashire Teaching Hospitals NHS Foundation Trust		2	2		4		

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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Leeds Teaching Hospitals NHS Trust	1		3		4		
Leicestershire Partnership NHS Trust				1	1		
Lewisham and Greenwich NHS Trust	3				3		
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		
Medici Medical Practise Luton				1	1		
Medway NHS Foundation Trust	1		2	1	4		
Mid Cheshire Hospitals NHS Foundation Trust				1	1		
Mid Essex Hospital Services NHS Trust			6	1	7		
Mid Staffs Foundation Trusts			1		1		
Mid Yorkshire Hospitals NHS Trust				1	1		
Milton Keynes General NHS Foundation Trust	1				1		
Moorfields Eye Hospital NHS Foundation Trust	1	3			4		
Niti Pharmacy: Hertfordshire and South Midlands Area Team				1	1		
Norfolk & Norwich University Hospitals NHS Foundation Trust	1		2		3		
North Bristol NHS Trust	1		2		3		
North Cumbria University Hospitals Trust	1		1		2		
North West London Hospitals NHS Trust			1	1	2		
Northampton General Hospital NHS Trust	1		1		2		
Northern Devon Healthcare 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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Nottingham NHS Treatment Centre			2		2		
Nottingham University Hospitals NHS Trust		2		1	3		
Nuffield Health Taunton Hospital		1			1		
Nuffield, Brentwood Hospital		2			2		
Oxford University Hospitals NHS Trust	2		3	1	6		
Peninsula Community Health			2		2		
Peterborough and Stamford NHS Foundation Trust	1		1		2		
Plymouth Hospitals NHS Trust	1				1		
Poole Hospital NHS Foundation Trust	1				1		
Queen Elizabeth Hospital - King's Lynn - NHS Foundation Trust	2		2	2	6		
Queen Victoria Hospital NHS Foundation Trust			1		1		
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust			1		1		
Rowley Hall Hospital (Ramsay Health Care UK)			1		1		
Royal Berkshire NHS Foundation Trust			2		2		
Royal Brompton & Harefield NHS Foundation Trust	4				4		
Royal Cornwall Hospitals NHS Trust	1				1		
Royal Free London NHS Foundation Trust	1	1	2		4		
Royal Liverpool & Broadgreen NHS Trust			2		2		
Royal Orthopaedic Hospital NHS Foundation 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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Royal Surrey County Hospital NHS Foundation Trust			2		2		
Royal United Hospital Bath NHS Trust	1				1	1	
Salford Royal NHS Foundation Trust			1		1		
Salisbury NHS Foundation Trust	2				2		
Sheffield Teaching Hospitals NHS Foundation Trust	2		1		3		
Shepton Mallet Treatment Centre	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		
Southampton Treatment Centre			1		1		
Southport & Ormskirk Hospital NHS Trust				1	1		
Spire Hartswood Hosiptal			1		1		
Spire Methley Park Hospital	1				1		
Spire Sussex Hospital			1		1		
Spire Wellesley Hospital		1			1		
St George's Healthcare NHS Trust	3				3		
Stockport NHS Foundation Trust	1				1		1
Surrey and Sussex Healthcare NHS Trust	1		1	1	3		
Tameside Hospital NHS Foundation Trust	2				2		
The Dudley Group NHS Foundation Trust	1				1		
The Hillingdon Hospital NHS Foundation Trust			1	1	2		

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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
The Ipswich Hospital NHS Trust			2	2	4		
The Princess Alexandra Hospital NHS Trust	2				2		
The Priory Thornford Park Hospital				1	1		
The Rotherham NHS Foundation Trust	1				1		
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	2		2		4		
The Royal National Orthopaedic Hospital NHS Trust			3		3		
The Royal Wolverhampton NHS Trust			1		1		
The Walton Centre NHS Foundation Trust			1		1		
United Lincolnshire Hospitals NHS Trust	3				3		
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	1		1		2		
University Hospitals Birmingham NHS Foundation Trust			1		1		
University Hospitals Bristol NHS Foundation Trust			6	1	7		
University Hospitals Coventry and Warwickshire NHS Trust	1			1	2		
University Hospitals of Leicester NHS Trust	1	1	1		3		

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	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
University Hospitals of North Midlands NHS Trust	1			1	2		
Walsall Healthcare NHS 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	1		2		3		
Weston Area Health NHS Trust			2		2		
Winfield Hospital (Ramsay Health Care UK)	1				1		
Wirral University Teaching Hospital NHS Foundation Trust	2	1		1	4		
Worcestershire Acute Hospitals NHS Trust			1	1	2		
Wrightington, Wigan and Leigh NHS Foundation Trust	5		1		6		
Wye Valley NHS Trust	1	1		1	3		
Yeovil District Hospital NHS Foundation Trust			1		1		
Yorkshire Clinic (Ramsay Health Care UK)	1				1		
Total	**102**	**38**	**126**	**42**	**308**	**2**	**1**

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.