Never Events reported as occurring between 1 April 2017 and 31 March 2018 – final update

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Contents

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Now that sufficient time has elapsed to allow for local incident investigation and national analysis of data following the end of the 2017/18 reporting year, this report provides a final update of Never Events reported as occurring between 1 April 2017 and 31 March 2018. It replaces and supersedes the previously published provisional data reports for 2017/18.

Important note on how this data is published

From 1 February 2018, providers were asked to report Never Events against a revised Never Events policy and framework and list of incidents designated as Never Events. This revised list includes additional incident types now designated as Never Events, the removal of a previously designated Never Event, and definitional changes to some types of Never Events.

As a result, Never Events reported after 1 February 2018 are not comparable with those reported earlier in the 2017/18 financial year as the definitions and designated list of Never Events had changed.

This report has therefore been published as two separate data sets. Data set 1 covers the period 1 April 2017 to 31 January 2018 (see page 6); Data set 2 covers the period 1 February to 31 March 2018 (see page 46).

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The Never Events policy and framework – revised January 2018 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 may not be robust.

The concept of Never Events is not about apportioning blame to organisations when these incidents occur but rather to learn from what happened. This is why, following consultation, in the revised Never events policy and framework we removed the option for commissioners to impose financial sanctions when Never Events were reported. The foreword to the framework states: "……allowing commissioners to impose financial sanctions following Never Events reinforced the perception of a 'blame culture'. Our removal of financial sanctions should not be interpreted as a weakening of effort to prevent Never Events. It is about emphasising the importance of learning from their occurrence, not blaming." 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 February 2018, this update has been split into two data sets which cover before and after the revision and direct comparison of the number of Never Events with earlier periods is not appropriate.

The revised 2018 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 on the revised Never Events list, commissioners are asked to discuss this with the provider organisation and either add extra detail to StEIS to confirm it is a Never Event or remove its Never Event designation from the StEIS system.

Supporting healthcare providers to prevent Never Events

To help prevent 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 organisations to share best practice.

To help prevent 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 materials to help trust boards, or their equivalents, assess whether previous alerts and guidance about nasogastric tubes have been implemented and embedded in their organisations.

The Care Quality Commission has undertaken a recent thematic review in collaboration with NHS Improvement to get a better understanding of what can be done to prevent the occurrence of Never Events. The report 'Opening the door to change' was published in December 2018.

The report found that: "Never Events continue to happen despite the hard work and efforts of frontline staff. Staff are struggling to cope with large volumes of safety guidance, they have little time and space to implement guidance effectively, and the systems and processes around them are not always supportive. Where staff are trying to implement guidance, they are often doing this on top of a demanding and busy role that makes it difficult to give the work the time it requires."

The report includes a recommendation that "NHS Improvement should review the Never Events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes; and those that could be designed out entirely such as through the removal of equipment or fitting/using physical barriers to risks). This review should focus on the leadership and culture needed to underpin safety. It should take into account the different settings in which Never Events occur, including acute, mental health and community settings"

Work to implement those recommendations may involve changes to the approach of the Never Events framework and the list of Never Events in the future.

Investigating and learning from Never Events

NHS providers are encouraged to learn from mistakes and any organisation that reports a Never Event is 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 so that necessary action can be taken.

Data on Never Events for 2016/17 and previous years can be found on the NHS Improvement website.

Data set 1

Never Events reported as occurring between 1 April 2017 and 31 January 2018

Please note: for the reasons mentioned at the beginning of this report, data set 1 is not comparable with data set 2 covering the period 1 February to 31 March 2018.

Summary

This set of data is drawn from the StEIS system, and includes all Serious Incidents with a reported incident date between 1 April 2017 and 31 January 2018 and which on 26 September 2018 were designated by their reporters as Never Events.

When data for this report was extracted, 418 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2017 and 31 January 2018. Of these 418:

- 407 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 2017 and 31 January 2018
- A further 10 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly
- One was a duplicate entry.

More detail is provided in the tables below.

Table 1: Never Events 1 April 2017 to 31 January 2018 by month of incident*

Month in which Never Event occurred	Number
April 2017	40
May 2017	39
June 2017	41
July 2017	49
August 2017	39
September 2017	28
October 2017	60
November 2017	46
December 2017	29
January 2018	36
Total	**407**

Note: A further 10 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly. One was a duplicate entry.

Table 2: Never Events 1 April 2017 to 31 January 2018 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**175**
Angiogram intended for another patient	1
Ascites drained rather than seroma	1
Carpal tunnel release instead of trigger finger release	1
Central line intended for another patient	1
Cervical biopsy taken rather than colon biopsy	1
Cheek biopsy on wrong patient	1

Colonoscopy instead of cystoscopy	1
Colposcopy intended for another patient	1
Contraceptive implant to wrong arm	1
Contrast injection to wrong groin	1
Cystoscopy performed that was not consented for	1
Cystoscopy intended for another patient	2
Exploration of wrong part of ear to remove foreign body	1
Excision of skin lesion that was intended for another patient	1
Filshie clip applied to round ligament rather than fallopian tube	1
Fusion of the wrong finger joint	1
Gastroscopy intended for another patient	1
Gastroscopy performed in addition to the planned procedure	1
Grommets inserted that were intended for another patient	1
Haemorrhoidectomy instead of incision and drainage of pilonidal sinus	1
Hip injection intended for another patient	1
Incision to wrong area of arm	1
Incision to wrong finger	1
Incision to wrong leg	1
Incision to wrong toe	1
Injection to wrong eye	2
Injection to wrong leg	1
Injection to wrong vocal chord	1
K wire to wrong finger	1
Laser surgery to wrong eye	1
Lumbar puncture intended for another patient	1

Oesophago gastro duodenoscopy instead of flexible sigmoidoscopy	1
Ovaries removed in error when the plan was to conserve them	4
Ovary and fallopian tube not removed when plan was to remove them	1
Perianal abscess incised instead of pilonidal abscess	1
PICC line intended for another patient	1
Removal of wrong side ureteric stent	1
Sigmoidoscopy intended for another patient	1
Ultrasound guided biopsy intended for another patient	1
Urodynamics examination intended for another patient	1
Wrong abscess excised	1
Wrong area of breast biopsied	1
Wrong area of breast excised	1
Wrong breast lesion removed	2
Wrong eye injection	4
Wrong finger	1
Wrong finger incision	1
Wrong hand tendon transfer	1
Wrong hernia repair	1
Wrong hip bursa excised	1
Wrong hip incision	1
Wrong incision - elbow instead of finger	1
Wrong kidney biopsy	1
Wrong level spinal surgery	12
Wrong lung biopsy	1
Wrong rib biopsy	1

Wrong rib removed	1
Wrong shoulder injection	1
Wrong side angioplasty	2
Wrong side angioplasty incision	1
Wrong side breast biopsy	1
Wrong side chest drain	3
Wrong side hernia repair	1
Wrong side jaw incision	1
Wrong side lithotripsy	1
Wrong side nephrostomy	1
Wrong side of elbow	1
Wrong side radio frequency ablation	1
Wrong side spinal injection	5
Wrong side spinal surgery	1
Wrong side stent removed	1
Wrong side ureteric stent	5
Wrong side ureteroscopy	1
Wrong site block	26
Wrong skin lesion biopsy	3
Wrong skin lesion removed	12
Wrong thumb injection	1
Wrong tooth/teeth removed	28
Wrong type of squint surgery - convergent rather than divergent	1
Retained foreign object post procedure	**102**
Cap from joint washout tubing	1

Cardiac valve armature	1
Catheter end piece that prevented removal	1
Dental pack	1
Digital tourniquet	1
Femoral lag screw	1
Guide wire - central line	13
Guide wire - chest drain	3
Guide wire - PICC line	1
Guide wire - temporary cardiac pacing wire	1
Guide wire - urodynamics sensor	1
Guide wire – vascath	2
K wire	2
Ophthalmic trocar	1
Part of a drill bit	1
Part of a screw	1
Part of a specimen retrieval bag	1
Part of a tracheostomy swab	1
Part of surgical needle	1
Part of umbilical venous catheter	1
Piece of amplatz wire	1
Piece of laparoscopic port tubing	1
Piece of plastic tubing	1
Plastic from pulse lavage system	1
Plastic sheath from ablation procedure	1
Raney arterial clamp	1

Ribbon gauze	1
Screw 'ears' from spinal fusion procedure	1
Screw from cabling system during hip replacement	1
Screw from knee replacement instrumentation	1
Sheath from ureteric balloon dilator	1
Small piece of metal following laparoscopic procedure	1
Specimen retrieval bag	3
Surgical clamp	2
Surgical drain	1
Surgical glove	1
Surgical needle	2
Surgical swab	15
Throat pack	5
Vaginal swab	22
Valve opener from cardiac procedure	1
Vascular clamp	1
Vascular sling	1
Wrong implant/prosthesis	**63**
Cranial plate that was custom made for another patient	1
Femoral nail instead of tibial nail	1
Hip	13
Knee	13
Lens	25
Wrong intrauterine device	4
Wrong stent	6

Misplaced naso- or orogastric tubes	**22**
Naso gastric tube in respiratory tract and feed administered	22
Wrong route administration of medication	**21**
Epidural medication given intravenously	9
Intravenous medication given intrathecally	1
Oral medication given intravenously	8
Oral medication given subcutaneously	3
Overdose of methotrexate for non-cancer treatment	**6**
Overdose of methotrexate for non-cancer treatment	6
Overdose of insulin due to abbreviations or incorrect device	**5**
Wrong syringe used	5
Transfusion or transplantation of ABO incompatible blood components or organs	**4**
Wrong blood transfused	4
Falls from poorly restricted windows	**3**
Window restrictors not fitted	2
Window restrictor removed	1
Chest or neck entrapment in bedrails	**2**
Chest or neck entrapment in bedrails	2
Scalding of patients	**2**
Small area of redness to buttock as bath water temperature not checked	1
Water temperature increased during use	1
Failure to install functional collapsible shower or curtain rails	**1**
Curtain rail failed to collapse	1
Mis-selection of a strong potassium containing solution	**1**

Potassium administered instead of fentanyl	1
Total	**407**

Note: A further 10 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly. One was a duplicate entry.

Table 3: Never Events 1 April 2017 to 31 January 2018 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Abbeyfield Medical Centre, reported by NHS North East Essex CCG	1													1
Aintree University Hospital NHS Foundation Trust	4		1											5
Airedale NHS Foundation Trust		2												2
Alder Hey Children's NHS Foundation Trust	1													1
Barking, Havering and Redbridge University Hospitals NHS Trust		3												3
Barnsley Hospital NHS Foundation Trust			2											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Barts Health NHS Trust	2	3	1											6
Basildon and Thurrock University Hospitals NHS Foundation Trust	2													2
Bedford Hospital NHS Trust		3												3
Birmingham Community Healthcare NHS Foundation Trust	2													2
Birmingham Women's and Children's Hospital NHS Foundation Trust		2												2
Blackpool Teaching Hospitals NHS Foundation Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
BMI Bath Private Hospital, reported by NHS Bath and North East Somerset CCG			1											1
BMI Bedford Private Hospital, reported by NHS Bedfordshire CCG		1												1
BMI Chelsfield Park Private Hospital, reported by NHS Bromley CCG			1											1
BMI Chiltern private hospital, reported by NHS Aylesbury Vale CCG		1												1
BMI Edgbaston private hospital, reported by Birmingham Cross City CCG	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
BMI The Hampshire private clinic, reported by NHS North Hampshire CCG	1													1
BMI Woodlands private hospital, reported by NHS Nene CCG			1											1
Bolton NHS Foundation Trust	1	1												2
BPAS Doncaster, reported by NHS Nene CCG	1													1
BPAS Liverpool, reported by NHS Halton CCG			1											1
Bradford Teaching Hospitals NHS Foundation Trust			1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Brighton and Sussex University Hospitals NHS Trust	2													2
Buckinghamshire Healthcare NHS Trust	1	1	2											4
Burton Hospitals NHS Foundation Trust			2											2
Calderdale and Huddersfield NHS Foundation Trust	1													1
Cambridgeshire Community Services NHS Trust	1													1
Cambridge University Hospitals NHS Foundation Trust	2	1	1											4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Care UK Peninsula Treatment Centre, reported by NHS North, East, West Devon CCG			1											1
Central and North West London Mental Health NHS Foundation Trust			1											1
Central Manchester University Hospitals NHS Foundation Trust (*now Manchester University NHS Foundation Trust*)	1				1									2
Chelsea and Westminster Hospital NHS Foundation Trust		2			1			1						4
City Hospitals Sunderland NHS Foundation Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Countess of Chester Hospital NHS Foundation Trust	1													1
County Durham and Darlington NHS Foundation Trust	1	2			1									4
Croydon Health Services NHS Trust					1									1
Cumbria Partnership NHS Foundation Trust										1				1
Dartford and Gravesham NHS Trust	1		1											2
Derby Teaching Hospitals NHS Foundation Trust (*now University Hospitals of Derby and Burton NHS Foundation Trust*)	1				1									2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Derbyshire Healthcare NHS Foundation Trust					1									1
Dorset County Hospital NHS Foundation Trust	1	1												2
Dudley Group NHS Foundation Trust		1			1						1			3
East and North Hertfordshire NHS Trust	1	1		1										3
East Cheshire NHS Trust	1													1
East Kent Hospitals University NHS Foundation Trust	1	2	2											5
East Lancashire Hospitals NHS Trust	4	1		1										6

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
East Suffolk and North Essex NHS Foundation Trust	2			1										3
East Sussex Healthcare NHS Trust			2	1										3
Emerson Green NHS Treatment Centre, Bristol, reported by South West team	1													1
Epsom and St Helier University Hospitals NHS Trust	1	1												2
Euxton Hall private hospital, reported by NHS Greater Preston CCG			1											1
Frimley Health NHS Foundation Trust	2		1											3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Gateshead Health NHS Foundation Trust	1													1
George Eliot Hospital NHS Trust	2													2
Gloucestershire Care Services NHS Trust	1													1
Gloucestershire Hospitals NHS Foundation Trust	1		2		1									4
Great Ormond Street Hospital for Children NHS Foundation Trust	1	1												2
Guy's and St Thomas' NHS Foundation Trust	3	4	1	1				1						10
Haddenham Dental Centre, reported by NHS South Central CCG	1			1										2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Hampshire Hospitals NHS Foundation Trust			1											1
Heart of England NHS Foundation Trust (*now University Hospitals Birmingham NHS Foundation Trust*)	1		1	2										4
Heatherwood and Wexham Park Hospitals NHS Foundation Trust (*now Frimley Health NHS Foundation Trust*)	4	1			1									6
Hillingdon Hospital NHS Foundation Trust	1	1												2
HMT St Hugh's, reported by NHS North East Lincolnshire CCG			2											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Homerton University Hospital NHS Foundation Trust		1												1
Hull and East Yorkshire Hospitals NHS Trust (*now Hull University Teaching Hospitals NHS Trust*)	2		1		1									4
Imperial College Healthcare 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		2					1		1					4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Lancashire Care NHS Foundation Trust						1								1
Lancashire Teaching Hospitals NHS Foundation Trust	2	1		1										4
Leeds Teaching Hospitals NHS Trust	2	1	1											4
Lewisham and Greenwich NHS Trust								1						1
Lincoln County Hospital, reported by NHS Lincolnshire West CCG		1												1
Liverpool Community Health NHS Trust (*now Mersey Care NHS Foundation Trust*)	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Liverpool Women's NHS Foundation Trust			1											1
London North West University Healthcare NHS Trust		1												1
Luton and Dunstable University Hospital NHS Foundation Trust	1		1	1			1							4
Maidstone and Tunbridge Wells NHS Trust	2				1									3
Manchester University NHS Foundation Trust	1	1												2
Medway NHS Foundation Trust		1		1			1							3
Mid Essex Hospital Services NHS Trust	2	1												3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Mid Yorkshire Hospitals NHS Trust	1													1
Middleton St George Dental Care, reported by NHS Darlington CCG	1													1
Milton Keynes University Hospital NHS Foundation Trust	1	1	1											3
Moorfields Eye Hospital NHS Foundation Trust			2											2
Mount Stuart Private Hospital, reported by NHS South Devon and Torbay CCG			1											1
mydentist Shepton Mallet, reported by NHS England South	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
New Hayesbank Surgery Cataract Clinic, reported by NHS South Kent Coast CCG			1											1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	1	1	1		2									5
Norfolk and Norwich University Hospitals NHS Foundation Trust	1	1	1											3
North Bristol NHS Trust	1		1											2
North East London NHS Treatment Centre reported by NHS Barking and Dagenham CCG		1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
North Middlesex University Hospital NHS Trust	3	2												5
North West Anglia NHS Foundation Trust		1												1
Northampton General Hospital NHS Trust	2		1											3
Northern Devon Healthcare NHS Trust	2													2
Northern Lincolnshire and Goole NHS Foundation Trust		1	1											2
Nottingham Healthcare NHS Foundation Trust	1													1
Nottingham University Hospitals NHS Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Nuffield Health Plymouth Private Healthcare, reported by NHS North, East, West Devon CCG			1											1
Nuffield Health Wolverhampton private hospital, reported by NHS Wolverhampton CCG	1													1
Oxford Health NHS Foundation Trust										1				1
Oxford University Hospitals NHS Foundation Trust	3						1							4
Pennine Acute Hospitals NHS Trust	3	1												4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Plymouth Hospitals NHS Trust *(now University Hospitals Plymouth NHS Trust)*	1	1											1	3
Poole Hospital NHS Foundation Trust	1													1
Portsmouth Hospitals NHS Trust	2	3	1											6
Priory Chelmsford Private Hospital, reported by East of England SCG												1		1
Q Dental Care, reported by South West area team	1													1
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	2													2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Queen Victoria Hospital NHS Foundation Trust	2	1												3
Ramsay Health, Fitzwilliam private hospital, reported by NHS Lincolnshire South CCG	1													1
Ramsay Health, Fulwood Hall private hospital, reported by NHS Greater Preston CCG	1													1
Ramsay Health, New Hall private hospital, reported by NHS Dorset CCG	1													1
Ramsay Health, Springfield private hospital, reported by NHS Mid Essex CCG	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Ramsay Health, The Yorkshire Clinic private hospital, reported by NHS Greater Huddersfield CCG			1											1
Ramsay Health, Woodland private hospital, reported by NHS Nene CCG	1													1
Ramsay Health, Woodthorpe private hospital, reported by NHS Nottingham West CCG	1													1
Riverside Medical Practice, reported by NHS Medway CCG			1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Riverside Medical Practice, reported by NHS Lambeth CCG						1								1
Rodericks Dental Practice, reported by NHS Gloucestershire CCG	1													1
Royal Berkshire NHS Foundation Trust		2												2
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	4	1	1	1										7
Royal Brompton and Harefield NHS Foundation Trust		1												1
Royal Cornwall Hospitals NHS Trust	2	1	4											7

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Royal Devon and Exeter NHS Foundation Trust	1	2												3
Royal Free London NHS Foundation Trust	3	3					1							7
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1	1												2
Royal National Orthopaedic Hospital NHS Trust	1													1
Royal Papworth Hospital NHS Foundation Trust	1	1												2
Royal Surrey County Hospital NHS Foundation Trust			2											2
Royal Wolverhampton NHS Trust	3	1												4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Salford Royal NHS Foundation Trust	6			1										17
Salisbury NHS Foundation Trust			1											1
Sandwell and West Birmingham Hospitals NHS Trust	3													3
Sheffield Teaching Hospitals NHS Foundation Trust	1		1	1										3
Sherwood Forest Hospitals NHS Foundation Trust	1	1												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Shropshire and Telford Hospitals NHS Trust (*now Shrewsbury and Telford Hospitals NHS Trust)*			1											1
Shropshire Community Health NHS Trust	2													2
Somerset Partnership NHS Foundation Trust	1													1
South Tees Hospitals NHS Foundation Trust	1													1
Southend University Hospital NHS Foundation Trust	2		1											3
Southport and Ormskirk Hospital NHS Trust	1													1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Spencer Private Hospital, reported by NHS Thanet CCG			1											1
Spire Leeds private hospital, reported by NHS Leeds West CCG	1		1											2
Spire Wellesley Private Healthcare, reported by NHS Southend CCG			1											1
St George's University Hospitals NHS Foundation Trust		3												3
St Helens and Knowsley Teaching Hospitals NHS Trust				2										2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
St John's Care Home, reported by NHS Croydon CCG									1					1
Superdrug Pharmacy, reported by NHS Bedfordshire CCG						1								1
Stocks Hall Mawdesley Care Home, reported by NHS Chorley and South Ribble CCG						1								1
Surrey and Sussex Healthcare NHS Trust		1												1
Tameside and Glossop Integrated Care NHS Foundation Trust	1	1												2
Taunton and Somerset NHS Foundation Trust		1						1						2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Tyne House, Percy Headly Foundation, reported by NHS Newcastle Gateshead CCG											1			1
United Lincolnshire Hospitals NHS Trust	2	1		1										4
University Hospital of South Manchester NHS Foundation Trust (now Manchester University NHS Foundation Trust	1													1
University Hospital Southampton NHS Foundation Trust	1													1
University Hospitals Birmingham NHS Foundation Trust	4			1										5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
University Hospitals Bristol NHS Foundation Trust	3	1		1										5
University Hospitals Coventry and Warwickshire NHS Trust	2	2			2									6
University Hospitals of Leicester NHS Trust	1	3		1	1									6
University Hospitals of Morecambe Bay NHS Foundation Trust	2													2
University Hospitals of North Midlands NHS Trust		1												1
Unknown, reported by NHS Rotherham CCG						1								1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Walsall Healthcare NHS Trust		1			1									2
Walton Centre NHS Foundation Trust	1													1
Warrington and Halton Hospitals NHS Foundation Trust	1	1												2
West Hertfordshire Hospitals NHS Trust					2									2
West Suffolk NHS Foundation Trust						1								1
Western Sussex Hospitals NHS Foundation Trust									1					1
Weston Area Health NHS Trust	1	1			1									3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Falls from poorly restricted windows	Chest or neck entrapment in bedrails	Scalding of patients	Failure to install functional collapsible shower or curtain rails	Mis-selection of a strong potassium containing solution	Total
Whittington Health NHS Trust		1												1
Wirral University Teaching Hospital NHS Foundation Trust	2	2												4
Worcestershire Acute Hospitals NHS Trust	1			1										2
Wrightington, Wigan and Leigh NHS Foundation Trust	2	1		1										4
Wye Valley NHS Trust	1	1												2
Yeovil District Hospital NHS Foundation Trust		1												1
York Teaching Hospital NHS Foundation Trust	2		1											3
Total	**175**	**102**	**63**	**22**	**21**	**6**	**5**	**4**	**3**	**2**	**2**	**1**	**1**	**407**

*Note: A further 10 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly. One was a duplicate entry.

Data set 2

Never Events reported as occurring between 1 February and 31 March 2018

Please note: for the reasons mentioned at the beginning of this report, data set 2 is not comparable with data set 1 covering the period 1 April 2017 to 31 January 2018.

Summary

When data for this report was extracted on 26 September 2018, 91 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 February and 31 March 2018. Of these 91:

- 88 Serious Incidents appeared to meet the definition of a Never Event in the *Never Events list 2018* (published 31 January 2018) and had an incident date between 1 February 2018 and 31 March 2018
- A further three Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

More detail is provided in the tables below.

Table 4: Never Events 1 February to 31 March 2018 by month of incident*

Month in which Never Event occurred	Number
February 2018	39
March 2018	49
Total	**88**

Note: A further three Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

Table 5: Never Events 1 February to 31 March 2018 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**34**
Incision to wrong groin	1
Laser surgery to wrong eye	1
Laser treatment to eye that was intended for another patient	2
Oesophago gastro duodenoscopy intended for another patient	1
Ovaries removed in error when the plan was to conserve them	1
Wrong breast injection	1
Wrong fallopian tube	1
Wrong groin aspiration	1
Wrong part of toe nail	1
Wrong rib removed	1
Wrong side hip arthrogram	1
Wrong side orchidopexy	1
Wrong side spinal injection	1
Wrong side ureteric stent	1
Wrong site block	12

Wrong skin lesion removed	1
Wrong tooth/teeth removed	6
Retained foreign object post procedure	**18**
Cotton wool ball	1
Guide wire - central line	2
Guide wire - from cruciate ligament repair	1
Guide wire - incomplete from urethral catheter	1
Guide wire - urinary catheter	1
Part of a Hickman line	1
Part of surgical forceps	1
Specimen retrieval bag	1
Surgical swab	4
Throat pack	1
Vaginal swab	4
Unintentional connection of a patient requiring oxygen to an air flowmeter	**16**
Patient connected to air flowmeter rather than oxygen flowmeter	16
Wrong implant/prosthesis	**8**
Hip	2
Knee	1
Wrong intrauterine device	2
Wrong pacemaker	2
Wrong type of tunnelled line	1
Misplaced naso- or orogastric tubes	**5**
Naso gastric tube in respiratory tract and feed administered	5
Wrong route administration of medication	**4**

Oral medication given intravenously	4
Transfusion or transplantation of ABO incompatible blood components or organs	**2**
Wrong blood transfused	2
Overdose of methotrexate for non-cancer treatment	**1**
Overdose of methotrexate for non-cancer treatment	1
Total	**88**

Note: A further three Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

Table 6: Never Events 1 February to 31 March 2018 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Aintree University Hospital NHS Foundation Trust	1		1						2
Airedale NHS Foundation Trust	1								1
Barking, Havering and Redbridge University Hospitals NHS Trust	1							1	2
Barts Health NHS Trust					1			1	2
Bedford Hospital NHS Trust			1						1
Berwick Castlegate Dental Practice, reported by Cumbria and North East Area Team	1								1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Birmingham Women's and Children's Hospital NHS Foundation Trust	1	1							2
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust	1								1
Bolton NHS Foundation Trust		1							1
Bridgewater Community Healthcare NHS Trust	1								1
Brighton and Sussex University Hospitals NHS Trust				1					1
Buckinghamshire Healthcare NHS Trust		2							2
Central and North West London Mental Health NHS Foundation Trust			1						1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Chelsea and Westminster Hospital NHS Foundation Trust		1	1						2
Dartford and Gravesham NHS Trust								1	1
Derby Teaching Hospitals NHS Foundation Trust (*now University Hospitals of Derby and Burton NHS Foundation Trust*)	1							1	2
East and North Hertfordshire NHS Trust		1					1	1	3
East Cheshire NHS Trust	1								1
East Lancashire Hospitals NHS Trust	1								1
Frimley Health NHS Foundation Trust	1	1	1						3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Gloucestershire Hospitals NHS Foundation Trust	1				1				2
Great Ormond Street Hospital for Children NHS Foundation Trust		1							1
Guy's and St Thomas' NHS Foundation Trust	1								1
Heart of England NHS Foundation Trust *(now University Hospitals Birmingham NHS Foundation Trust)*								1	1
Hull and East Yorkshire Hospitals NHS Trust *(Now Hull University Teaching Hospitals NHS Trust)*	2								2
Ipswich Hospital NHS Trust		1							1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
James Paget University Hospitals NHS Foundation Trust	1								1
King's College Hospital NHS Foundation Trust		1		1				1	3
Leeds Teaching Hospitals NHS Trust								1	1
London North West Healthcare NHS Trust				1				2	3
Luton and Dunstable University Hospital NHS Foundation Trust		1							1
Manchester University NHS Foundation Trust		1						1	2
Milton Keynes University Hospital NHS Foundation Trust					1				1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2		1						3
Norfolk and Norwich University Hospitals NHS Foundation Trust			1				1		2
North Cumbria University Hospitals Trust	1								1
North Middlesex University Hospital NHS Trust								1	1
North West Anglia NHS Foundation Trust	1								1
Northumbria Healthcare NHS Foundation Trust			1						1
Oxford University Hospitals NHS Foundation Trust	4								4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Poole Hospital NHS Foundation Trust		2							2
Portsmouth Hospitals NHS Trust								1	1
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1							1	2
Royal Free London NHS Foundation Trust		1						1	2
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1								1
Royal Surrey County Hospital NHS Foundation Trust	1								1
Salisbury NHS Foundation Trust	1	1							2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
Shrewsbury and Telford Hospitals NHS Trust					1				1
South Tees Hospitals NHS Foundation Trust		1							1
Southend University Hospital NHS Foundation Trust	1								1
Spire Hull and East Riding private hospital, reported by NHS East Riding of Yorkshire CCG	1								1
St George's University Hospitals NHS Foundation Trust				1				1	2
Tetbury Hospital, reported by South Central Area Team	1								1
Torbay and South Devon NHS Foundation Trust	1								1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Wrong route administration of medication	Overdose of methotrexate for non cancer treatment	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Total
University Hospitals of Leicester NHS Trust		1							1
University Hospitals of North Midlands NHS Trust	1								1
Walsall Healthcare NHS Trust	1								1
Wirral University Teaching Hospital NHS Foundation Trust						1			1
Wye Valley NHS Trust				1					1
Total	**34**	**18**	**8**	**5**	**4**	**1**	**2**	**16**	**88**

Note: A further three Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

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