Never Events reported as occurring between 1 April 2015 and 31 March 2016 – final update

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Never Events reported as occurring between 1 April 2015 and 31 March 2016 – final update

This report provides a final update of Never Events reported as occurring between 1 April 2015 and 31 March 2016 and supersedes the previously published monthly provisional data reports for 2015/16.

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. The current Never Events Policy and Framework 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 might not be robust. For more detail on Never Events, see: www.england.nhs.uk/ourwork/patientsafety/never-events/

The concept of Never Events is not about apportioning blame to organisations or individuals when these incidents occur but rather to learn from what happened. As the foreword to the Never Events Policy and Framework states: "Never Events are key indicators that there have been failures to put in place the required systemic barriers to error and their occurrence can tell commissioners something fundamental about the quality, care and safety processes in an organisation." 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.

The revised 2015 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 of a Never Event on the Never Events List 2015/16, commissioners are asked to discuss with the provider organisation and either add extra detail to StEIS to confirm it is a Never Event or to remove its Never Event designation from the StEIS system.

Comparisons with numbers of Never Events reported in previous years

Please note that because the definitions and designated list of Never Events was revised from April 2015, direct comparison of the number of Never Events with earlier periods would be misleading. The following points should be considered in how those changes to the Never Events definition and list has affected the numbers of Never Events in 2015/16 covered in this report:

- The definition of what constitutes a Never Event was amended as it now requires the potential to cause serious harm/death rather than actual harm to have occurred*

- Many of the definitions of Never Events on the list were refined, eg ‘wrong site surgery’ now includes ‘wrong site blocks’* (42 reported 2015/16); ‘wrong tooth extraction’ was clarified as a Never Event (33 reported 2015/16); and ‘wrong level spinal surgery’ was added to the Never Event list (11 reported 2015/16).
- The ‘wrong site surgery’ category of Never Event was clarified to include surgical interventions done outside the operating department environment and to include line insertions, eg Hickman, central lines, etc.
- In the ‘wrong implant/prosthesis’ category the revised framework removed the requirement for further surgery to replace the incorrect implant/prosthesis and the occurrence of complications.*

*most likely to have had an effect on the numbers of Never Events reported

Overall the NHS has also become more open and honest around incident reporting which is expected to have also led to an increase in the numbers of reported Never Events. We have also seen improved reporting from Independent Providers which led to an increase in the total numbers of Never Events reported.

Supporting healthcare providers to prevent Never Events

To support the prevention of 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 the sharing of best practice between organisations.

To support the prevention of nasogastric Never Events NHS Improvement published an Alert *Nasogastric tube misplacement: continuing risk of death and severe harm* and resource set in July 2016. These provide a range of materials designed to help trust boards, or their equivalents, assess whether previous alerts and guidance around nasogastric tubes have been implemented and embedded within their organisations.

Investigating and learning from Never Events

NHS providers are encouraged to learn from mistakes and any organisation that reports a Never Event is also 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 the Strategic Executive Information System (StEIS) and

all patient safety incidents to the National Reporting and Learning System (NRLS) to help us identify any risks and so that necessary action can be taken as appropriate.

Summary

When data for this report was extracted on 12 July 2016, 447 Serious Incidents on the StEIS system were designated by their reporters as Never Events with a reported incident date between 1 April 2015 and 31 March 2016. Of these 447 incidents:

- 442 Serious Incidents appeared to meet the definitions of a Never Event in the Never Events List 2015/16 where the actual date of incident fell between 1 April 2015 and 31 March 2016; this number is subject to change as local investigation takes place
- 3 reported Serious Incidents appeared to meet the definition of a Never Event but the actual date of the incident was before 1 April 2015 (see Table 4).
- 2 reported Serious Incidents did not appear to meet the definitions of a Never Event.

More detail is provided in the tables below:

Table 1: Never Events 1 April 2015 to 31 March 2016 by month of incident in which Never Event occurred

Month in which Never Event occurred	Number
April	29
May	27
June	34
July	31
August	27
September	41
October	50
November	42
December	34
January	32
February	45
March	50
Total	**442**
Note: As described above, two reported Serious Incidents did not appear to meet the definition of a Never Event and three reported Serious Incidents occurred before April 2015 (see Table 4).	

Table 2: Never Events 1 April 2015 to 31 March 2016 by type of incident with additional detail

Type and brief description of Never Event	Number
Wrong site surgery	**179**
Ablation of wrong saphenous vein	1
Botox injection to stomach rather than oesophagus	1
Burr holes to wrong side of head	1
Carpal tunnel release rather than trigger thumb procedure	1
Fallopian tube removed rather than appendix – patient 31 weeks pregnant and anatomy distorted	1
Gastroscopy rather than sigmoidoscopy	1
Incision to wrong aspect of ankle	1
Lung biopsy instead of bowel	1
Oesophago - gastro - duodenoscopy instead of colonoscopy	1
Ovaries removed in error during a hysterectomy when plan was to conserve them	1
Unnecessary procedure - screw already removed	1
Wrong ankle	1
Wrong aortic valve removed	1
Wrong area of breast excised	1
Wrong aspect of elbow	2
Wrong aspect of kidney	1
Wrong aspect of thyroid gland	1
Wrong aspect of wrist	1
Wrong excision to harvest bone graft	1
Wrong eye	12
Wrong eye injection	3
Wrong eye laser treatment	1
Wrong finger	2
Wrong hip	3
Wrong hip injection	1
Wrong incision for hernia repair	1
Wrong joint injections	1
Wrong patient identification - unnecessary procedure	7
Wrong procedure - Mirena coil implanted in error	1

Wrong procedure - oesophago gastro duodenoscopy done in error	1
Wrong side angioplasty	1
Wrong side Bartholins cyst removed	2
Wrong side chest drain	5
Wrong side chest incision	1
Wrong side hernia repair	1
Wrong side lithotripsy	1
Wrong side nephrostomy	1
Wrong side of perineum	1
Wrong side pleural biopsy	1
Wrong side ureteric stent	1
Wrong side ureteroscopy	1
Wrong side ureteroscopy and stent	1
Wrong site block	42
Wrong skin lesion removed	19
Wrong spinal level	11
Wrong testis	1
Wrong toe	1
Wrong toes	2
Wrong tooth/ teeth removed	33
Retained foreign object post procedure	**107**
Broken k wire	1
Corial guide	1
Dental roll	1
Drill tap sleeve	1
Endoretractor	1
Green bead from specimen retrieval system	1
Guide peg for internal fixation screws	1
Guide wire - ACL reconstruction	1
Guide wire - asitic drain	1
Guide wire - chest drain	3
Guide wire - CVC line	6
Guide wire - naso gastric tube	1
Guide wire - urethral catheter	1
Guide wire – vascath	1

Guide wire fragment - long line	1
Instrument screw	1
Ligaclip intended for removal	1
Microsurgical clamp	1
Part of a dental burr	1
Part of a perfusion catheter	1
Part of a resectascope	1
Part of a screw pin	1
Part of ureteric catheter	1
Part of varicose vein instrumentation	1
Pedicle screw	1
Percutaneous Endoscopic Gastrostomy (PEG) tube	1
Piece of plastic/elastic	1
Protective eye shield	1
Ribbon gauze	1
Scalpel blade	1
Screw pin	1
Specimen retrieval bag	3
Surgical needle	5
Surgical swab	18
Throat pack	7
Tip of chest catheter	1
Vaginal bung from an instrument	1
Vaginal swab	33
Wound protector	1
Wrong implant/prosthesis	**59**
Femoral instead of tibial nail	1
Fracture fixation plate	1
Fracture fixation plate and screws	1
Gastrostomy tube	1
Hip	14
Knee	10
Lens	26
Mirena coil	1
PICC line instead of Hickman line	1

Portocath instead of Hickman line	1
Wrong cochlear implant	1
Wrong cochlear implant lead	1
Misplaced naso or oro gastric tubes	**40**
Naso gastric tube in respiratory tract	40
Wrong route administration of medication	**25**
Epidural medication given intravenously	7
Oral medication given intravenously	16
Oral medication given subcutaneously	1
Oral medication given via prn site	1
Overdose of insulin due to abbreviations or incorrect device	**11**
Abbreviations used	1
Wrong syringe used	10
Transfusion or transplantation of ABO incompatible blood components or organs	**7**
Wrong blood transfused	7
Overdose of methotrexate for non cancer treatment	**5**
Overdose of methotrexate for non cancer treatment	5
Falls from poorly restricted windows	**4**
Falls from poorly restricted windows	4
Failure to install functional collapsible shower or curtain rails	**3**
Blinds failed to collapse	1
Curtain rail failed to collapse	2
Mis selection of a strong potassium containing solution	**1**
Potassium selected instead of sodium chloride	1
Mis selection of high strength midazolam during conscious sedation	**1**
Higher strength midazolam administered	1
Total	**442**

Note: As described above, two reported Serious Incidents did not appear to meet the definition of a Never Event and three reported Serious Incidents occurred before April 2015 (see Table 4).

Table 3: Never Events 1 April 2015 to 31 March 2016 by healthcare provider

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Aintree University Hospital NHS Foundation Trust			1										1
Alder Hey Children's NHS Foundation Trust	4												4
Ashford and St. Peters Hospitals NHS Foundation Trust	1		1	1									3
Barlborough NHS Treatment Centre – reported by NHS Hardwick CCG	1		1										2
Barnsley Hospital NHS Foundation Trust	1		1										2
Barts Health NHS Trust	2	3	1	5	1	2							14
Basildon and Thurrock University Hospitals NHS Foundation Trust	2						1						3
Bedford Hospital NHS Trust	1						1						2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Birmingham Children's Hospital NHS Foundation Trust	2	3	1	1									7
Birmingham Community Healthcare NHS Foundation Trust						1							1
Blackpool Teaching Hospitals NHS Foundation Trust	1												1
BMI The Alexandra Private Hospital – reported by NHS Stockport CCG	1												1
BMI The Beardwood Private Hospital – reported by NHS East Lancashire CCG	1												1
BMI The Droitwich Spa Private Hospital – reported by NHS Redditch & Bromsgrove CCG			1										1
BMI The Hampshire Private Clinic – reported by NHS North Hampshire CCG	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
BMI The Sandringham Private Hospital – reported by NHS Norfold and Waveny CSU	1												1
BMI The Somerfield Private Hospital – reported by NHS Medway CCG	1												1
BMI The South Cheshire Private Hospital – reported by NHS South Cheshire CCG	1												1
BMI Three Shires Private Hospital – reported by NHS Nene CCG			2										2
Bolton NHS Foundation Trust	1	2											3
BPAS Oxford – reported by NHS Oxfordshire CCG			1										1
BPAS Birmingham South Clinic – reported by NHS Birmingham Cross City CCG		1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
BPAS Richmond – reported by NHS Sutton CCG		1											1
Bradford Hospitals NHS Foundation Trust		1		1									2
Bradley Resource Centre – reported by NHS Wolverhampton CCG								1					1
Braintree Community Hospital Day Surgery – reported by NHS Mid Essex CCG	1												1
Brighton and Sussex University Hospitals NHS Trust	4		2	1	1								8
Buckinghamshire Healthcare NHS Trust			1										1
Calderdale and Huddersfield NHS Foundation Trust		2											2
Cambridge University Hospitals NHS Foundation Trust	1	1											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Central Manchester University Hospitals NHS Foundation Trust	2	3	3										8
Chelsea and Westminster Healthcare NHS Foundation Trust		2	1										3
Chesterfield Royal Hospital NHS Foundation Trust	1		1										2
City Hospital Sunderland NHS Foundation Trust		2		1									3
Colchester Hospital University NHS Foundation Trust	1	1		1									3
Suffolk Hospital – reported by East Primary Care	1												1
Cornwall Partnership NHS Foundation Trust	1												1
Countess of Chester Hospital NHS Foundation Trust	1	1											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
County Durham and Darlington NHS Foundation Trust				1									1
Croydon Health Services NHS Trust		1											1
Derby Teaching Hospitals NHS Foundation Trust	2	2	1					1					6
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	1	1											2
Dorset County Hospital NHS Foundation Trust	1							1					2
Ealing Hospital NHS Trust					1		1						2
East and North Hertfordshire NHS Trust	1	2			1								4
East Cheshire NHS Trust	1	2											3
East Kent Hospitals University NHS Foundation Trust	3	2		1			1						7

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
East Lancashire Hospitals NHS Trust	2	1		1									4
East Sussex Healthcare NHS Trust			1	1	1								3
Epsom and St Helier NHS Trust	1	1		2									4
Foscote Private Hospital – reported by NHS Oxfordshire CCG			1										1
Frimley Park Hospital NHS Foundation Trust	4												4
Gateshead Health NHS Foundation Trust	2												2
George Eliot Hospital NHS Trust		1											1
Gloucestershire Care Services NHS Trust	1												1
Gloucestershire Hospitals NHS Foundation Trust			1	1									2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Great Western Hospitals NHS Foundation Trust	2	1	2										5
Guy's and St Thomas' NHS Foundation Trust	6	4		3	1						1		15
Hampshire Hospitals NHS Foundation Trust	3	1			1	1							6
Harrogate and District NHS Foundation Trust	1												1
Health Partnerships Notts Healthcare NHS Trust				1									1
Heart of England NHS Foundation Trust	2	1			1								4
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	2	1											3
Hinchingbrooke Health Care NHS Trust	2												2
Homerton Hospital NHS Foundation Trust		1		1	1	1							4

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Hull and East Yorkshire Hospitals NHS Trust	2	1											3
Imperial College Healthcare NHS Trust	1	1	2										4
Ipswich Hospital NHS Trust	2	1			2								5
Isle of Wight NHS Trust		2			1								3
Kettering General Hospital NHS Foundation Trust			1										1
Kingfisher Nursing Home – reported by NHS Birmingham Cross City CCG				1									1
King's College Hospital NHS Foundation Trust		5	4	2									11
Lancashire Care NHS Foundation Trust									1				1
Lancashire Teaching Hospitals NHS Foundation Trust	2		1										3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Leeds and York Partnership NHS Foundation Trust										1			1
Leeds Teaching Hospitals NHS Trust	3	1	1										5
Lewisham and Greenwich NHS Trust	1		1										2
Lincolnshire Partnership NHS Foundation Trust										1			1
Liverpool Heart and Chest NHS Foundation Trust	1												1
Liverpool Women's Hospital NHS Foundation Trust						1							1
Luton and Dunstable University Hospital NHS Foundation Trust	1	1			1								3
Maidstone and Tunbridge Wells NHS Trust		1					1						2
Mid Cheshire Hospitals NHS Foundation Trust			1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Mid Essex Hospital Services NHS Trust		2	1										3
Midland Eye Hospital - reported by NHS Solihull CCG			1										1
Milton Keynes University Hospital NHS Foundation Trust	1												1
Moorfields Eye Hospital NHS Foundation Trust			1										1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	3				1								4
Norfolk and Norwich University Hospitals NHS Foundation Trust	3	1		1									5
North Bristol NHS Trust	1	1			1								3
North Cumbria University Hospitals Trust	3	2	1	1									7
North Middlesex Hospital NHS Trust					1								1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
North Tees and Hartlepool NHS Foundation Trust	1	1											2
North West London Hospitals NHS Trust	1		2	1					1				5
Northampton General Hospital NHS Trust	2	1	1										4
Northern Devon Healthcare NHS Trust						1							1
Northern Lincolnshire & Goole NHS Foundation Trust	1	1	1										3
Northumbria Healthcare NHS Foundation Trust		1											1
Nottingham University Hospitals NHS Trust		1	2		3								6
Nuffield Health Leeds Private Hospital – reported by NHS Leeds West CCG	1												1

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Nuffield Health Private Hospital, Cambridge – reported by NHS Cambridgeshire and Peterborough CCG	1												1
Nunwell Surgery – reported by West Midlands Area Team								1					1
Oxford University Hospitals NHS Foundation Trust	4	1											5
Papworth Hospital NHS Foundation Trust	1	1											2
Pennine Acute Hospitals NHS Trust	1		1										2
Peterborough and Stamford NHS Foundation Trust	1	1	1										3
Pinehill Private Hospital – reported by NHS East and North Hertfordshire CCG	1												1
Plymouth Hospitals NHS Trust	1												1

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Poole Hospital NHS Foundation Trust	1	1											2
Portsmouth Hospitals NHS Trust		1											1
Princess Alexandra Hospital NHS Trust			1										1
Huddersfield Hospital (Private) – reported by NHS Greater Huddersfield CCG	1												1
Probus Surgical Centre – reported by NHS Kernow CCG	1												1
Ramsay Woodthorpe Private Hospital – reported by NHS Nottingham City CCG			1										1
Ramsey Private Treatment Centre – reported by NHS Oxfordshire CCG			1										1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Ramsey Private Treatment Centre, Horton – reported by NHS Oxfordshire CCG		1											1
Ramsey Winfield Private Hospital – reported by NHS Gloucestershire CCG	1												1
Renacres Private Hospital – reported by NHS Greater Preston CCG	1												1
Royal Berkshire NHS Foundation Trust		1											1
Royal Cornwall Hospitals NHS Trust	2												2
Royal Devon and Exeter NHS Foundation Trust	1	1	1										3
Royal Free London NHS Foundation Trust	3	4			1								8
Royal Liverpool & Broadgreen NHS Trust	1	1		1			1						4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Salford Royal NHS Foundation Trust	4	1											5
Salisbury NHS Foundation Trust	2												2
Sandwell and West Birmingham Hospitals NHS Trust	3	1											4
Patients home, Serco and reported by East Anglia Area Team					1								1
Sheffield Children's NHS Foundation Trust	3			1									4
Sheffield Teaching Hospitals NHS Foundation Trust	2		2										4
Sherwood Forest Hospitals NHS Foundation Trust	1												1
Shrewsbury and Telford Hospitals NHS Trust	1	1											2
South Tees Hospitals NHS Foundation Trust	2												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
South Tyneside NHS Foundation Trust	1												1
South Warwickshire NHS Foundation Trust				1									1
Southampton Treatment Centre – reported by NHS Southampton CCG	1												1
Southend University Hospital NHS Foundation Trust		1	1									1	3
Southport and Ormskirk Hospital NHS Trust					1			1					2
Spire Clare Park Private Hospital – reported by NHS North East Hamsphire and Farnham CCG	1												1
Spire Fylde Coast Private Hospital – reported by NHS Fylde & Wyre CCG	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Spire Hartswood Private Hospital – reported by NHS Southend CCG			1										1
Spire Washington Private Healthcare – reported by NHS Sunderland CCG	1		1										2
St George's Healthcare NHS Trust	1	2		1		1							5
Stockport NHS Foundation Trust	1	1											2
Surrey and Sussex Healthcare NHS Trust	1			1									2
Sussex Community NHS Trust	1												1
Tameside Hospital NHS Foundation Trust		1											1
Taunton and Somerset NHS Foundation Trust	2												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
The Dudley Group NHS Foundation Trust		1											1
The Hillingdon Hospital NHS Foundation Trust				2									2
The Princess Alexandra Hospital NHS Trust	1												1
The Rotherham NHS Foundation Trust	1												1
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust			1			1							2
The Royal National Orthopaedic Hospital NHS Trust	1												1
The Royal Wolverhampton NHS Trust	2	1											3
The Wirral Community NHS Foundation Trust	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
The Yorkshire Clinic Private Healthcare - reported by NHS Bradford Districts CCG	1												1
Torbay and South Devon NHS Foundation Trust		2											2
United Lincolnshire Hospitals NHS Trust		2	1										3
University College London Hospitals NHS Foundation Trust	3	1			1								5
University Hospital of South Manchester NHS Foundation Trust	1												1
University Hospital Southampton NHS Foundation Trust	3	1											4
University Hospitals Birmingham NHS Foundation Trust	2	1		1			1						5
University Hospitals Bristol NHS Foundation Trust	2				1								3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
University Hospitals Coventry and Warwickshire NHS Trust	2												2
University Hospitals of Leicester NHS Trust									1				1
University Hospitals of Morecambe Bay NHS Foundation Trust	1	2											3
Victoria Care Centre – reported by North West London Collaboration of CCGs									1				1
West Hertfordshire Hospitals NHS Trust		1											1
West London Mental Health NHS Trust										1			1
West Suffolk NHS Foundation Trust	1	1											2
Western Sussex Hospitals NHS Foundation Trust		2											2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/prosthesis	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Overdose of insulin due to abbreviations or incorrect device	Transfusion or transplantation of ABO incompatible blood components or organs	Overdose of methotrexate for non cancer treatment	Falls from poorly restricted windows	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium containing solution	Mis selection of high strength midazolam during conscious sedation	Total
Weston Area Health NHS Trust		1		1									2
Whittington Health NHS Trust				1									1
Wirral University Teaching Hospital NHS Foundation Trust	2	1			1								4
Worcestershire Acute Hospitals NHS Trust			1			1							2
Worcestershire Health and Care NHS Trust	1												1
Wrightington, Wigan and Leigh NHS Foundation Trust				1									1
Yeovil District Hospital NHS Foundation Trust	1												1
York Hospitals NHS Foundation Trust						1							1
Total	**179**	**107**	**59**	**40**	**25**	**11**	**7**	**5**	**4**	**3**	**1**	**1**	**442**

Note: As described above, two reported Serious Incidents did not appear to meet the definition of a Never Event and three reported Serious Incidents occurred before April 2015 (see Table 4).

Table 4: Never Events occurring before 1 April 2015 that have not been identified in previous reports

Provider organisation where Never Event occurred	Date	Retained foreign object post procedure	Wrong site surgery
Northern Lincolnshire and Goole NHS Foundation Trust	Unspecified date 2014	1	
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	23 March 2015	1	
University Hospitals Coventry and Warwickshire NHS Trust	November 2013		1
Total		**2**	**1**

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