Provisional publication of Never Events reported as occurring between 1 April 2019 and 29 February 2020

Published 30 March 2020

NHS England and NHS Improvement

Contents

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 – published January 2018 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, 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 Never Events list 2018 (published 31 January 2018) 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.

To help prevent the use of curtain or shower rails being used as a ligature point, an Estates and Facilities Alert A*nti-ligature' type curtain rail systems: Risks from incorrect installation or modification* has been published in March 2019. The alert is not accessible publicly but can be accessed via log in to the Central Alerting System.

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" This work may involve changes to the approach of the Never Events framework and the list of Never Events in the future.

The CQC report also suggested that organisations did not always have strong systems for implementing alerts. Key problems included disseminating alerts for local awareness

rather than taking the actions the alerts set out, delegating responsibility for recording action had been completed to junior levels of their organisation, and localised implementation that relied on many local team or unit leaders taking duplicative actions, with the most effective systemic actions left incomplete. Fundamental change was needed, and the National Patient Safety Alerting Committee (NaPSAC) was established to deliver that change.

NaPSAC is providing governance for the new National Patient Safety Alerts (NatPSA). All national bodies and teams issuing alerts are required to go through a process of accreditation to issue NatPSAs. This ensures their systems and processes for producing and developing alerts meet NaPSAC's standards, so that:

- alerts are only issued for safety-critical issues (risk of death or disability)
- alerts have a concise and clear explanation of the risk
- the required actions are assessed for feasibility, risk of unintended consequences, equalities impact, effectiveness, and cost-effectiveness
- the actions are SMART (specific, measurable, achievable, realistic and timely).

Providers are required to fundamentally review their systems for implementing the actions required by NatPSAs. This includes revising policies, processes and governance systems to meet the management and oversight requirements for the implementation of these alerts.

NatPSAs typically require action to be centrally coordinated on behalf of the whole organisation, rather than by multiple individual teams, divisions or directorates, as had often been the case for previous alerts. All NatPSAs also need executive level oversight (or the equivalent in organisations without executive boards) of governance systems that provide evidence that the required actions have been fully completed.

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.

Important notes on the provisional nature of this data

To support learning from Never Events we are committed to publishing this data as early as possible. However, because reports of apparent Never Events are submitted by healthcare providers as soon as possible, often before local investigation is complete, all data is provisional and subject to change.

Because of the complex combination of incidents identified as Never Events when first

reported, Serious Incidents designated as Never Events at a later date, and incidents initially reported as Never Events that on investigation are found not to meet the criteria, our monthly provisional Never Event reports provide cumulative totals for the current financial year. This is to ensure the information provided is as consistent and as accurate as possible.

This provisional report is drawn from the StEIS system and includes all Serious Incidents with a reported incident date between 1 April 2019 and 29 February 2020, and which on 11 March 2020 were designated by their reporters as Never Events.

Data on Never Events for 2018/19 and previous years can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2019/20 reporting year for local incident investigation and national analysis of data, we will produce a final whole-year report of Never Events, which will replace this provisional data.

Summary

When data for this report was extracted on 11 March 2020, 476 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2019 and 29 February 2020. Of these 476 incidents:

- 435 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 April 2019 and 29 February 2020; this number is subject to change as local investigations are completed
- 41 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April 2019 and 29 February 2020.

More detail is provided in the tables below:

Table 1: Never Events 1 April 2019 and 29 February 2020 by month of incident*

Month in which Never Event occurred	Number
Apr	35
May	48
Jun	40
Jul	44
Aug	48
Sep	39
Oct	34
Nov	40
Dec	38
Jan	41
Feb	28
Total	**435**

Note: As described above, a further 41 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

*Numbers are subject to change as local investigations are completed.

Table 2: Never Events 1 April 2019 and 29 February 2020 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**218**
Biopsy taken from gastrointestinal tumour rather than kidney	1
Central line intended for another patient	1
Cervical biopsy instead of colon/rectal biopsy	1
Circumcision instead of planned frenuloplasty	1
Colonoscopy intended for another patient	1
Colposcopy intended for another patient	1
Contrast injection to wrong breast	1
Cystoscopy instead of sigmoidoscopy	1
Cystoscopy intended for another patient	1
Fallopian tube removed in error when plan was to remove the appendix	1
Flexible cystoscopy intended for another patient	1
Gastroscopy instead of colonoscopy	1
Gastroscopy intended for another patient	1
Gastrostomy instead of colostomy	1
Guide wire positioned into wrong lesion	1
Hip injection intended for another patient	1
Incision to wrong eye lid	1
Incision to wrong finger	2
Incision to wrong side of gum	1
Incision to wrong side of knee	1
Incision to wrong testicle	1
Injection to carpal tunnel intended for another patient	1
Injection to face rather than neck	1
Injection to wrong breast	1
Injection to wrong eye	7
Injection to wrong eye muscle	1
Injection to wrong finger joint	1
Injection to wrong foot	1
Injection to wrong hip	1
Injection to wrong joint	1
Injection to wrong leg	2
Injection to wrong leg muscle	1
Injections to both eyelids instead of one	1
Injections to both eyes rather than one	1
K wires to wrong part of thumb	1
Knee injection instead of elbow aspiration	1
Laser eye treatment intended for another patient	1

Laser therapy to wrong eye	1
Lesion removed from neck instead of gum	1
Lumbar puncture intended for another patient	2
Needle aspiration of wrong lung	1
Needle aspiration to wrong lung	1
Ovaries removed when plan was to conserve them	1
Part of pancreas removed instead of adrenal gland	1
Perineal fistulotomy instead of incision and drainage of pilonidal abscess	1
Pilonidal sinus excised instead of groin abscess	1
Removal of wrong breast lesion	1
Screws removed from wrong toe joint	1
Shoulder injection intended for another patient	1
Ureteroscopy intended for another patient	1
Varicose vein removal from the wrong leg	1
Wrong area of breast tissue removed	2
Wrong breast lesion removed	1
Wrong eye procedure	1
Wrong finger	2
Wrong finger incision	2
Wrong finger injection	1
Wrong hernia incision	1
Wrong hernia repair	1
Wrong lung biopsy	1
Wrong rectus muscle in squint surgery	2
Wrong side angiogram	2
Wrong side angioplasty	1
Wrong side ankle arthroscopy	1
Wrong side chest drain	3
Wrong side hernia repair	1
Wrong side labial lesion removed	1
Wrong side of leg	1
Wrong side of nose	1
Wrong side of toe	1
Wrong side of toenail removed	1
Wrong side parietal catheter	1
Wrong side spinal injection	11
Wrong side spinal surgery	2
Wrong side ureteric stent	2
Wrong side ureterorenoscopy	1
Wrong site block	53
Wrong site pleural aspiration	1
Wrong skin lesion biopsy	3

Wrong skin lesion removed	14
Wrong testicle	1
Wrong toe	1
Wrong toe removed	1
Wrong tooth/teeth removed	38
Wrong vulval lesion removed	2
Retained foreign object post procedure	**90**
Angioplasty cover	2
Bladder loop	1
Bladder resectoscope tip	1
Corneal guard	1
Coronary wire	1
Guide wire - anterior cruciate ligament reconstruction	1
Guide wire - central line	14
Guide wire - chest drain	5
Guide wire - gastrostomy stent	1
Guide wire - long line	1
Guide wire - percutaneous coronary intervention (PCI)	1
Guide wire - PICC line	2
Guide wire - renal dialysis line	1
Guide wire - renal vascath	1
Guide wire - superior vena cava (SVC) cannula	1
Guide wire - ureteric stent	1
Intracranial pressure bolt washer	1
Intraoperative retractor sponge	1
Laser eye shield	1
Ophthalmic pars plana vitrectomy (PPV) port	1
Ophthalmic trocar	1
Part of a dental instrument	1
Part of a Jacques catheter	1
Part of a periosteal elevator	1
Part of a surgical needle	1
Part of a uterine manipulator	1
Part of a vascular ablation sheath	1
PEG insertion device	1
Renal catheter inserter	1
Rubber collar from uterine manipulator	1
Surgical forcep	2
Surgical needle	3
Surgical swab	18
Throat pack	1
Tip of resectoscope	2

Vaginal swab	15
Wrong implant/prosthesis	**43**
Femoral nail	1
Fracture fixation plate - right instead of left	1
Hip	9
Intramedullary nail	1
Intra uterine device	1
IUCD implanted that was not consented for	1
Knee	13
Lens	9
Shoulder	1
Shoulder plate	1
VP shunt valve	1
Wrong breast implant	1
Wrong compression screws for femoral nail	1
Wrong intrauterine device	2
Unintentional connection of a patient requiring oxygen to an air flowmeter	**27**
Patient connected to air flowmeter rather than oxygen	27
Misplaced naso or oro gastric tube	**21**
Naso gastric tube in the respiratory tract and feed administered	21
Administration of medication by the wrong route	**10**
Enteral medication given intravenously	1
Oral medication given intravenously	7
Oral medication given subcutaneously	2
Mis selection of high strength midazolam during conscious sedation	**6**
Wrong strength midazolam administered	6
Overdose of methotrexate for non-cancer treatment	**6**
Methotrexate overdose prescribed and administered	6
Overdose of insulin due to abbreviations or incorrect device	**6**
Insulin withdrawn from an insulin pen	1
Wrong syringe	5
Transfusion or transplantation of ABO incompatible blood components or organs	**5**
Wrong blood transfused	5
Failure to install functional collapsible shower or curtain rails	**1**
Curtain rail failed to collapse	1
Mis selection of a strong potassium solution	**1**
Potassium administered instead of paracetamol	1
Mis selection of a strong potassium solution	**1**
Wrong strength potassium given	1
Total	**435**

Note: As described above, a further 41 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

*Numbers are subject to change as local investigations are completed.

Table 3: Never Events 1 April 2019 and 29 February 2020 by healthcare provider*

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Airedale NHS Foundation Trust													2	**2**
Alder Hey Children's NHS Foundation Trust									1				2	**3**
Alexandra Group Medical Practice, reported by NHS Oldham CCG								1						**1**
Ashford and St. Peters Hospitals NHS Foundation Trust													4	**4**
Barbara Castle Way Health Centre, reported by NHS East Lancashire CCG													2	**2**
Barking, Havering and Redbridge University Hospitals NHS Trust									5					**5**
Barnet, Enfield and Haringey Mental Health NHS Trust		1												**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Barts Health NHS Trust					1	2			1		1	1	4	**10**
Basildon and Thurrock University Hospitals NHS Foundation Trust									1					**1**
Birmingham Women's and Children's NHS Foundation Trust									1				1	**2**
Blackpool Teaching Hospitals NHS Foundation Trust			1									1	1	**3**
BMI - The Chiltern Hospital, reported by NHS Aylesbury Vale CCG												1		**1**
BMI - The Lancaster Hospital, reported by NHS East Lancashire CCG													1	**1**
BMI Goring Hall Hospital, reported by NHS Horsham and Mid Sussex CCG													1	**1**
Bolton NHS Foundation Trust									1				1	**2**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
BPAS Merseyside, reported by NHS Halton CCG												1		**1**
Bradford District Care NHS Foundation Trust													1	**1**
Bradford Teaching Hospitals NHS Foundation Trust									1					**1**
Brighton and Sussex University Hospitals NHS Trust									1					**1**
Buckinghamshire Healthcare NHS Trust									1					**1**
Calderdale & Huddersfield NHS Foundation Trust													1	**1**
Cambridge University Hospitals NHS Foundation Trust						1			2		1		1	**5**
Chesterfield Royal Hospital NHS Foundation Trust									1				3	**4**
City Hospital Sunderland NHS Foundation Trust												1		**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
County Durham and Darlington NHS Foundation Trust					1						1	1		**3**
Croydon Health Services NHS Trust	1												1	**2**
Cumbria Partnership NHS Foundation Trust													1	**1**
Dartford and Gravesham NHS Trust									1				1	**2**
Derbyshire Community Health Services NHS Foundation Trust									1				1	**2**
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust							1					1	1	**3**
Dorset County Hospital NHS Foundation Trust													1	**1**
Dorset Healthcare University NHS Foundation Trust													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
East and North Hertfordshire NHS Trust									1		1		1	**3**
East Cheshire NHS Trust													1	**1**
East Kent Hospitals University NHS Foundation Trust									2			2		**4**
East Lancashire Hospitals NHS Trust									3				1	**4**
East Suffolk and North Essex NHS Foundation Trust									1		1		3	**5**
East Sussex Healthcare NHS Trust										1			3	**4**
Emersons Green NHS Treatment centre, reported by NHS Bristol North Somerset and South Gloucestershire CCG												1		**1**
Epsom and St Helier University Hospitals NHS Trust												1	2	**3**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Frimley Health NHS Foundation Trust						1			1				2	**4**
Gateshead Health NHS Foundation Trust								1					1	**2**
George Eliot Hospital NHS Trust											1		2	**3**
Gloucestershire Health and Care NHS Foundation Trust												1	3	**4**
Gloucestershire Hospitals NHS Foundation Trust											1		1	**2**
Great Ormond Street Hospital for Children NHS Foundation Trust									1					**1**
Great Western Hospitals NHS Foundation Trust									1				1	**2**
Guy's and St Thomas' NHS Foundation Trust	1					1			1			1	5	**9**
Hampshire Hospitals NHS Foundation Trust								1			1		3	**5**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Homerton University Hospital NHS Foundation Trust									1			1	1	**3**
Hull University Teaching Hospitals NHS Trust						1			1		1		5	**8**
Imperial College Healthcare NHS Trust						1			1				1	**3**
InHealth, Mobile Endoscopy Unit, reported by NHS Manchester CCG					1									**1**
InHealth, Rochdale Mobile Unit, reported by NHS Heywood, Middleton & Rochdale CCG													1	**1**
Ironstone Centre, Scunthorpe, reported by NHS North Lincolnshire CCG													1	**1**
iSIGHT Private Eye Care, Southport, reported by NHS South Sefton CCG													1	**1**
Isle of Wight NHS Trust													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
James Paget University Hospitals NHS Foundation Trust												2		**2**
Kettering General Hospital NHS Foundation Trust													1	**1**
King's College Hospital NHS Foundation Trust											1		2	**3**
Kingston Hospital NHS Foundation Trust									1					**1**
Lancashire Teaching Hospitals NHS Trust									1				1	**2**
Leeds Teaching Hospitals NHS Trust							1		1		1		1	**4**
Lewisham and Greenwich NHS Trust									1				2	**3**
Liverpool Heart and Chest Hospital NHS Foundation Trust													1	**1**
Liverpool University Hospitals NHS Foundation Trust					3			1		1			1	**6**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Liverpool Women's NHS Foundation Trust									1					**1**
London North West University Healthcare NHS Trust											2		2	**4**
Luton and Dunstable University Hospital NHS Foundation Trust						1							2	**3**
Maidstone and Tunbridge Wells NHS Trust	1												1	**2**
Manchester University NHS Foundation Trust						1	1		2				5	**9**
Medway NHS Foundation Trust									2					**2**
Mid Cheshire Hospitals NHS Foundation Trust												1		**1**
Mid Essex Hospital Services NHS Trust						1								**1**
Mid Yorkshire Hospitals NHS Trust				1					1		1			**3**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Moorfields Eye Hospital NHS Foundation Trust												1	1	**2**
My Dentist, Bridgwater, reported by Somerset CCG													3	**3**
My Dentist, Hebburn, reported by NHS England - Cumbria and North EastMy Dentist, Newton Abbot, reported by NHS Devon CCG													1	**1**
Newcastle upon Tyne Hospitals NHS Foundation Trust	1												3	**4**
Norfolk and Norwich University Hospitals NHS Foundation Trust									1		4		2	**7**
Norfolk Community Health and Care NHS Trust													1	**1**
North Bristol NHS Trust	1													**1**
North Cumbria Integrated Care NHS Foundation Trust													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
North Middlesex University Hospital NHS Trust									1		1			**2**
North Somerset Community Partnership, reported by NHS Bristol North Somerset and South Gloucestershire CCG													1	**1**
North Tees and Hartlepool NHS Foundation Trust													1	**1**
North West Anglia NHS Foundation Trust												1		**1**
Northampton General Hospital NHS Trust									1				1	**2**
Northern Devon Healthcare NHS Trust													1	**1**
Northern Lincolnshire and Goole NHS Foundation Trust									1				1	**2**
Northumberland, Tyne and Wear NHS Foundation Trust	1													**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Northumbria Healthcare NHS Foundation Trust									1			1		**2**
Nottingham University Hospitals NHS Trust									1			1		**2**
Oaklands Hospital, reported by NHS Salford CCG													1	**1**
Oxford Health NHS Foundation Trust													1	**1**
Oxford University Hospitals NHS Foundation Trust						1			1				4	**6**
Pennine Acute Hospitals NHS Trust						1						1		**2**
Pennine Care NHS Foundation Trust													1	**1**
Pennine MSK Partnership, reported by NHS Oldham CCG								1						**1**
Poole Hospital NHS Foundation Trust									1				1	**2**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Portsmouth Hospitals NHS Trust	1								2		2	1	1	**7**
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust												1	2	**3**
Queen Victoria Hospital NHS Foundation Trust													1	**1**
Ramsay Health Care UK - Mount Stuart Hospital, reported by NHS Devon CCG												1		**1**
Ramsay Health Care UK - Springfield Hospital, reported by NHS Mid Essex CCG												1	1	**2**
Rowley Hall Hospital, reported by NHS Stafford and Surrounds CCG												1		**1**
Royal Berkshire NHS Foundation Trust									1				1	**2**
Royal Brompton and Harefield NHS Foundation Trust									1					**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Royal Liverpool and Broadgreen University Hospitals NHS Trust													2	**2**
Royal Orthopaedic Hospital NHS Foundation Trust													1	**1**
Royal Papworth Hospital NHS Foundation Trust									1					**1**
Royal United Hospitals Bath NHS Foundation Trust											1		1	**2**
Salford Royal NHS Foundation Trust													1	**1**
Salisbury NHS Foundation Trust									1		1			**2**
Sandwell and West Birmingham Hospitals NHS Trust									2				1	**3**
Sheffield Children's NHS Foundation Trust													1	**1**
Sheffield Teaching Hospitals NHS Foundation Trust							1		1			2	5	**9**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Shepton Mallet Treatment Centre, reported by NHS Somerset CCG												1		**1**
Sherwood Forest Hospitals NHS Foundation Trust													2	**2**
Shrewsbury and Telford Hospitals NHS Trust													1	**1**
Smiles Orthodontics Dental Practice reported by NHS East and North Hertfordshire CCG													1	**1**
Somerset Partnership NHS Foundation Trust									1					**1**
South Tees Hospitals NHS Foundation Trust						1			2				5	**8**
South Tyneside and Sunderland NHS Foundation Trust													1	**1**
South Warwickshire NHS Foundation Trust													3	**3**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Southampton Treatment Centre - Care UK, reported by NHS Southampton CCG												1	1	**2**
Southend University Hospital NHS Foundation Trust									1				3	**4**
Southport and Ormskirk Hospital NHS Trust													1	**1**
Spire - Clare Park, reported by NHS North East Hampshire and Farnham CCG													1	**1**
Spire - Hull and East Riding Hospital, reported by NHS North Lincolnshire CCG												1		**1**
Spire - London East Hospital, reported by NHS Redbridge CCG													1	**1**
Spire - Manchester, reported by NHS Manchester CCG													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Spire - Murrayfield, reported by NHS Wirral CCG									1					**1**
St George's University Hospitals NHS Foundation Trust						1	1		2				1	**5**
Stockport NHS Foundation Trust							1		1					**2**
Surrey and Sussex Healthcare NHS Trust													2	**2**
Tameside and Glossop Integrated Care NHS Foundation Trust									2					**2**
Taunton and Somerset NHS Foundation Trust									1				1	**2**
Tesco Plymouth Pharmacy, reported by Somerset CCG								1						**1**
The Christie NHS Foundation Trust										1			1	**2**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
The Dudley Group NHS Foundation Trust									3					**3**
The Hillingdon Hospital NHS Foundation Trust									1					**1**
The McIndoe Centre, reported by NHS High Weald Lewes Havens CCG													1	**1**
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1								1		1			**3**
The Royal Free NHS Foundation Trust										1				**1**
The Royal Marsden NHS Foundation Trust													1	**1**
The Royal National Orthopaedic Hospital NHS Trust													1	**1**
The Royal Wolverhampton NHS Trust													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
The Walton Centre NHS Foundation Trust									1					**1**
The Westbourne Centre, reported by NHS West Midlands CCG													1	**1**
The Royal Orthopaedic Hospital NHS Foundation Trust									1				1	**2**
Torbay and South Devon NHS Foundation Trust													2	**2**
United Lincolnshire Hospitals NHS Trust	1					2			2			1	3	**9**
University College London Hospitals NHS Foundation Trust											1		2	**3**
University Hospital Southampton NHS Foundation Trust						2			1				3	**6**
University Hospitals Birmingham NHS Foundation Trust										1		2	4	**7**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
University Hospitals Bristol NHS Foundation Trust									1			1	3	**5**
University Hospitals of Derby and Burton NHS Foundation Trust													4	**4**
University Hospitals of Leicester NHS Trust									1				2	**3**
University Hospitals of Morecambe Bay NHS Foundation Trust												1		**1**
University Hospitals of North Midlands NHS Trust												1	2	**3**
University Hospitals Plymouth NHS Trust									1			1	3	**5**
Warrington and Halton Hospitals NHS Foundation Trust													1	**1**
West Hertfordshire Hospitals NHS Trust						1							2	**3**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Western Sussex Hospitals NHS Foundation Trust													1	**1**
Weston Area Health NHS Trust													2	**2**
Whittington Health NHS Trust											2		2	**4**
Wirral University Teaching Hospital NHS Foundation Trust									1				1	**2**
Worcestershire Acute Hospitals NHS Trust									1			1	4	**6**
Wrightington, Wigan and Leigh NHS Foundation Trust						1			1			1	1	**4**
Wye Valley NHS Trust									2				3	**5**
Yeovil District Hospital NHS Foundation Trust													2	**2**
York Teaching Hospital NHS Foundation Trust	1								1				1	**3**
Yorkshire Ambulance Service NHS Trust													1	**1**

	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tube	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Grand Total	**10**	**1**	**1**	**1**	**6**	**21**	**6**	**6**	**90**	**5**	**27**	**43**	**218**	**435**

Note: As described above, a further 41 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review them accordingly.

*Numbers are subject to change as local investigations are completed.
** Reported by North East Ambulance Service NHS Foundation Trust but appears related to an air flowmeter left in situ in University Hospital of North Durham.

Table 4: Never Events reported as occurring after 1 April 2019 but actually occurring prior to this

. None reported.

* Numbers are subject to change as local investigations are completed.

Contact us:

NHS England and NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

This publication can be made available in a number of other formats on request