

Provisional publication of Never Events reported as occurring between 1 April 2018 and 31 March 2019

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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 since that date 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 *Anti-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. <https://www.cas.mhra.gov.uk/Home.aspx>

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.

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 2018 and 31 March 2019 and which on 9 April 2019 were designated by their reporters as Never Events.

Data on [Never Events for 2017/18 and previous years](#) can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2018/19 reporting year for local incident investigation and national analysis of data, NHS Improvement 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 9 April 2019, 504 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2018 and 31 March 2019. Of these 504:

- 496 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 2018 and 31 March 2019; this number is subject to change as local investigations are completed
- A further seven Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations
- One was a duplicate entry.

More detail is provided in the tables below.

Table 1: Never Events 1 April 2018 to 31 March 2019 by month of incident*

Month in which Never Event occurred	Number
April 2018	36
May 2018	52
June 2018	61
July 2018	33
August 2018	56
September 2018	33
October 2018	45
November 2018	40
December 2018	32
January 2019	39
February 2019	30
March 2019	39
Total	496

Note: A further seven Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 2: Never Events 1 April 2018 to 31 March 2019 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	207
Adenoids removed in error during a tonsillectomy when plan was to conserve them	1
Biopsy of wrong breast	1
Botox injection instead of nerve block	1

Botulinum injection to wrong leg	1
Cervical biopsy rather than biopsy of colon	1
Circumcision rather than a flexible cystoscopy	1
Cystoscopy undertaken that was intended for another patient	1
Exploration of wrong oral cyst	1
Gastroscopy and colonoscopy intended for another patient	1
Grommet inserted to wrong ear	1
Hysterectomy and salpingo-oophorectomy when the plan was to conserve one or both ovaries	6
Incision to wrong part of ear	1
Incision to wrong side of elbow	1
Incision to wrong side of head	1
Incision to wrong side of knee	1
Incision to wrong side of toe nail	1
Injection to both eyes rather than just one	1
Injection to wrong area of foot	1
Injection to wrong eye	6
Injection to wrong hip	1
Injection to wrong toe	1
K wire to wrong thumb joint	1
Knee aspiration performed instead of joint injection	1
Laser surgery to wrong eye	1
Lumbar puncture performed on wrong patient	1
Midline catheter intended for another patient	1
Misplacement of central line	1
Myometrial biopsy performed on the wrong patient	1

Perianal abscess incised instead of pilonidal	1
Scaphoid bone removed instead of trapezium	2
Tonsillectomy performed when not consented for	2
Unnecessary shoulder injection as patient had already had it	1
Wrong breast biopsy	1
Wrong breast lump removed	1
Wrong ear lesion removed	1
Wrong eye injection	2
Wrong eye muscle resected as part of squint surgery	2
Wrong eyelid injection	1
Wrong finger	3
Wrong finger incision	2
Wrong hip	2
Wrong hip aspiration	1
Wrong incision for removal of tooth	1
Wrong injection to eye	1
Wrong joint arthrogram and injection	1
Wrong laparoscopic port site re explored	1
Wrong patient - central line inserted that was intended for another patient	1
Wrong patient had a colonoscopy intended for another patient	1
Wrong patient had laser eye surgery intended for another patient	1
Wrong side angiogram	2
Wrong side angioplasty	3
Wrong side Bartholin's cyst	1
Wrong side burr hole	1

Wrong side chest drain	2
Wrong side excision of vas and testicular vessels	1
Wrong side hernia incision	1
Wrong side lung biopsy	1
Wrong side of colon removed	1
Wrong side of elbow	1
Wrong side of elbow incision	1
Wrong side of toe nail removed	1
Wrong side spinal injection	12
Wrong side ureteric stent	4
Wrong side ureteric stent removed	2
Wrong side ureteroscopy	2
Wrong site block	34
Wrong skin lesion biopsy	2
Wrong skin lesion removed	20
Wrong squint surgery esotropia rather than exotropia	1
Wrong thyroid lobe removed	1
Wrong toe	1
Wrong toe incision	1
Wrong toe nail removed	1
Wrong toe removed	1
Wrong tooth/teeth removed	42
Retained foreign object post procedure	104
Acetabular sizing trial	1
Cotton wool ball	1

Filshie bung	1
Gauze roll	1
Guide peg from internal fixation fractured radius	1
Guide wire - central line	8
Guide wire - chest drain	2
Guide wire - coronary artery stent	2
Guide wire - femoral line	1
Guide wire - haemodialysis line	1
Guide wire - Hickman line	1
Guide wire - PICC line	2
Guide wire - vascath	1
Guide wire from pelvic fracture repair	1
Guide wire tip - PICC line	1
Guide wire tip - urinary catheter	1
Haemostatic material	1
K wire	1
Knee replacement pin	2
Loop electrode from uterine resectoscope	1
Metallic object	1
Mouth props	1
Part of a catheter from a Transjugular intrahepatic portosystemic shunt	1
Part of a drill bit	1
Part of a laparoscopic grasper	1
Part of a supra pubic catheter	1
Part of guide wire - haemodialysis catheter	1

Plastic tubing	1
Ribbon gauze	1
Screw caps	1
Specimen retrieval bag	2
Surgical drain	1
Surgical forcep	1
Surgical glove	1
Surgical needle	2
Surgical swab	11
Throat pack	2
Tonsil swab	1
Trocar protector	1
Vaginal swab	40
Vein cannula	1
Wrong implant/prosthesis	63
Breast implant	1
Ear implant	1
Femoral nail	1
Hip	25
Knee	10
Lens	8
Wrong bone cement	1
Wrong fracture fixation plate	4
Wrong intra uterine device	6
Wrong k wires	1

Wrong neuro stimulator	1
Wrong spinal cord stimulator	1
Wrong stent	1
Wrong type of corneal graft	1
Wrong vascular graft	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	50
Patient connected to air flowmeter rather than oxygen	50
Misplaced naso- or orogastric tubes	29
Nasogastric tube in the respiratory tract and feed administered	29
Overdose of insulin due to abbreviations or incorrect device	14
Abbreviations	1
Insulin withdrawn from an insulin pen	2
Wrong syringe used	11
Administration of medication by the wrong route	10
Oral medication given intravenously	7
Oral medication given subcutaneously	1
Oral medication given via endotracheal tube	1
Subcutaneous medication given intravenously	1
Failure to install functional collapsible shower or curtain rails	7
Curtain rail failed to collapse	3
Shower curtain rail failed to collapse	4
Transfusion or transplantation of ABO incompatible blood components or organs	4
Blood transfused that was intended for another patient	1
Wrong blood transfused	3

Mis selection of high strength midazolam during conscious sedation	3
Overdose of midazolam	3
Overdose of methotrexate for non-cancer treatment	3
Higher dose prescribed	1
Overdose of methotrexate for non-cancer treatment	2
Falls from poorly restricted windows	2
No window restrictors in place	1
Window restrictors damaged	1
Total	496

Note: A further seven Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 3: Never Events 1 April 2018 to 31 March 2019 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Abbeyfield Medical Centre, reported by NHS North East Essex CCG	1												1
Aintree University Hospital NHS Foundation Trust			1										1
Airedale NHS Foundation Trust	2				1								3
Alder Hey Children's NHS Foundation Trust	1		1				1						3
Ashford and St. Peter's Hospitals NHS Foundation Trust		1											1
Barking, Havering and Redbridge University Hospitals NHS Trust				2									2
Barnet, Enfield and Haringey Mental Health NHS Trust							1						1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Barnsley Hospital NHS Foundation Trust	1						1						2
Barts Health NHS Trust	5	5	1	1	1								13
Basildon and Thurrock University Hospitals NHS Foundation Trust	1	1		1		1	1						5
Bedford Hospital NHS Trust	4	1											5
Birmingham Community Healthcare NHS Foundation Trust	2												2
Birmingham Women's and Children's NHS Foundation Trust	1	1			2								4
Blackpool Teaching Hospitals NHS Foundation Trust	1												1
Bolton NHS Foundation Trust	3												3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Bradford Teaching Hospitals NHS Foundation Trust	1	2											3
Bridgewater Community Healthcare NHS Foundation Trust	1	1											2
Brighton and Sussex University Hospitals NHS Trust	1	1											2
Buckinghamshire Healthcare NHS Trust	1	1		1									3
Calderdale and Huddersfield NHS Foundation Trust		1		3									4
Cambridge University Hospitals NHS Foundation Trust	1				2								3
Cambridgeshire Community Services NHS Trust	1		2										3

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Chelsea and Westminster Hospital NHS Foundation Trust	1	1		1									3
Chesterfield Royal Hospital NHS Foundation Trust	1	1											2
City Healthcare Dental Services, Goole Hospital - reported by NHS Hull CCG	1												1
City Healthcare Dental Services, Highlands Health Centre - reported by NHS Hull CCG	1												1
City Hospitals Sunderland NHS Foundation Trust	3												3
Community Dental Services, reported by NHS Luton CCG	1												1
Countess of Chester Hospital NHS Foundation Trust	1											1	2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
County Durham and Darlington NHS Foundation Trust	1		1			1			1				4
Dartford and Gravesham NHS Trust				2									2
Dental Services, reported by South West regional team	1												1
Derbyshire Community Health Services NHS Foundation Trust		1											1
Devizes NHS Treatment Centre (Care UK) reported by NHS England	1												1
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	1												1
Dudley Group NHS Foundation Trust	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
East and North Hertfordshire NHS Trust	4				1								5
East Cheshire NHS Trust			2										2
East Kent Hospitals University NHS Foundation Trust	2	2	2									1	7
East Lancashire Hospitals NHS Trust				1		1							2
East Suffolk and North Essex NHS Foundation Trust	1	1	2				1						5
East Sussex Healthcare NHS Trust		1											1
Epsom and St Helier University Hospitals NHS Trust						1			1				2
Essex Partnership University NHS Foundation Trust								3					3

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Euxton Hall Private Hospital, reported by NHS Greater Preston CCG		1											1
Frimley Health NHS Foundation Trust	3												3
Gateshead Health NHS Foundation Trust	2												2
Gentle Dental Care, reported by Croydon CCG	1												1
George Eliot Hospital NHS Trust				1									1
Gibraltar House Dental Clinic, Reported by NHS South East CCG	1												1
Gloucestershire Hospitals NHS Foundation Trust	3												3

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Great Western Hospitals NHS Foundation Trust	1	1	3										5
Guy's and St Thomas' NHS Foundation Trust	6			1		1							8
Hampshire Hospitals NHS Foundation Trust			1										1
Hillingdon Hospitals NHS Foundation Trust	2		1										3
HMP Wakefield, reported by Care UK Yorkshire and the Humber							1						1
HMT St Hugh's Private Hospital, reported by NHS Lincolnshire East CCG	1												1
Homerton University Hospital NHS Foundation Trust		1	1										2

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Hull City Health Care Partnership, reported by NHS Hull CCG	2												2
Imperial College Healthcare NHS Trust	3	3											6
James Paget University Hospitals NHS Foundation Trust					1								1
Kettering General Hospital NHS Foundation Trust		1											1
King's College Hospital NHS Foundation Trust	3	2		2		1	1						9
Kingston Hospital NHS Foundation Trust						1							1
Lancashire Care NHS Foundation Trust	1												1
Lancashire Teaching Hospitals NHS Foundation Trust	2	1			2		1						6

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Leeds Teaching Hospitals NHS Trust	1	2	2	2	1								8
Leicestershire Partnership NHS Trust								1					1
Liverpool Heart and Chest NHS Foundation Trust				1									1
Liverpool Women's NHS Foundation Trust		1	1										2
Locala Community Partnerships CIC reported by NHS Greater Huddersfield CCG	1		1										2
London North West University Healthcare NHS Trust	2	1	1	1									5
Luton and Dunstable University Hospital NHS Foundation Trust	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Maidstone and Tunbridge Wells NHS Trust		1											1
Manchester University NHS Foundation Trust	1		1	1	2								5
Medway Community Healthcare	1												1
Medway NHS Foundation Trust		1											1
Mersey Care NHS Foundation Trust								1					1
Mid Cheshire Hospitals NHS Foundation Trust		1											1
Mid Essex Hospital Services NHS Trust	3		1										4
Mid Yorkshire Hospitals NHS Trust	1				1								2

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Milton Keynes University Hospital NHS Foundation Trust	1	1				1							3
Moorfields Eye Hospital NHS Foundation Trust	2												2
My dentist Leigh, reported by Greater Manchester Direct Commissioning	1												1
Mydentist, Bognor Regis reported by South East Provider	1												1
Newcastle upon Tyne Hospitals NHS Foundation Trust	2	1				1	1						5
Norfolk and Norwich University Hospitals NHS Foundation Trust	2	2	2										6
North Bristol NHS Trust		1		4									5
North Cumbria University Hospitals NHS Trust		1				1							2

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North Middlesex University Hospital NHS Trust	1	1	3										5
North West Anglia NHS Foundation Trust	1												1
Northampton General Hospital NHS Trust	1												1
Northamptonshire Healthcare NHS Foundation Trust											1		1
Northern Devon Healthcare NHS Trust	1												1
Northern Lincolnshire and Goole NHS Foundation Trust	2	1											3
Northumbria Healthcare NHS Foundation Trust	3			1		2							6
Nottingham University Hospitals NHS Trust		1											1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Nuffield Health North Staffordshire private hospital, reported by NHS North Staffordshire CCG		1											1
Nuffield North Staffordshire Private Hospital, reported by Stoke on Trent CCG	1												1
Oxford Health NHS Foundation Trust	1							1					2
Oxford University Hospitals NHS Foundation Trust	4	5		1									10
Parkside private hospital, reported by NHS Wandsworth CCG			1										1
Pennine Acute Hospitals NHS Trust	2			1									3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Pinehill private hospital, reported by NHS East and North Hertfordshire CCG			1										1
Poole Hospital NHS Foundation Trust	2	1											3
Portsmouth Hospitals NHS Trust	3				1								4
Priory Hospital Southampton, reported by NHS England								1					1
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	1												1
Queen Victoria Hospital NHS Foundation Trust		1											1
Ramsay Healthcare Bedford, reported by NHS Bedfordshire CCG	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Ramsay Rivers Hospital, reported by NHS West Essex CCG	1												1
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust			1										1
Rotherham NHS Foundation Trust	3				1								4
Rowley Hall Hospital, reported by NHS Stafford and Surrounds CCG	1												1
Royal Berkshire NHS Foundation Trust	1	3		3									7
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1		2										3
Royal Brompton and Harefield NHS Foundation Trust					1								1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Royal Cornwall Hospitals NHS Trust	1	2											3
Royal Devon and Exeter NHS Foundation Trust	3	1			1								5
Royal Free London NHS Foundation Trust	4	2	1	2									9
Royal Liverpool and Broadgreen University Hospitals NHS Trust			1		1						1		3
Royal Papworth Hospital NHS Foundation Trust					1								1
Royal Surrey County Hospital NHS Foundation Trust		1											1
Royal United Hospitals Bath NHS Foundation Trust	3	1											4
Royal Wolverhampton NHS Trust	2	2											4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Salford Royal NHS Foundation Trust	1												1
Salisbury NHS Foundation Trust	2			1									3
Sandwell and West Birmingham Hospitals NHS Trust	1	2											3
Sheffield Children's NHS Foundation Trust	2	1											3
Sheffield Teaching Hospitals NHS Foundation Trust	2	2											4
Sherwood Forest Hospitals NHS Foundation Trust	1												1
Shrewsbury and Telford Hospital NHS Trust	1	2			1								4
Somerset Partnership NHS Foundation Trust	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
South Tees Hospitals NHS Foundation Trust	1	3		1									5
South Warwickshire NHS Foundation Trust	2												2
Southampton General Hospital, reported by NHS Southampton CCG	1												1
Southampton NHS Treatment Centre (Care UK) reported by NHS Southampton CCG	1												1
Southend University Hospital NHS Foundation Trust	1												1
Southport and Ormskirk Hospital NHS Trust		2											2
Spire Little Aston Hospital, reported by NHS Birmingham and Solihull CCG	1												1

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Spire London East Private Hospital, reported by NHS Redbridge CCG	1												1
Spire Manchester private Hospital, reported by NHS Manchester CCG		1											1
Spire Methley Park Hospital, reported by NHS Leeds West CCG		1											1
Spire Regency private hospital, reported by NHS Eastern Cheshire CCG	1												1
St Catherine's Hospital, reported by NHS Wirral CCG			1										1
St George's University Hospitals NHS Foundation Trust		1	1		1				1				4

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
St Helens and Knowsley Teaching Hospitals NHS Trust		1											1
Stockport NHS Foundation Trust		1											1
Surrey and Sussex Healthcare NHS Trust	1		1										2
Sussex Community NHS Foundation Trust	1												1
Tameside and Glossop Integrated Care NHS Foundation Trust		1			1								2
Taunton and Somerset NHS Foundation Trust	1	1	1										3
Torbay and South Devon NHS Foundation Trust	1	1											2
United Lincolnshire Hospitals NHS Trust	3				1					2			6

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
University College London Hospitals NHS Foundation Trust	5	4		2									11
University Hospital Southampton NHS Foundation Trust	1	1	1										3
University Hospitals Birmingham NHS Foundation Trust	1	2	1	2	2	1							9
University Hospitals Bristol NHS Foundation Trust	3	2											5
University Hospitals of Derby and Burton NHS Foundation Trust	3	1		3			1						8
University Hospitals of Leicester NHS Trust	5		1	1									7
University Hospitals of Morecambe Bay NHS Foundation Trust	1		1		1								3

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
University Hospitals of North Midlands NHS Trust		4	1						1				6
University Hospitals Plymouth NHS Trust	5		1			1							7
Wallace House Surgery, reported by South West regional team	1												1
Walsall Healthcare NHS Trust			12	1									13
Walton Centre NHS Foundation Trust			1										1
Warrington and Halton Hospitals NHS Foundation Trust					1								1
West Hertfordshire Hospitals NHS Trust			2										2
West Suffolk NHS Foundation Trust	2												2

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Western Sussex Hospitals NHS Foundation Trust	1	1		1									3
Weston Area Health NHS Trust										1			1
Whitehouse Dental Surgery, reported by Central Midlands area team	1												1
Whittington Health NHS Trust	1												1
Wirral University Teaching Hospital NHS Foundation Trust					1								1
Woodland Hospital, reported by NHS Nene CCG	1												1
Worcestershire Acute Hospitals NHS Trust	1												1
Wrightington, Wigan and Leigh NHS Foundation Trust	2	1	1	1									5

	Wrong site surgery	Retained foreign object post procedure	Wrong implant/ prosthesis	Unintentional connection of a patient requiring oxygen to an air flowmeter	Misplaced naso- or orogastric tubes	OD of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Failure to install functional collapsible shower or curtain rails	Transfusion or transplantation of ABO incompatible blood components or organs	Mis selection of high strength midazolam during conscious sedation	OD of methotrexate for non cancer treatment	Falls from poorly restricted windows	Total
Wye Valley NHS Trust				3									3
York Teaching Hospital NHS Foundation Trust	2			1							1		4
Total	207	104	63	50	29	14	10	7	4	3	3	2	496

Note: A further seven Serious Incidents did not appear to meet the definition of a Never Event and are currently being reviewed by the relevant organisations. One was a duplicate entry.

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

Table 4: Never Events occurring before 1 April 2018 not previously reported

Provider organisation where Never Event occurred	Month in which Never Event occurred	Incident Type
Great Western Hospitals NHS Foundation Trust	January 2011	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	March 2013	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	February 2016	Wrong implant/prosthesis
Great Western Hospitals NHS Foundation Trust	November 2016	Wrong implant/prosthesis
Total		4

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