# Never Events reported as occurring between 1 April 2019 and 31 March 2020 – final update

Published 14 January 2020

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# Never Events reported as occurring between 1 April 2019 and 31 March 2020 – final update

Now that sufficient time has elapsed to allow for local incident investigation and national analysis of data following the end of the 2019/20 reporting year, this report provides a final update of Never Events reported as occurring between 1 April 2019 and 31 March 2020. It replaces and supersedes the previously published provisional data report for 2019/20.

## 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 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

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

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 introducing physical barriers to risks).

The report also suggested that organisations did not always have strong systems for implementing alerts. Key problems included organisations circulating alerts to raise awareness rather than taking the required actions to address an issue; responsibility taken at a junior level for recording an organisation's completion of the actions required by an alert; and instead of central coordination across an organisation, individual teams being asked to implement the required actions locally, leading to duplication and the most effective systemic actions left incomplete.

To help address these issues, a new National Patient Safety Alerting Committee (NaPSAC) has been established, whose role includes the development and governance of the new National Patient Safety Alerts. These alerts require healthcare providers to introduce new systems for planning and coordinating the required actions, including executive oversight.

In September 2015, a set of National Safety Standards for Invasive Procedures (NatSSIPs) were published to help prevent Never Events, with all relevant NHS organisations in England instructed to develop and implement their own local standards based on the national principles. The standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice.

The national patient safety team and our partners also continue to work to further prevent individual types of Never Events. Examples include our 2016 Alert *Nasogastric tube misplacement: continuing risk of death and severe harm* and resource set; the May 2020 aide-memoire produced by professional bodies for nutrition, anaesthetics and intensive care to help prevent nasogastric tube Never Events, including special considerations for COVID-19 patients; and the 2019 Estates and Facilities Alert A*nti-ligature' type curtain rail systems: Risks from incorrect installation or modification* (note: this alert is not accessible publicly but can be accessed via log in to the Central Alerting System).

As set out in the NHS Patient Safety Strategy, patient safety research and innovation also has an important role to play. We are continuing to work with partners including the Patient Safety Translational Research Centres, Academic Health Science Networks and other researchers, in conjunction with the National Institute for Health Research and the Department of Health and Social Care, to develop new technical solutions to Never Events.

## 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 NRLS, to help us identify any risks so that necessary action can be taken.

Data on Never Events for previous years and provisional data for the current financial year can be found on the NHS England website.

# Summary

When data for this report was extracted on 09 October 2020, 502 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 31 March 2020. Of these 502 incidents:

- 472 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 31 March 2020
- 30 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April 2019 and 31 March 2020.

More detail is provided in the tables below:

### Table 1: Never Events 1 April 2019 and 31 March 2020 by month of incident*

| Month in which Never Event occurred | Total |
|---|---|
| Apr-19 | 36 |
| May-19 | 46 |
| Jun-19 | 41 |
| Jul-19 | 44 |
| Aug-19 | 47 |
| Sep-19 | 38 |
| Oct-19 | 33 |
| Nov-19 | 39 |
| Dec-19 | 38 |
| Jan-20 | 45 |
| Feb-20 | 33 |

| | |
|---|---|
| Mar-20 | 32 |
| **Total** | **472** |

Note: As described above, a further 30 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

## Table 2: Never Events 1 April 2019 and 31 March 2020 by type of incident with additional detail*

| Type and brief description of Never Event | Total |
|---|---|
| **Wrong site surgery** | **226** |
| Biopsy taken from gastrointestinal tumour rather than kidney | 1 |
| Botulinum injection to face rather than neck | 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 | 2 |
| Colposcopy intended for another patient | 1 |
| Contrast injection to wrong breast | 1 |
| Cystoscopy intended for another patient | 2 |
| Fenton's procedure instead of marsupialisation of Bartholin's cyst | 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 wrong eye | 5 |
| Injection to wrong eye muscle | 1 |
| Injection to wrong finger joint | 2 |
| Injection to wrong foot | 1 |
| Injection to wrong leg | 2 |
| Injection to wrong leg muscle | 1 |
| Injection to wrong toe joint | 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 intended for another patient | 1 |
| Laser eye treatment intended for another patient | 1 |
| Laser treatment to wrong eye | 2 |
| Laser treatment intended for another patient | 1 |

| | |
|---|---|
| Lesion removed from cheek instead of gum | 1 |
| Lumbar puncture intended for another patient | 2 |
| Marsupialisation of Bartholin's cyst instead of Fenton's procedure | 1 |
| Needle aspiration of 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 |
| Procedure done that was not part of the surgical plan or consented | 2 |
| 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 | 2 |
| Wrong side hernia repair | 1 |
| Wrong side labial lesion removed | 1 |
| Wrong side lithotripsy | 1 |
| Wrong side nasal sinus | 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 | 12 |
| Wrong side spinal surgery | 2 |
| Wrong side thyroidectomy | 1 |
| Wrong side ureteric stent | 3 |
| Wrong side ureterorenoscopy | 1 |
| Wrong site block | 56 |

| | |
|---|---|
| Wrong site pleural aspiration | 1 |
| Wrong skin lesion biopsy | 5 |
| Wrong skin lesion removed | 11 |
| Wrong testicle | 1 |
| Wrong toe | 1 |
| Wrong tooth/teeth removed | 40 |
| Wrong vulval lesion removed | 2 |
| **Retained foreign object post procedure** | **101** |
| Angioplasty cover | 2 |
| Bladder resectoscope tip not identified as missing at the time of the procedure | 1 |
| Central line | 1 |
| Corneal guard | 1 |
| Coronary wire | 1 |
| Guide wire - anterior cruciate ligament reconstruction | 1 |
| Guide wire - central line | 13 |
| Guide wire - chest drain | 4 |
| Guide wire - gastrostomy stent | 1 |
| Guide wire - long line | 2 |
| Guide wire - percutaneous coronary intervention (PCI) | 1 |
| Guide wire - PICC line | 3 |
| Guide wire - renal dialysis line | 1 |
| Guide wire - renal vascath | 1 |
| Guide wire - superior vena cava (SVC) cannula | 1 |
| Guide wire - ureteric stent | 1 |
| Guide wire - vascath | 2 |
| 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 not identified as missing at the time of the procedure | 1 |
| Part of a Jacques catheter not identified as missing at the time of the procedure | 1 |
| Part of a periosteal elevator not identified as missing at the time of the procedure | 1 |
| Part of a surgical needle | 1 |
| Part of a uterine manipulator not identified as missing at the time of the procedure | 1 |
| Part of a vascular ablation sheath not identified as missing at the time of | 1 |

| | |
|---|---|
| the procedure | |
| Part of an angioseal device not identified as missing at the time of the procedure | 1 |
| Part of spinal surgery instrument not identified as missing at the time of the procedure | 1 |
| PEG insertion device | 1 |
| PEG trocar | 1 |
| Piece of wire - unknown origin | 1 |
| Rubber collar from uterine manipulator not identified as missing at the time of the procedure | 1 |
| Specimen retrieval bag | 1 |
| Surgical forcep | 2 |
| Surgical needle | 2 |
| Surgical swab | 20 |
| Throat pack | 1 |
| Tip of resectoscope not identified as missing at the time of the procedure | 2 |
| Vaginal swab | 18 |
| Vascath stylet | 1 |
| **Wrong implant/prosthesis** | **47** |
| Femoral nail | 1 |
| Fracture fixation plate - right instead of left | 1 |
| Hip | 10 |
| Intramedullary nail | 1 |
| Intra uterine device | 4 |
| Knee | 13 |
| Lens | 10 |
| Shoulder | 1 |
| Shoulder plate | 1 |
| Breast implant | 1 |
| Compression screws for femoral nail | 1 |
| Wrong stent | 2 |
| Wrong stent/feeding tube inserted | 1 |
| **Unintentional connection of a patient requiring oxygen to an air flowmeter** | **30** |
| Patient connected to air flowmeter rather than oxygen | 30 |
| **Misplaced naso or oro gastric tube** | **25** |
| Naso gastric tube in the respiratory tract and feed administered | 25 |
| **Administration of medication by the wrong route** | **11** |
| Enteral medication given intravenously | 1 |
| Oral medication given intravenously | 8 |
| Oral medication given subcutaneously | 2 |

| | |
|---|---|
| **Mis selection of high strength midazolam during conscious sedation** | **8** |
| Wrong strength midazolam administered | 8 |
| **Overdose of methotrexate for non-cancer treatment** | **7** |
| Methotrexate overdose prescribed and administered | 7 |
| **Overdose of insulin due to abbreviations or incorrect device** | **7** |
| Insulin withdrawn from an insulin pen | 1 |
| Wrong syringe | 6 |
| **Transfusion or transplantation of ABO incompatible blood components or organs** | **5** |
| Wrong blood transfused | 5 |
| **Falls from poorly restricted windows** | **2** |
| Window restrictor failed | 2 |
| **Mis selection of a strong potassium solution** | **2** |
| Potassium administered instead of paracetamol | 1 |
| Wrong strength potassium given | 1 |
| **Failure to install functional collapsible shower or curtain rails** | **1** |
| Curtain rail failed to collapse | 1 |
| **Total** | **472** |

Note: As described above, a further 30 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

## Table 3: Never Events 1 April 2020 and 30 September 2020 by healthcare provider*

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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** |
| Barking, Havering and Redbridge University Hospitals NHS Trust | | | | | | | | | 5 | | | | | **5** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Barnet, Enfield and Haringey Mental Health NHS Trust | | 1 | | | | | | | | | | | | **1** |
| Barnsley Hospital NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| Barts Health NHS Trust | | | | | 1 | 3 | | | 1 | | 1 | 1 | 5 | **12** |
| Basildon and Thurrock University Hospitals NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |
| Birmingham Women's and Children's NHS Foundation Trust | | | | | | 1 | | | 1 | | | | 1 | **3** |
| Blackpool Teaching Hospitals NHS Foundation Trust | | | | 1 | | | | | | | | 1 | 1 | **3** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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** |
| BPAS Merseyside, reported by NHS Halton CCG | | | | | | | | | | | | 1 | | **1** |
| Bradford District Care NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bradford Teaching Hospitals NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |
| Brighton and Sussex University Hospitals NHS Trust | | | | | | | | | 1 | | | | | **1** |
| Buckinghamshire Healthcare NHS Trust | | | | | | | | | 1 | | | | | **1** |
| Calderdale and 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| City Hospital Sunderland NHS Foundation Trust | | | 1 | | | | | | | | | 1 | | **2** |
| County Durham and Darlington NHS Foundation Trust | | | | | 1 | | | | | | 1 | 1 | 1 | **4** |
| 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dewsbury Road Dental Practice reported by NHS Leeds CCG | | | | | | | | | | | | | 1 | **1** |
| Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust | | | | | | | 1 | | | | | 1 | | **2** |
| Dorset County Hospital NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| Dorset Healthcare University NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| East and North Hertfordshire NHS Trust | | | | | | | | | 1 | | 1 | | 1 | **3** |
| East Cheshire NHS Trust | | | | | | | | | | | | | 1 | **1** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 Kent Hospitals University NHS Foundation Trust | | | | | | | | | 1 | | | 2 | 1 | **4** |
| East Lancashire Hospitals NHS Trust | | | | | | | | | 4 | | | | 1 | **5** |
| East Suffolk and North Essex NHS Foundation Trust | | | | | | | | | 1 | | 1 | | 5 | **7** |
| 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Epsom and St Helier University Hospitals NHS Trust | | | | | | | | | | | 1 | 1 | 2 | **4** |
| Frimley Health NHS Foundation Trust | | | | | | 1 | | | 1 | | | | 3 | **5** |
| 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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** |
| Homerton University Hospital NHS Foundation Trust | | | | | | | | | 1 | | | 1 | 1 | **3** |
| Hull University Teaching Hospitals NHS Trust | | | | | | 1 | | | 1 | | 1 | | 4 | **7** |
| Imperial College Healthcare NHS Trust | | | | | | 1 | | | 1 | | | | 1 | **3** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| InHealth, Mobile Endoscopy Unit, reported by NHS Manchester CCG | | | | | 1 | | | | | | | | | **1** |
| InHealth, Rochdale Mobile Unit, reported by NHS Heywood, Middleton and 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 | Falls from poorly restricted windows | 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 | | 1 | | 2 | **4** |
| Kingston Hospital NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |
| Lancashire and South Cumbria NHS Foundation Trust | | | 1 | | | | | | | | | | | **1** |
| Lancashire Teaching Hospitals NHS Trust | | | | | | | | | 1 | | | | 1 | **2** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Leeds Teaching Hospitals NHS Trust | | | | | | | 1 | | 1 | | 1 | | 1 | **4** |
| Lewisham and Greenwich NHS Trust | | | | | | | | | 3 | | | | 2 | **5** |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| Liverpool University Hospitals NHS Foundation Trust | | | | | 4 | | | 1 | | 1 | | 1 | 1 | **8** |
| Liverpool Women's NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |
| London North West University Healthcare NHS Trust | | | | | | | | | 2 | | 2 | | 2 | **6** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | 4 | **8** |
| Medway NHS Foundation Trust | | | | | | | | | 2 | | | | | **2** |
| Mid Cheshire Hospitals NHS Foundation Trust | | | | | | | | | | | | 1 | | **1** |
| Mid Essex Hospital Services NHS Trust | | | | | | 1 | | | 1 | | | | | **2** |
| 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 | Falls from poorly restricted windows | 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 | | | | | | | | | | | | | 2 | **2** |
| My Dentist, Hebburn, reported by NHS England - Cumbria and North East | | | | | | | | | | | | | 1 | **1** |
| My Dentist, Newton Abbot, reported by NHS Devon CCG | | | | | | | | | | | | | 1 | **1** |
| My Dentist, Tavistock, reported by Somerset CCG | | | | | | | | | | | | | 1 | **1** |
| Newcastle upon Tyne Hospitals NHS Foundation Trust | 1 | | | | | | | | | | | | 3 | **4** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Norfolk and Norwich University Hospitals NHS Foundation Trust | | | | | | | | | 1 | | 4 | | 1 | **6** |
| Norfolk Community Health and Care NHS Trust | | | | | | | | | | | | | 1 | **1** |
| North Bristol NHS Trust | 1 | | | | | | | | | | | | | **1** |
| North Cumbria Integrated Care NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| North Middlesex University Hospital NHS Trust | | | | | | | 1 | | 1 | | 1 | | | **3** |
| North Tees and Hartlepool NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| North West Anglia NHS Foundation Trust | | | | | | | | | | | | 2 | 1 | **3** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Northampton General Hospital NHS Trust | | | | | | | | | 2 | | | | 2 | **4** |
| Northern Lincolnshire and Goole NHS Foundation Trust | | | | | | | | | 1 | | | | 1 | **2** |
| Northumberland, Tyne and Wear NHS Foundation Trust | 1 | | | | | | | | | | | | | **1** |
| 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oxford University Hospitals NHS Foundation Trust | | | | | | 1 | | | 1 | | | | 4 | **6** |
| Park Hill Hospital, reported by NHS Doncaster CCG | | | | | | | | | | | | | 1 | **1** |
| 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** |
| Pinehill Hospital, reported by NHS East and North Hertfordshire CCG | | | | | | | | | | | | | 2 | **2** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Poole Hospital NHS Foundation Trust | | | | | | | | | 2 | | | 2 | | **4** |
| Portsmouth Hospitals NHS Trust | 2 | | | | | 1 | | | 2 | | 2 | 1 | 1 | **9** |
| 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 - Springfield Hospital, reported by NHS Mid Essex CCG | | | | | | | | | | | | 1 | 1 | **2** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rivergreen Dental Practice, Nottingham, reported by NHS England Midlands | | | | | | | | | | | | | 1 | **1** |
| 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** |
| Royal Devon and Exeter NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |
| Royal Free London NHS Foundation Trust | | | | | | 1 | | | 1 | | | 2 | 1 | **5** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 | **2** |
| Salisbury NHS Foundation Trust | | | | | | | | | 1 | | 1 | | | **2** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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** |
| 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 | | | | 2 | **3** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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** |
| Southampton Treatment Centre - Care UK, reported by NHS Southampton CCG | | | | | | | | | | | | 1 | 1 | **2** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Southend University Hospital NHS Foundation Trust | | | | | | | | | 1 | | | 1 | 2 | **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 | Falls from poorly restricted windows | 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** |
| St Helens and Knowsley Hospitals NHS Trust | | | | | | | | | 1 | | | | | **1** |
| 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Taunton and Somerset NHS Foundation Trust | | | | | | | | | | | | | 2 | **2** |
| Tesco Plymouth Pharmacy, reported by Somerset CCG | | | | | | | | 1 | | | | | | **1** |
| The Boathouse Surgery, reported by NHS Berkshire West CCG | | | | | | | | | | | | | 1 | **1** |
| The Christie NHS Foundation Trust | | | | | | | | | | 1 | | | | **1** |
| The Dudley Group NHS Foundation Trust | | | | | | | | | 3 | | | | | **3** |
| The Hillingdon Hospital NHS Foundation Trust | | | | | | | | | 1 | | | | | **1** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 McIndoe Centre, reported by NHS High Weald Lewes Havens CCG | | | | | | | | | | | | | 1 | **1** |
| The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust | 1 | | | | | | | | 1 | | 1 | | 1 | **4** |
| 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 | Falls from poorly restricted windows | 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** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 Hospital Southampton NHS Foundation Trust | | | | | | 2 | | | 1 | | | | 3 | **6** |
| University Hospitals Birmingham NHS Foundation Trust | | | | | | | | | 1 | 1 | | 2 | 4 | **8** |
| University Hospitals Bristol NHS Foundation Trust | | | | | | | | | | | | 1 | 4 | **5** |
| University Hospitals Coventry and Warwickshire NHS Trust | | | | | | 1 | | | | | | | | **1** |
| University Hospitals of Derby and Burton NHS Foundation Trust | | | | | | | | | | | 1 | | 4 | **5** |
| University Hospitals of Leicester NHS Trust | | | | | | | | | 1 | | | | 2 | **3** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 of Morecambe Bay NHS Foundation Trust | | | | | | | | | | | | 1 | | **1** |
| University Hospitals of North Midlands NHS Trust | | | | | | | | | | | | 1 | 2 | **3** |
| University Hospitals Plymouth NHS Trust | | | | | | | | | 1 | | | | 4 | **5** |
| Warrington and Halton Hospitals NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |
| West Hertfordshire Hospitals NHS Trust | | | | | | 1 | | | | | | | 2 | **3** |
| Western Sussex Hospitals NHS Foundation Trust | | | | | | | | | | | | | 1 | **1** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Weston Area Health NHS Trust | | | | | | | | | | | | | 2 | **2** |
| Whittington Health NHS Trust | | | | | | | | | | | 3 | | 2 | **5** |
| Wirral University Teaching Hospital NHS Foundation Trust | | | | | | | | | 1 | | | | 1 | **2** |
| Woodthorpe Hospital, reported by NHS Nottingham North and East CCG | | | | | | | | | | | | | 1 | **1** |
| Worcestershire Acute Hospitals NHS Trust | | | | | | | | | 1 | | | 1 | 5 | **7** |
| Wrightington, Wigan and Leigh NHS Foundation Trust | | | | | | 1 | | | 1 | | | 1 | 1 | **4** |
| Wye Valley NHS Trust | | | | | | | | | 2 | | | | 2 | **4** |

| | Administration of medication by the wrong route | Failure to install functional collapsible shower or curtain rails | Falls from poorly restricted windows | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yeovil District Hospital NHS Foundation Trust | | | | | 1 | | | | | | | | 2 | **3** |
| York Teaching Hospital NHS Foundation Trust | 1 | | | | | | | 1 | 1 | | | | 1 | **4** |
| **Total** | **11** | **1** | **2** | **2** | **8** | **25** | **7** | **7** | **101** | **5** | **30** | **47** | **226** | **472** |

Note: As described above, a further 30 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review.

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