Provisional publication of Never Events reported as occurring between 1 April and 31 July 2021

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Contents

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The Never Events policy and framework – revised January 2018 suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes. Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing existing safety advice/alerts may not be robust.

The concept of Never Events is not about apportioning blame to organisations when these incidents occur but rather to learn from what happened. This is why, following consultation, in the revised Never Events policy and framework – published January 2018 we removed the option for commissioners to impose financial sanctions when Never Events were reported. The foreword to the framework states: "……allowing commissioners to impose financial sanctions following Never Events reinforced the perception of a 'blame culture'. Our removal of financial sanctions should not be interpreted as a weakening of effort to prevent Never Events. It is about emphasising the importance of learning from their occurrence, not blaming." Identifying and addressing the reasons behind this can potentially improve safety in ways that extend far beyond the department where the Never Event occurred, or the type of procedure involved.

We are currently working to systematically review the barriers for each type of Never Event to identify if they are truly strong and systemic, starting with those that occur most frequently. As a result, we are making changes to the Never Events list during 2021/22 which means direct comparison of the number of Never Events with earlier periods is not appropriate. The definitions and designated list of Never Events were also revised from February 2018. You can find about more about these changes on the Revised Never Events policy and framework webpage.

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 fitting/using physical barriers to risks). As mentioned above, we are in the process of conducting this review, and details of any resulting changes to the Never Events list can be found on the Revised Never Events policy and framework webpage.

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; 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.

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 and 31 July 2021, and which on 12 August 2021 were designated by their reporters as Never Events.

Data on Never Events for 2020/21 and previous years can be found on the NHS England website.

Once sufficient time has elapsed after the end of the 2021/22 reporting year for local incident investigation and national analysis of data, we will produce a final whole-year report of Never Events, which will replace this provisional data.

Summary

When data for this report was extracted on 12 August 2021, 145 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April and 31 July 2021. Of these 145 incidents:

- 131 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 and 31 July 2021; this number is subject to change as local investigations are completed
- 14 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April and 31 July 2021.

More detail is provided in the tables below:

Table 1: Never Events 1 April - 31 July 2021 by month of incident*

Month in which Never Event occurred	Number
Apr	36
May	31
Jun	26
Jul	38
Total	**131**

Note: As described above, a further 14 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review accordingly.

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

Table 2: Never Events 1 April - 31 July 2021 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**56**
Biopsy from wrong breast	1
Biopsy of mediastinal mass rather than pleura	1
Biopsy of wrong lobe of lung	1
Bone marrow biopsy intended for another patient	1
Embolisation to the wrong area of the kidney	1
Flexible sigmoidoscopy intended for another patient	1
Gastroscopy intended for another patient	1
Incision to wrong area of buttock	1
Incision to wrong finger	1
Incision to wrong side of head	1
Incision to wrong toe	1
Injection to wrong eye	4
Injection to wrong finger joint	2
Injection to wrong fingers	1
Injection to wrong toe joint	1
Insertion of radioactive plaque to the wrong area of the eye	1
Nerve root block intended for another patient	1
Not described	3
Rectal drain intended for another patient	1
Release of elbow nerve rather than muscle	1
Resection of wrong eye muscle during squint surgery	1
Wrong aspect of knee	1
Wrong side angiogram	1
Wrong side angioplasty	2
Wrong side angioplasty incision	1
Wrong side burr holes	1
Wrong side spinal surgery	1
Wrong side ureteroscopy	2
Wrong site block	15
Wrong skin lesion biopsy	1
Wrong skin lesion removed	2
Wrong thyroid lobe removed	1
Wrong type of stoma - stomach rather than colon	1
Retained foreign object post procedure	**28**
Dental mouth prop	1
Guide wire - central line	2
Guide wire - chest drain	1

Guide wire - PICC line	2
Laparoscopic specimen bag	1
Part of a drill bit not identified as missing at the time of the procedure	1
Raney cranial clip	1
Scalpel blade	1
Screw from spinal instrumentation not identified as missing at the time of the procedure	1
Small piece of metal from knee instrumentation not identified at the time of the procedure	1
Surgical swab	8
Vaginal swab	8
Wrong implant/prosthesis	**24**
Hip	6
Intra uterine contraceptive device	1
Knee	8
Lens	4
Mandibular plate	1
Vascular access device	2
Wrong side radial plate	1
Wrong type of ureteric stent	1
Misplaced naso or oro gastric tubes and feed administered	**11**
Apparently misleading pH test result	1
Placement checks not described or not clearly described	7
X-ray misinterpretation; no indication 'four criteria' used	3
Unintentional connection of a patient requiring oxygen to an air flowmeter	**5**
Patient connected to air instead of oxygen	5
Overdose of insulin due to abbreviations or incorrect device	**2**
Insulin withdrawn from an insulin pen	1
Wrong syringe	1
Falls from poorly restricted windows	**2**
Patient fell from first floor window	1
Window restrictor failed	1
Administration of medication by the wrong route	**2**
Oral medication given intravenously	2
Transfusion or transplantation of ABO-incompatible blood components or organs	**1**
Wrong blood transfused	1
Total	**131**

Note: As described above, a further 14 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review accordingly.

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

Table 3: Never Events 1 April - 31 July 2021 by healthcare provider*

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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
Birmingham Women's and Children's Hospital NHS Foundation Trust					1					**1**
Blackpool Teaching Hospitals NHS Foundation Trust			1		1					**2**
BMI Hospitals/Circle Health reported by NHS Herts Valleys CCG'								1		**1**
Bradford Teaching Hospitals NHS Foundation Trust						1				**1**
Brighton and Sussex University Hospitals NHS Trust			1							**1**
Cambridge University Hospitals NHS Foundation Trust									1	**1**
Chelsea and Westminster Hospital NHS Foundation Trust								1		**1**
Circle Hospital Reading, reported by NHS Berkshire West CCG								1	1	**2**
Countess of Chester Hospital NHS Foundation Trust								1		**1**
County Durham and Darlington NHS Foundation Trust									1	**1**
Croydon Health Services NHS Trust					1				1	**2**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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
Dartford and Gravesham NHS Trust	1									**1**
Dorset County Hospital NHS Foundation Trust					1					**1**
East and North Hertfordshire NHS Trust									1	**1**
East Kent Hospitals University NHS Foundation Trust					1					**1**
East Lancashire Hospitals NHS Trust								1	1	**2**
East Suffolk and North Essex NHS Foundation Trust			1		1				3	**5**
Frimley Health NHS Foundation Trust					1					**1**
Gloucestershire Hospitals NHS Foundation Trust								1	1	**2**
Guy's and St Thomas' NHS Foundation Trust								1	1	**2**
Harrogate and District NHS Foundation Trust									1	**1**
Homerton University Hospital NHS Foundation Trust									1	**1**
Hull University Teaching Hospitals NHS Trust								1	1	**2**
Humber Teaching NHS Foundation Trust				1						**1**
Kettering General Hospital NHS Foundation Trust									1	**1**
King's College Hospital NHS Foundation Trust					1					**1**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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
Kingston Hospital NHS Foundation Trust							1		1	**2**
Lancashire Teaching Hospitals NHS Foundation Trust								1	1	**2**
Leeds Teaching Hospitals NHS Trust	1				1				3	**5**
Liverpool Heart and Chest NHS Foundation Trust, reported by NHS Liverpool CCG							1			**1**
Liverpool University Hospitals NHS Foundation Trust					2				1	**3**
London North West Healthcare NHS Trust					2					**2**
Maidstone and Tunbridge Wells NHS Trust			1		1				1	**3**
Manchester University NHS Foundation Trust		1			1			1	2	**5**
Mid Cheshire Hospitals NHS Foundation Trust								1		**1**
Mid Essex Hospital Services NHS Trust									1	**1**
Mid Yorkshire Hospitals NHS Trust								1		**1**
Moorfields Eye Hospital NHS Foundation Trust									1	**1**
Newcastle Upon Tyne Hospitals NHS Foundation Trust									1	**1**
North Bristol NHS Trust									1	**1**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Retained foreign object post procedure	Transfusion or transplantation of ABO-incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/ prosthesis	Wrong site surgery	Total
North Middlesex University Hospital NHS Trust								1		**1**
North West Anglia NHS Foundation Trust					1				1	**2**
Northampton General Hospital NHS Trust								1		**1**
Northern Lincolnshire and Goole NHS Foundation Trust					1			2	2	**5**
Oxford University Hospitals NHS Foundation Trust					1					**1**
Pennine Acute Hospitals NHS Trust									1	**1**
Portsmouth Hospitals University NHS Trust			1						3	**4**
Ramsay Health Care UK, Clifton Park Hospital, reported by NHS Vale of York CCG								1		**1**
Ramsay Health Care UK, The Cherwell Hospital, reported by NHS Oxfordshire CCG								1		**1**
Royal Cornwall Hospitals NHS Trust				1						**1**
Royal Devon and Exeter NHS Foundation Trust			1						1	**2**
Royal Free London NHS Foundation Trust					1					**1**
Royal Orthopaedic Hospital NHS Foundation Trust					1					**1**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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 Papworth Hospital NHS Foundation Trust			1							**1**
Royal Surrey County Hospital NHS Foundation Trust			1							**1**
Royal United Hospitals Bath NHS Foundation Trust								1		**1**
Sandwell and West Birmingham Hospitals NHS Trust							1		1	**2**
Sheffield Teaching Hospitals NHS Foundation Trust					1				1	**2**
Sherwood Forest Hospitals NHS Foundation Trust									2	**2**
Solent NHS Trust					1					**1**
South Tees Hospitals NHS Foundation Trust					1					**1**
South Tyneside and Sunderland NHS Foundation Trust								1		**1**
Spire Montefiore Hospital reported by NHS Brighton and Hove CCG								1		**1**
St George's University Hospitals NHS Foundation Trust					1					**1**
St Helens and Knowsley Teaching Hospitals NHS Trust							1			**1**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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 Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust									2	**2**
United Lincolnshire Hospitals NHS Trust			1							**1**
University College London Hospitals NHS Foundation Trust			1							**1**
University Hospital Southampton NHS Foundation Trust									2	**2**
University Hospitals Birmingham NHS Foundation Trust								1		**1**
University Hospitals Bristol NHS Foundation Trust							1		1	**2**
University Hospitals Coventry and Warwickshire NHS Trust								1	1	**2**
University Hospitals of Derby and Burton NHS Foundation Trust									2	**2**
University Hospitals of Leicester NHS Trust					1				2	**3**
University Hospitals of Morecambe Bay NHS Foundation Trust								1		**1**
University Hospitals Plymouth NHS Trust									1	**1**

	Administration of medication by the wrong route	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	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 Sussex NHS Foundation Trust									1	**1**
West Suffolk NHS Foundation Trust		1			1					**2**
Wirral University Teaching Hospital NHS Foundation Trust									1	**1**
Worcestershire Acute Hospitals NHS Trust			1		1				2	**4**
Yeovil District Hospital NHS Foundation Trust					1				1	**2**
Total	**2**	**2**	**11**	**2**	**28**	**1**	**5**	**24**	**56**	**131**

Note: As described above, a further 14 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review.
*Numbers are subject to change as local investigations are completed.

Table 4: Never Events reported as occurring after 1 April 2021 but actually occurring prior to this

. None reported.

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

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