

Provisional publication of Never Events reported as occurring between 1 April 2021 and 31 January 2022

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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.

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 *Anti-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 2021 and 31 January 2022, and which on 11 January 2022 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 11 January 2022, 342 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2021 and 31 January 2022. Of these 377 incidents:

- 349 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 2021 and 31 January 2022; this number is subject to change as local investigations are completed
- 28 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April 2021 and 31 January 2022.

More detail is provided in the tables below:

Table 1: Never Events 1 April 2021 – 31 January 2022 by month of incident*

Month in which Never Event occurred	Number
Apr	36
May	33
Jun	29
Jul	46
Aug	28
Sep	33
Oct	48
Nov	38
Dec	28
Jan	30
Total	349

Note: As described above, a further 28 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

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

Table 2: Never Events 1 April 2021 - 31 January 2022 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	146
Angiogram intended for another patient	1
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
Cervical biopsies taken instead of colon	1
Colposcopy intended for another patient	1
Embolisation to the wrong area of the kidney	1
Excision of skin tags rather than removal of cyst	1
Excision of vaginal tissue instead of anal tissue	1
Eye injection that was not required	1
Flexible sigmoidoscopy intended for another patient	1
Gastric dilatation intended for another patient	1
Gastroscopy intended for another patient	2
Haemorrhoids removed rather than repair of anal fistula	1
Incision to wrong area of buttock	1
Incision to wrong area of nose	1
Incision to wrong aspect of ankle	1
Incision to wrong finger	3
Incision to wrong part of leg	1
Incision to wrong side of head	1
Incision to wrong toe	1
Injection to foot rather than ankle	1
Injection to wrist rather than thumb	1
Injection to wrong area of hip	1
Injection to wrong breast	2
Injection to wrong eye	6
Injection to wrong finger joint	2
Injection to wrong finger/s	4
Injection to wrong shoulder	1
Injection to wrong toe joint	1
Injections to lumbar spine rather than neck	1
Insertion of radioactive plaque to the wrong area of the eye	1
Knee aspiration intended for another patient	1
Lumbar puncture rather than fluid drainage from lung	1
Nerve root block intended for another patient	1

Not described	3
Position of laser eye surgery not the intended procedure	1
Procedure not required	1
Rectal drain intended for another patient	1
Release of elbow nerve rather than muscle	1
Resection of wrong eye muscle during squint surgery	1
Toe procedure intended for another patient	1
Wound debridement intended for another patient	1
Wrong aspect of knee	1
Wrong aspect of knee biopsied	1
Wrong eye	1
Wrong finger	1
Wrong hand	1
Wrong labial cyst removed	1
Wrong lung decompressed	1
Wrong lymph node excision	1
Wrong side angiogram	2
Wrong side angiogram incision	1
Wrong side angioplasty	2
Wrong side angioplasty incision	1
Wrong side burr holes	1
Wrong side chest drain	2
Wrong side hernia incision	1
Wrong side pacemaker placement	1
Wrong side spinal injection	3
Wrong side spinal surgery	1
Wrong side stent removed	1
Wrong side ureteric stent	1
Wrong side ureteroscopy	2
Wrong site block	39
Wrong site botulinum injection	1
Wrong skin lesion biopsy	3
Wrong skin lesion removed	14
Wrong thyroid lobe removed	1
Wrong type of stoma - stomach rather than colon	2
Retained foreign object post procedure	85
Bolt from surgical forceps	1
Catheter used as part of a surgical procedure	1
Dental mouth prop	1
Dilatation balloon sheath	1
Guide wire - central line	4
Guide wire - chest drain	2

Guide wire - femoral line	1
Guide wire - PICC line	2
Guide wire - vascath	3
K wire	1
Laparoscopic specimen bag	2
Ophthalmic port	1
Ophthalmic trocar	1
Part of a drill bit not identified as missing at the time of the procedure	3
Part of a guide wire - PICC line	1
Part of a k wire	1
Part of a pair of wire cutters	1
Part of a suture anchor introducer	1
Part of an intra uterine contraceptive device introducer	1
Part of uterine manipulator	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	18
Throat pack	1
Trial shoulder prosthesis	1
Vaginal swab	30
Valve from breast prosthesis	1
Wrong implant/prosthesis	42
Aortic valve	1
Breast implant	1
Hip	11
Intra uterine contraceptive device	1
Knee	11
Lens	9
Mandibular plate	1
Shoulder	1
Vascular access device	2
Wrong side radial plate	1
Wrong side wrist plate	2
Wrong type of ureteric stent	1
Misplaced naso or oro gastric tubes and feed administered	27
Apparently misleading pH test result	3
Placement checks not described or not clearly described	11
X-ray misinterpretation; no indication 'four criteria' used	13

Administration of medication by the wrong route	17
Oral medication given intravenously	15
Oral medication given subcutaneously	2
Unintentional connection of a patient requiring oxygen to an air flowmeter	12
Patient connected to air instead of oxygen	12
Overdose of insulin due to abbreviations or incorrect device	8
Insulin withdrawn from an insulin pen	1
Wrong syringe	7
Transfusion or transplantation of ABO incompatible blood components or organs	6
Wrong blood transfused	6
Falls from poorly restricted windows	3
Window restrictor failed	3
Mis selection of high strength midazolam during conscious sedation	1
Wrong strength midazolam selected and administered	1
Overdose of methotrexate for non-cancer treatment	1
Methotrexate overdose prescribed and administered	1
Mis selection of a strong potassium solution	1
Potassium selected inadvertently	1
Total	349

Note: As described above, a further 28 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

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

Table 3: Never Events 1 April 2021 - 31 January 2022 by healthcare provider*

	Administration of medication by the wrong route	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 tubes and feed administered	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
Ashford and St Peter's Hospitals NHS Foundation Trust											1		1
Barking, Havering and Redbridge University Hospitals NHS Trust								1				1	2
Barts Health NHS Trust					1			1					2
Basildon and Thurrock University Hospitals NHS Foundation Trust												1	1
Birmingham Women's and Children's Hospital NHS Foundation Trust						1		1				1	3
Blackpool Teaching Hospitals NHS Foundation Trust					1			1				3	5
BMI Hospitals/Circle Health reported by NHS Herts Valleys CCG											1		1

	Administration of medication by the wrong route	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 tubes and feed administered	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 Ridgeway Hospital, reported by NHS Bath and Northeast Somerset, Swindon and Wiltshire CCG								1				1	2
BMI The Huddersfield Hospital, reported by NHS Greater Huddersfield CCG												1	1
BMI The Meriden Hospital, reported by NHS Coventry and Rugby CCG												1	1
Bolton NHS Foundation Trust												1	1
Bradford Teaching Hospitals NHS Foundation Trust									1			1	2
Brighton and Sussex University Hospitals NHS Trust					1						1		2
Buckinghamshire Healthcare NHS Trust								1		1	1		3

	Administration of medication by the wrong route	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 tubes and feed administered	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
Cambridge University Hospitals NHS Foundation Trust											1	1	2
Chelsea and Westminster Hospital NHS Foundation Trust											1	1	2
Circle Hospital Reading, reported by NHS Berkshire West CCG											1	1	2
Countess Of Chester Hospital NHS Foundation Trust								1			1	1	3
County Durham and Darlington NHS Foundation Trust								1				1	2
Croydon Health Services NHS Trust								1				1	2
Dartford and Gravesham NHS Trust	1											1	2
Derbyshire Community Health Services NHS Foundation Trust								1					1

	Administration of medication by the wrong route	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 tubes and feed administered	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
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust								1					1
Dorset County Hospital NHS Foundation Trust						1							1
East and North Hertfordshire NHS Trust												3	3
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				5	7
East Sussex Healthcare NHS Trust				1				1					2
Epsom and St Helier NHS Trust					1								1
Epsomedical, Epsom General Hospital, reported by NHS Surrey Heartlands CCG								1			1		2

	Administration of medication by the wrong route	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 tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
Frimley Health NHS Foundation Trust								1				1	2
Gloucestershire Hospitals NHS Foundation Trust	1				1			1			2	3	8
Great Ormond Street Hospital for Children NHS Foundation Trust												1	1
Great Western Hospitals NHS Foundation Trust								2				1	3
Guy's and St Thomas' NHS Foundation Trust	1							1			1	4	7
Hampshire Hospitals NHS Foundation Trust							1	1					2
Harrogate and District NHS Foundation Trust								1				1	2

	Administration of medication by the wrong route	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 tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Overdose of methotrexate for non-cancer treatment	Retained foreign object post procedure	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
Homerton University Hospital NHS Foundation Trust											1		1
Hull University Teaching Hospitals NHS Trust	1							1			1	2	5
Humber Teaching NHS Foundation Trust						1							1
Imperial College Healthcare NHS Trust								1	2			1	4
Kettering General Hospital NHS Foundation Trust	2											1	3
KIMS Hospital, Kent, reported by NHS Kent and Medway CCG											1		1
King's College Hospital NHS Foundation Trust								1				2	3
Kingston Hospital NHS Foundation Trust								1		1		1	3

	Administration of medication by the wrong route	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 tubes and feed administered	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
Lancashire Teaching Hospitals NHS Foundation Trust											1	2	3
Leeds Teaching Hospitals NHS Trust	1					1		1				4	7
Leicester, Leicestershire and Rutland PCL (Patient Care Locally) Alliance, Heatherbrook Surgery reported by NHS East Leicestershire and Rutland CCG												1	1
Lewisham and Greenwich NHS Trust								1				3	4
Liverpool Heart and Chest NHS Foundation Trust, reported by NHS Liverpool CCG										1			1
Liverpool University Hospitals NHS Foundation Trust					3			3				1	7
Liverpool Women's NHS Foundation Trust								1					1

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London Northwest Healthcare NHS Trust	1							3					4
Maidstone and Tunbridge Wells NHS Trust					1			2				1	4
Manchester University NHS Foundation Trust		1			2			3			1	3	10
Mid Cheshire Hospitals NHS Foundation Trust										1		2	3
Mid Essex Hospital Services NHS Trust						1						1	2
Mid Yorkshire Hospitals NHS Trust								2		1			3
Milton Keynes University Hospital NHS Foundation Trust												2	2
Moorfields Eye Hospital NHS Foundation Trust												1	1

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Newcastle Upon Tyne Hospitals NHS Foundation Trust												2	2
North Bristol NHS Trust	1											1	2
North Cumbria Integrated Care NHS Foundation Trust											1		1
North Middlesex Hospital NHS Trust								1	1	1	1		4
North Tees and Hartlepool NHS Foundation Trust												2	2
Northwest Anglia NHS Foundation Trust		1						2				1	4
Northampton General Hospital NHS Trust											1		1
Northern Care Alliance NHS Foundation Trust	1												1
Northern Devon Healthcare NHS Trust												1	1

	Administration of medication by the wrong route	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 tubes and feed administered	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
Northern Lincolnshire and Goole NHS Foundation Trust								2				2	4
Northumbria Healthcare NHS Foundation Trust											2	2	4
Nottingham University Hospitals NHS Trust	1							3				1	5
Oxford University Hospitals NHS Foundation Trust								2		2			4
Pennine Acute Hospitals NHS Trust												2	2
Pioneer Healthcare, Kinvara Private Hospital, Rotherham, reported by NHS Kirklees CCG								1					1
Portsmouth Hospitals University NHS Trust					2							3	5

	Administration of medication by the wrong route	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 tubes and feed administered	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
Practice Plus Group, Shepton Mallet Community Hospital, reported by NHS Somerset CCG												1	1
Ramsay Health Care UK, Cherwell Hospital, reported by NHS Oxfordshire CCG										1			1
Ramsay Health Care UK, Clifton Hospital, reported by NHS Vale of York CCG										1			1
Royal Berkshire NHS Foundation Trust					1			2				1	4
Royal Cornwall Hospitals NHS Trust						1							1
Royal Devon and Exeter NHS Foundation Trust					1				1			3	5
Royal Free London NHS Foundation Trust								1					1

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Royal Orthopaedic Hospital NHS Foundation Trust								1			1		2
Royal Papworth Hospital NHS Foundation Trust					1								1
Royal Surrey County Hospital NHS Foundation Trust					1								1
Royal United Hospital Bath NHS Trust											1		1
Salisbury NHS Foundation Trust	1				1							1	3
Sandwell and West Birmingham Hospitals NHS Trust	2				1					3		3	9
Sheffield Teaching Hospitals NHS Foundation Trust								1				2	3
Sherwood Forest Hospitals NHS Foundation Trust								1				4	5

	Administration of medication by the wrong route	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 tubes and feed administered	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
Solent NHS Trust								1				1	2
South Tees Hospitals NHS Foundation Trust								2				1	3
South Tyneside and Sunderland NHS Foundation Trust										1	2		3
South Warwickshire NHS Foundation Trust								1			1		2
SpaMedica, Manchester, reported by NHS Manchester CCG										1			1
Spire Liverpool Hospital, reported by NHS Liverpool CCG								1				1	2
Spire Montefiore Hospital, reported by NHS Brighton and Hove CCG										1			1

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St George's University Hospitals NHS Foundation Trust						1		1				1	3
St Helens and Knowsley Teaching Hospitals NHS Trust										1			1
St Stephens Gate Medical Practice, reported by NHS Arden and GEM CSU											1		1
Stockport NHS Foundation Trust												1	1
Tameside and Glossop Integrated Care NHS Foundation Trust											1		1
The Berkshire Independent Hospital, reported by NHS Berkshire West CCG												1	1
The Hillingdon Hospital NHS Foundation Trust												1	1

	Administration of medication by the wrong route	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 tubes and feed administered	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 Princess Alexandra Hospital NHS Trust	1							1					2
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust											1	2	3
The Rotherham NHS Foundation Trust								1	1				2
The Royal National Orthopaedic Hospital NHS Trust								1					1
The Shrewsbury and Telford Hospital NHS Trust												1	1
The Walton Centre NHS Foundation Trust	1											1	2
United Lincolnshire Hospitals NHS Trust	1				1								2

	Administration of medication by the wrong route	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 tubes and feed administered	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 College London Hospitals NHS Foundation Trust					2							1	3
University Hospital Southampton NHS Foundation Trust			1					1			1	3	6
University Hospitals Birmingham NHS Foundation Trust						1					1		2
University Hospitals Bristol NHS Foundation Trust									1	1	1	1	3
University Hospitals Coventry and Warwickshire NHS Trust					1			1			2	1	5
University Hospitals of Derby and Burton NHS Foundation Trust												6	6
University Hospitals of Leicester NHS Trust								3				4	7

	Administration of medication by the wrong route	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 tubes and feed administered	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	2
University Hospitals of North Midlands NHS Trust								2				1	3
University Hospitals Plymouth NHS Trust								1				2	3
University Hospitals Sussex NHS Foundation Trust												1	1
Walsall Healthcare NHS Trust								1				2	3
West Hertfordshire Teaching Hospitals NHS Trust												1	1
West Suffolk NHS Foundation Trust		1						1					2
Whittington Health NHS Trust								1		1			2
Wirral University Teaching Hospital NHS Foundation Trust					1			1				2	4

	Administration of medication by the wrong route	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 tubes and feed administered	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
Worcestershire Acute Hospitals NHS Trust					1			2			1	5	9
Wrightington, Wigan and Leigh NHS Foundation Trust								1				1	2
Wye Valley NHS Trust					1								1
Yeovil District Hospital NHS Foundation Trust								1				1	2
York and Scarborough Teaching Hospitals NHS Foundation Trust								1				1	2
Total	17	3	1	1	27	8	1	85	6	12	42	146	349

Note: As described above, a further 28 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have 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.

**NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH**

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