Provisional publication of Never Events reported as occurring between 1 April and 30 September 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 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 28 February 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 30 September 2022, and which on 1 November 2022 were designated by their reporters as Never Events.

Data on Never Events for 2021/22 and previous years can be found on the NHS England website.

Once sufficient time has elapsed after the end of the 2022/23 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 1 November 2022, 209 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April and 30 September 2022. Of these 209 incidents:

- 199 Serious Incidents appeared to meet the definition of a Never Event in the Never Events list 2018 (published 28 February 2018) and had an incident date between 1 April and 30 September 2022; this number is subject to change as local investigations are completed
- 10 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April and 30 September 2022.

More detail is provided in the tables on the following pages.

Table 1: Never Events 01 April 2022 – 30 September 2022 by month of incident*

Month in which Never Event occurred	Number
April	37
May	43
June	27
July	33
August	34
September	25
Total	**199**

Note: As described above, a further 10 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 01 April 2022 – 30 September 2022 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**89**
Bilateral eye injections instead of one side	1
Biopsy of the cervix instead of rectal biopsy/colonoscopy	2
Both tonsils removed when surgical plan was to remove one tonsil	1
Botulinum injection to wrong site	3
Gastroscopy instead of colonoscopy	1
Gastroscopy intended for another patient	1
Incision to hand rather than forearm	1
Incision to wrist rather than finger	1
Incision to wrong side of groin	1
Injection to wrong breast	1
Injection to wrong eye	3
Injection to wrong finger	2
Injection to wrong hip	1
Knee injection intended for another patient	2
Laser treatment to wrong eye	1
Lesion removed from wrong breast	1
Lumbar puncture intended for another patient	2
Midline insertion intended for another patient	1
Not described	1
Perineal biopsy intended for another patient	1
Procedure intended for another patient	1
Procedure not required	1
Procedure not required as already carried out	1
Removal of both ovaries when surgical plan was to remove one of them	1
Removal of ovaries when surgical plan was to conserve them	1
Skin biopsy intended for another patient	1
Wrong area of breast	1
Wrong eye procedure	1
Wrong side angiogram	2
Wrong side epididymectomy	1
Wrong side intrapleural catheter	1
Wrong side lung aspiration	1
Wrong side removal of submandibular duct stone	1
Wrong side spinal injection	3
Wrong side ureteric stent insertion	2
Wrong site block	23

Wrong skin lesion biopsy	3
Wrong skin lesion removed	15
Wrong toe joint	1
Retained foreign object post procedure	**49**
Breast prosthesis sizer	1
Dental block	1
Guide wire - abdominal drain	1
Guide wire - central line	8
Guide wire - chest drain	3
Laparoscopic specimen bag	1
Part of a drill bit not identified as missing at the time of the procedure	1
Part of a guidewire not identified as missing at the time of the procedure	1
Part of instrumentation not identified as missing at the time of the procedure	1
Part of knee instrument not identified as missing at the time of the procedure	1
Part of a percutaneous lead	1
Sponge retractor	1
Surgical swab	10
Suture anchor tips not identified as missing at the time of the procedure	1
Temporal port	1
Unknown	1
Vaginal swab	15
Wrong implant/prosthesis	**22**
Aortic graft	1
Hip	5
Intrauterine contraceptive device	3
Intrauterine contraceptive device intended for another patient	1
Knee	4
Lens	5
Wrong gastrojejunal tube	1
Wrong sacral nerve stimulation device	1
Wrong side plate	1
Misplaced naso or oro gastric tubes and feed administered	**14**
Apparently misleading pH test result	3
Placement checks not described or not clearly described	4
X-ray misinterpretation; no indication 'four criteria' used	7
Administration of medication by the wrong route	**9**
Nebuliser medication given intravenously	1
Oral medication given intravenously	5
Oral medication given subcutaneously	3
Transfusion or transplantation of ABO incompatible blood components or organs	**5**

Unintentional ABO mismatched solid organ transplant	1
Wrong blood transfused	4
Unintentional connection of a patient requiring oxygen to an air flowmeter	**4**
Patient connected to air instead of oxygen	4
Overdose of insulin due to abbreviations or incorrect device	**4**
Wrong syringe	4
Falls from poorly restricted windows	**1**
Window restrictor failed	1
Mis selection of a strong potassium solution	**1**
Potassium administered instead of fentanyl	1
Overdose of methotrexate for non-cancer treatment	**1**
Weekly dose administered too early	1
Total	**199**

Note: As described above, a further 10 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 2022 – 30 September 2022 by healthcare provider*

Organisation Name	Total
Airedale NHS Foundation Trust	1
Alder Hey Children's NHS Foundation Trust	1
Ashford and St. Peters Hospitals NHS Foundation Trust	3
Barking, Havering and Redbridge University Hospitals NHS Trust	3
Basildon and Thurrock University Hospitals NHS Foundation Trust	1
Bedfordshire Hospitals NHS Trust	1
Birmingham Community Healthcare NHS Foundation Trust	1
Birmingham Women's and Children's Hospital NHS Foundation Trust	4
Bolton NHS Foundation Trust	1
BPAS Birmingham South Clinic, reported by NHS Birmingham and Solihull CCG	1
Bridgewater Community Healthcare NHS Foundation Trust - Warrington, reported by NHS Warrington CCG	1
Brighton and Sussex University Hospitals NHS Trust	1
Buckinghamshire Healthcare NHS Trust	1

Calderdale and Huddersfield NHS Foundation Trust	1
Cambridge University Hospitals NHS Foundation Trust	2
Chelsea and Westminster Healthcare NHS Foundation Trust	1
Circle Health Group, The Winterbourne Hospital, reported by NHS Dorset CCG	1
Countess of Chester Hospital NHS Foundation Trust	2
Dartford and Gravesham NHS Trust	1
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	1
East Kent Hospitals University NHS Foundation Trust	4
East Lancashire Hospitals NHS Trust	1
East Suffolk and North Essex NHS Foundation Trust	3
East Sussex Healthcare NHS Trust	1
Epsom and St Helier University Hospitals NHS Trust	1
Frimley Health NHS Foundation Trust	4
George Eliot Hospital NHS Trust	2
Gloucestershire Hospitals NHS Foundation Trust	1
Great Ormond Street Hospital for Children NHS Foundation Trust	1
Guy's and St Thomas' NHS Foundation Trust	2

Hampshire Hospitals NHS Foundation Trust	1
Harrogate and District NHS Foundation Trust	2
HMT St Hugh's Private Hospital, reported by NHS North East Lincolnshire CCG	1
Homerton Healthcare NHS Foundation Trust	3
Hull University Teaching Hospitals NHS Trust	5
Imperial College Healthcare NHS Trust	2
Independent Health Group, Millstream Medical Centre, Salisbury, reported by NHS Banes, Swindon and Wiltshire CCG	1
James Paget University Hospitals NHS Foundation Trust	1
King's College Hospital NHS Foundation Trust	1
Kingston Hospital NHS Foundation Trust	1
Lewisham and Greenwich NHS Trust	2
Liverpool University Hospitals NHS Foundation Trust	1
Maidstone and Tunbridge Wells NHS Trust	1
Manchester University NHS Foundation Trust	6
Medway NHS Foundation Trust	3
Mid Essex Hospital Services NHS Trust	1

Milton Keynes University Hospital NHS Foundation Trust	1
Moorfields Eye Hospital NHS Foundation Trust	1
Norfolk And Norwich University Hospitals NHS Foundation Trust	2
North Bristol NHS Trust	1
North Middlesex Hospital NHS Trust	3
North Tees and Hartlepool NHS Foundation Trust	2
North West Anglia NHS Foundation Trust	3
Northern Care Alliance NHS Foundation Trust	2
Northern Devon Healthcare NHS Trust	4
Northumbria Healthcare NHS Foundation Trust	1
Nottingham University Hospitals NHS Trust	2
Oxford University Hospitals NHS Foundation Trust	1
Poole Hospital NHS Foundation Trust	3
Portsmouth Hospitals University National Health Service Trust	1
Practice Plus Group, Southampton, reported by NHS Southampton CCG	1
Queen Victoria Hospital NHS Foundation Trust	1
Ramsey Healthcare UK, Euxton Hall Hospital, reported by NHS Greater Preston CCG	1

Royal Berkshire NHS Foundation Trust	2
Royal Cornwall Hospitals NHS Trust	1
Royal Devon University Healthcare NHS Foundation Trust	3
Royal Free London NHS Foundation Trust	6
Royal Surrey County Hospital NHS Foundation Trust	1
Royal United Hospital Bath NHS Trust	1
Royal United Hospitals Bath NHS Foundation Trust	1
Sandwell and West Birmingham Hospitals NHS Trust	3
Sheffield Teaching Hospitals NHS Foundation Trust	4
Sherwood Forest Hospitals NHS Foundation Trust	1
Somerset NHS Foundation Trust	2
South Tees Hospitals NHS Foundation Trust	5
South Tyneside and Sunderland NHS Foundation Trust	2
South Warwickshire NHS Foundation Trust	1
Southport and Ormskirk Hospital NHS Trust	2
SpaMedica Watford, reported by NHS Hertfordshire and West Essex ICB	1
Spire Claremont Hospital, reported by NHS Halton CCG	1

Spire Hospital, Nottingham, reported by NHS Nottingham and Nottinghamshire CCG	1
St George's University Hospitals NHS Foundation Trust	1
St Helens and Knowsley Hospitals NHS Trust	1
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	3
The Princess Alexandra Hospital NHS Trust	2
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2
The Royal Marsden Hospital NHS Foundation Trust	2
The Shrewsbury and Telford Hospital NHS Trust	1
The Westbourne Centre, reported by NHS Birmingham and Solihull CCG	1
Torbay And South Devon NHS Foundation Trust	1
United Lincolnshire Hospitals NHS Trust	3
University College London Hospitals NHS Foundation Trust	2
University Hospitals Birmingham NHS Foundation Trust	4
University Hospitals Bristol and Weston NHS Foundation Trust	2
University Hospitals Coventry and Warwickshire NHS Trust	1
University Hospitals of Derby and Burton NHS Foundation Trust	2
University Hospitals of Leicester NHS Trust	5

University Hospitals of North Midlands NHS Trust	2
University Hospitals Plymouth NHS Trust	2
Walsall Healthcare NHS Trust	1
Warrington and Halton Teaching Hospitals NHS Foundation Trust	1
West Hertfordshire Teaching Hospitals NHS Trust	1
Wirral University Teaching Hospital NHS Foundation Trust	1
Worcestershire Acute Hospitals NHS Trust	3
Wrightington, Wigan and Leigh NHS Foundation Trust	2
Wye Valley NHS Trust	1
Yeovil District Hospital NHS Foundation Trust	1
York and Scarborough Teaching Hospitals NHS Foundation Trust	2
Total	199

Note: As described above, a further 10 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 2022 but actually occurring prior to this

. None reported.

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

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