Provisional publication of Never Events reported as occurring between 1 April and 31 July 2023

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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, the first set of National Safety Standards for Invasive Procedures (NatSSIPs) were published by NHS England 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 Centre for Perioperative Care published revised National Safety Standards for Invasive Procedures (NatSSIPs 2) in January 2023.

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 June 2023, and which on the 27 July 2023 were designated by their reporters as Never Events.

Data on Never Events for 2022/23 and previous years can be found on the NHS England website. Once sufficient time has elapsed after the end of the 2023/24 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 27 July 2023, 120 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 2023. Of these 120 incidents:

- 111 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 31 July 2023; this number is subject to change as local investigations are completed
- 9 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April and 31 July 2023.

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

Table 1: Never Events 01 April – 31 July 2023 by month of incident*

Month in which Never Event occurred	Number
April	31
May	27
June	29
July	24
Total	**111**

Note: As described above, a further 9 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 – 31 July 2023 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**58**
Biopsy of cervix instead of colon	1
Biopsy of liver rather than abdominal mass	1
Bronchoscopy intended for another patient	1
Colonoscopy intended for another patient	1
Fixation of wrong foot joint	1
Iliac block intended for another patient	1
Incision to wrong side inguinal hernia repair	1
Incision to wrong side of abdomen	1
Injection to wrist rather than ring finger	1
Injection to wrong ankle joint	1
Injection to wrong breast	1
Injection to wrong eye	5
Injection to wrong joint	1
Intrauterine contraceptive device (IUCD) insertion that was not planned as part of the surgical procedure	1
Laser treatment to wrong eye	1
Removal of ovary when surgical plan was to conserve it	1
Wrong side abdominal incision	1
Wrong side chest aspiration	1
Wrong side chest drain	1
Wrong side spinal injection	6
Wrong side spinal surgery	1
Wrong side ureteric stent insertion	1
Wrong site block	13
Wrong site chest drain	1
Wrong skin lesion biopsy	2
Wrong skin lesion removed	11
Retained foreign object post procedure	**21**
Guide wire - central line	2
Guide wire - chest drain	1
Guide wire - gastrostomy	1
Guide wire - midline	1
Guide wire - naso gastric tube	1
Surgical instrument - vein tester	1
Surgical swab	6
Throat pack	1

Type and brief description of Never Event	Number
Vaginal swab	7
Wrong implant/prosthesis	**13**
Hip	5
Incorrect screw cap for femoral nail	1
Knee	5
Lens	1
Wrong type of stent	1
Misplaced naso or oro gastric tubes	**6**
Apparently misleading pH test result	2
Placement checks not described or not clearly described	2
X-ray misinterpretation; no indication 'four criteria' used	2
Administration of medication by the wrong route	**5**
Oral medication given intravenously	5
Unintentional connection of a patient requiring oxygen to an air flowmeter	**2**
Patient connected to air rather than oxygen	2
Transfusion or transplantation of ABO-incompatible blood components or organs	**3**
Kidney with wrong blood type transplanted	1
Wrong blood transfused	2
Failure to install functional collapsible shower or curtain rails	**1**
Curtain rail failed to collapse	1
Overdose of insulin due to abbreviations or incorrect device	**1**
Wrong syringe	1
Scalding of patients	**1**
Bowl of water for washing at the bedside from kettle	1
Total	111

Note: As described above, a further 9 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 – 31 July 2023 by healthcare provider*

Organisation Name	Total
Ashford and St Peter's Hospitals NHS Foundation Trust	1
Barking, Havering and Redbridge University Hospitals NHS Trust	1
Barts Health NHS Trust	3
Basildon and Thurrock University Hospitals NHS Foundation Trust	1
Brighton and Sussex University Hospitals NHS Trust	2
Buckinghamshire Healthcare NHS Trust	2
Calderdale and Huddersfield NHS Foundation Trust	3
Chelsea and Westminster Hospital NHS Foundation Trust	3
Circle Health Group - Harbour Hospital, reported by NHS Dorset CCG	1
Circle Health Group, Hampshire Clinic, reported by NHS Hampshire, Southampton and Isle of Wight CCG	1
Circle Health Group, Highfield Hospital, reported by NHS Greater Manchester ICB	1
Circle Health Group, Thornbury Hospital, reported by South Yorkshire ICB	1
Derbyshire Community Health Services NHS Foundation Trust	1
East and North Hertfordshire NHS Trust	1

East Kent Hospitals University NHS Foundation Trust	4
East Lancashire Hospitals NHS Trust	3
East Suffolk and North Essex NHS Foundation Trust	3
Epsom and St Helier University Hospitals NHS Trust	1
Frimley Health NHS Foundation Trust	1
Great Western Hospitals NHS Foundation Trust	1
Guy's and St Thomas' NHS Foundation Trust	2
Harrogate and District NHS Foundation Trust	1
Hull University Teaching Hospitals NHS Trust	1
Isle of Wight NHS Trust	1
King's College Hospital NHS Foundation Trust	3
Kingston Hospital NHS Foundation Trust	2
Leeds Teaching Hospitals NHS Trust	1
Liverpool University Hospitals NHS Foundation Trust	2
Manchester University NHS Foundation Trust	1
Mid and South Essex NHS Foundation Trust	1
Mid Yorkshire Hospitals NHS Trust	1

Norfolk and Norwich University Hospitals NHS Foundation Trust	2
North West Anglia NHS Foundation Trust	2
Nottingham University Hospitals NHS Trust	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	1
Royal Surrey County Hospital NHS Foundation Trust	1
Royal United Hospitals Bath NHS Foundation Trust	2
Salisbury NHS Foundation Trust	1
Sheffield Children's NHS Foundation Trust	2
Sheffield Teaching Hospitals NHS Foundation Trust	1
Somerset NHS Foundation Trust	2
South Tees Hospitals NHS Foundation Trust	1
SpaMedica Bromley, reported by NHS Bromley CCG	1
St George's University Hospitals NHS Foundation Trust	4
Surrey and Sussex Healthcare NHS Trust	1

The Hillingdon Hospital NHS Foundation Trust	1
The Horder Centre (Crowborough), reported by NHS East Sussex CCG	1
The Haldon, Devon Partnership NHS Trust	1
The Princess Alexandra Hospital NHS Trust	1
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	1
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1
The Royal Wolverhampton NHS Trust	1
The Shrewsbury and Telford Hospital NHS Trust	1
The Walton Centre NHS Foundation Trust	1
University College London Hospitals NHS Foundation Trust	1
University Hospital Southampton NHS Foundation Trust	4
University Hospitals Birmingham NHS Foundation Trust	3
University Hospitals Coventry and Warwickshire NHS Trust	2
University Hospitals of Leicester NHS Trust	1
University Hospitals of Morecambe Bay NHS Foundation Trust	3
University Hospitals of North Midlands NHS Trust	1
University Hospitals Plymouth NHS Trust	1

Warrington and Halton Teaching Hospitals NHS Foundation Trust	2
West Midlands Hospital, reported by NHS Dudley CCG	1
Worcestershire Acute Hospitals NHS Trust	1
Wrightington, Wigan and Leigh NHS Foundation Trust	2
Wye Valley NHS Trust	1
Total	**111**

Note: As described above, a further 9 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 2023 but actually occurring prior to this

. None reported.

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

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: enquiries@england.nhs.uk

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