NHS
Maidstone and Tunbridge Wells
NHS Trust

Ref: FOI/GS/ID 6054

Please reply to:
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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Never Events.

You asked:

1. How many 'never events' have occurred at your trust over the past ten years? (please break this down by year and speciality department, and if possible also include information collected for 2020)
2. Details for each of these 'never events'. What happened? Were there any contributing factors?
3. How the issue was resolved for each? (i.e was there any compensation involved and if so what was the total amount paid in compensation for these 'never events' by year and over the past 10 years?)
4. Has NHS England (or another body) issued guidance or any other form of support to prevent the occurrence of 'never events' in the future?

Trust response:

Details of all Never Events are discussed at the Trust Board meetings. The board papers can be found on the Trust website www.MTW.NHS.UK .

Please find below the information requested.

Further details will not be released in order to protect patient confidentiality.

Never Events for 2010/2011- 6

Date of Incident	2010
Type of Never Event	Retained Swab

Directorate	Women’s and Children’s
Description: Retained vaginal sanitary pad post delivery	
Contributory: None	
Was this a claim: No	

Date of Incident	2010
Type of Never Event	Retained Instrument
Directorate	Theatres and Critical Care
Description: Tip of surgical scalpel broke off during procedure	
Contributory: None	
Was this a claim: Unknown	

Date of Incident	2010
Type of Never Event	Retained Swab
Directorate	Women’s and Children’s
Description: X-ray detectable swab retained in vagina post delivery	
Contributory: None	
Was this a claim: Yes settled £55,000 including costs	

Date of Incident	2010
Type of Never Event	Retained Swab
Directorate	Women’s and Children’s
Description: Retained vaginal swab removed from patient.	
Contributory: None	
Was this a claim: Unknown	

Date of Incident	2010
Type of Never Event	Wrong Site Surgery
Directorate	Unknown
Description: Incision made on incorrect upper eye lid	
Contributory: None	
Was this a claim: Unknown	

Date of Incident	2011
Type of Never Event	Retained Swab
Directorate	Women’s and Children’s
Description: Retained vaginal swab post delivery	
Contributory: None	
Was this a claim: No	

Never Events for 2011/2012 - 3

Date of Incident	2011
Type of Never Event	Retained Instrument
Directorate	Theatres and Critical Care
Description: Detachable end from a cement restrictor instrument had been cemented in situ in the patient's femoral canal.	
Contributory: This case was performed when there is a change over from day to night staff. • Instrument checklist not completed correctly • WHO safety checklist not fully completed • Staff member did not know the cement restrictor had a detachable head with 2 sizes available. This supports the fact that the instrument check cannot have been performed properly • Surgeon accepted ultimate responsibility	
Was this a claim: No	

Date of Incident	2011
Type of Never Event	Wrong Prosthesis Fitted
Directorate	Theatres and Critical Care
Description: The surgeon requested a (plus)+8.00 diopter lenses after extracting a cataract and the scrub practitioner took out of the prosthesis cupboard a (minus) -8.00 diopter lens which was fitted.	
Contributory: Surgeon wears glasses which makes it difficult to check the lens once set-up on the microscope. No clear distinction in store room from positive & negative lens	
Was this a claim: No	

Date of Incident	2012
Type of Never Event	Wrong Prosthesis Fitted
Directorate	Head and Neck
Description: Biometry reading of wrong patient filed in notes. Not identified by any staff prior to surgery. Wrong dioptre lens inserted as a results of incorrect biometry reading in patient notes Identified at post- operative check.	
Contributory: Disorganised process undertaking biometry assessment Patient ID incomplete on documentation Lack of accountability of Technicians in double checking and signing off Patients having biometry readings who do not need it which adds pressure on available resources Staff expectation of what is in the notes belongs to the patient- e.g. thinking and believing that the notes will not belong to a different patient	

Was this a claim: No

Never Events for 2013/2014 - 1

Date of Incident	2013
Type of Never Event	Other - Patient received un-necessary surgical procedure
Directorate	Pathology
Description: A radical prostatectomy specimen for patient 1 contained no tumour. On review of the previous prostate core biopsies it was realised that the slides were mislabelled with the labels of another patient – Patient 2.	
Contributory: Laboratory undergoing change (recent service transfer from DVH) Staffing shortages Recently transferred staff were technically competent but unfamiliar with local working patterns and procedures at MTW (i.e. skills gap and training burden) Stress due to bottlenecks and pressure of work High volume work in restricted lab space	
Was this a claim: Yes settled £86,198.17 including costs	

Never Events 2014/2015 - 2

Date of Incident	2014
Type of Never Event	Wrong Site Surgery
Directorate	Imaging
Description: Chest drain inserted incorrect site	
Contributory: 1) Equipment failure contributed to the incident, because if the image had passed through the processor successfully, having been correctly described as an AP projection by the Radiographer at the time of identifying the cassette, the error would not have occurred. 2) The CXR image appearance gave the impression that the collapsed right lung was the left heart border on the mirrored x-ray image. The image was also not thoroughly examined. 3) The patient had abnormal left sided chest signs, and in context of deteriorating and unstable observations (low saturations and a low blood pressure) was thought to have an unstable left sided pneumothorax, consistent with the original x-ray performed, so a chest drain was put in the left side. Prior to the chest drain insertion only the left chest was re-examined.	
Was this a claim: No	

Date of Incident	2014
Type of Never Event	Wrong prosthesis
Directorate	Trauma & Orthopaedic
Description: Incorrect prosthesis used – returned to theatre for correct prosthesis	
Contributory: At the time, the existing checks were not adequate or robust enough to avoid the wrong prosthesis being inserted.	

Was this a claim: Yes ongoing

Never Events for 2015/2016 - 2

Date of Incident	2015
Type of Never Event	Incompatible blood products
Directorate	Pathology
Description: Incorrect FFP transfused to baby	
Contributory: • No second person to check processes and product issues or support workload in an emergency. BMS coming to the end of fourth successive, night shift lone working. • BMS reliant on 'virtual' checks of product by the in-house computer system. This was inadequate and failed to provide BMS with vital checks during the process. • Midwives unable to access fridge on Deliver Suite that contained emergency red cells – BMS had to arrange supply of two units of RBC as well as FFP adding to workload and stress. • The BMS received a total of eight separate telephone calls / bleeps from the wards, spoke to three different doctors and at least three nurses, made three calls to the ward and various calls to porters to arrange delivery over the course of one hour. This was in addition to calls coming into the lab which they were unable to answer as they were on other lines. As a lone worker this is extremely stressful and the continuous interruption a massive risk to accuracy of work. • At the time of the incident there was not good signage on the plasma freezer door as to contents or advice on which products to issue.	
Was this a claim: No	

Date of Incident	2015
Type of Never Event	Retained laparoscopic bag
Directorate	Theatres and Critical Care
Description: Retained laparoscopic retrieval bag following surgical procedure	
Contributory: Issues of general business and feeling under pressure and 'rushed' were discussed by the theatre nurses and the surgeon.	
Was this a claim: No	

Never Events for 2016/2017 – 4

Date of Incident	2016
Type of Never Event	Wrong Prosthesis
Directorate	Trauma and Orthopaedics
Description: Wrong side knee component implanted	
Contributory: Possible tiredness from working without break	
Was this a claim: No	

Date of Incident	2016
Type of Never Event	Wrong site surgery
Directorate	Theatres and Critical Care
Description: Central line misplacement	
Contributory: Deemed an emergency operation Sub-optimal conditions – carried out under drapes in theatre	
Was this a claim: Yes, ongoing	

Date of Incident	2016
Type of Never Event	Wrong site surgery
Directorate	Women's and Children's
Description: Incorrect procedure	
Contributory: Unknown	
Was this a claim: Yes ongoing	

Date of Incident	2017
Type of Never Event	Misplaced naso- or oro-gastric tubes
Directorate	Surgery
Description: NG tube sited in bronchus not stomach	
Contributory: Busy night. Competing demands on medical staff. FY1 had a sick patient on next ward. SHO busy with surgical referrals in A&E Locum Registrar	
Was this a claim: No	

Never Events for 2017/18 - 4

Date of Incident	2017
Type of Never Event	Wrong site surgery
Directorate	Theatres and Critical Care
Description: Incorrect side nerve block	
Contributory: Teaching SAS doctor Ultrasound guided blocks No mark visible at time of block Anaesthetic chart not completed contemporaneously with seeing patient, so marked with incorrect side Anaesthetic staff did not feel empowered to challenge senior colleagues	
Was this a claim: No	

Date of Incident	2017
Type of Never Event	Retained foreign object
Directorate	Theatres and Critical Care
Description: Retained swab	
Contributory: Several circulating practitioners performing the swab counts with the scrub practitioner which was not a consistent approach and no consideration given to the fact that the second theatre practitioner was scrubbing for the second case 3 x 4 swabs do not have tags sewn into them so they can be clipped onto the sterile field as a precautionary measure (the retained swab was found in the right upper quadrant and almost tucked under the liver). A clear plastic bag was used for the countdown of the swabs leaving the sterile field which causes the swabs to all bunch together.	
Was this a claim: No	

Date of Incident	2017
Type of Never Event	Administration of medication by the wrong route
Directorate	Urgent Care
Description: Oral medication administered subcutaneously	
Contributory: Complex pain management scenario, which distressed the patient, relatives and care staff. Staffing pressures on the ward that day with a high acuity of patients and acute short notice gaps in staffing. Enfit connectors not supplied with oxycodone elixir. Failure to fully review the patients drug chart fully at each ward round and drug round Prescribing error, the prescription was not complete or signed.	

Was this a claim: No

Date of Incident	2018
Type of Never Event	Wrong site surgery
Directorate	Theatres and Critical Care
Description: Incorrect procedure carried out	
Contributory: Wrong referral form sent/multiple referrals sent including by fax, which is not an acceptable route Failure to confirm the procedure requested during conversations between CAU/booking clerk and Ward team. Patient was booked into an OGD only list and the nurse Endoscopist was only able to perform OGD's Receiving Nurse also looking after patients in Endoscopy recovery No formal Handover process in place.	
Was this a claim: No	

Never Events for 2018/19 - 1

Date of Incident	2018
Type of Never Event	Retained foreign object
Directorate	Women's and Children's
Description: Retained part of a swab	
Contributory: Two Policies in place linked to swab counting Training - no formal competency	
Was this a claim: No	

Never Events for 2019/20 - 3

Date of Incident	2019
Type of Never Event	Wrong site surgery
Directorate	Women's and Children's
Description: Procedure carried out on wrong patient	
Contributory: There were no formal guidelines in place for lumbar puncture on the Neonatal unit. The consent process for an invasive procedure was not adhered to.	

Was this a claim: No

Date of Incident	2020
Type of Never Event	Administration of medication by the wrong route
Directorate	Theatres and Critical Care
Description: Oral medication administered via the wrong route	
Contributory: TBC	
Was this a claim: No	

Date of Incident	2020
Type of Never Event	Wrong site surgery
Directorate	Head and Neck
Description: Procedure carried out on wrong eye	
Contributory: TBC	
Was this a claim: No	