Did you know?
Retained foreign object post procedure
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From 1st April 2015 to 31st March 2020, NHS Resolution received 800 claims for incidents of retained foreign object post procedure. Out of these 800 claims, 454 were settled with damages paid, 193 without merit and 153 remain open. This has cost the NHS:

£14,546,778

*This includes payments for claimant legal costs, NHS legal costs and damages.

The percentage of retained foreign object post procedure claims reported by speciality from a total of 800 claims

- General Surgery: 22%
- Obstetrics: 13%
- Orthopaedic Surgery: 10%
- Gynaecology: 10%
- Urology: 7%
- Other: 38%

Of the 454 settled with damages paid, 389 were Never Events. This has cost the NHS

£12,472,347*

“Never Events are serious, wholly preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations”.
Retained foreign object post procedure is listed within the Never Event list (2018), and is defined as, “retention of a foreign object in a patient after a surgical/invasive procedure”.

‘Surgical/invasive procedure’ includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment – for example, central line placement in ward areas.

‘Foreign object’ includes any items subject to a formal counting/checking process at the start of the procedure and before its completion (such as for swabs, needles, instruments and guidewires). Please refer to NHS Improvement Never Event list (2018) for full details.

Retained foreign object post procedure from all 389 Never Event claims

- Instruments: 46%
- Swabs: 44%
- Guidewires: 7%
- Needles: 3%

The concept of Never Events is about learning from what happened and taking immediate action to prevent future occurrences.

What can you do?

Understand the hidden costs of investigating serious incidents and claims by reading the serious incident cost calculator:


Ensure your organisation has implemented existing national guidance and recommendations from patient safety alerts

Ensure clinicians attend ongoing education and training regularly

Review your organisation’s claims history regarding Never Events and ensure that learning is shared with all clinicians

For further resources on Never Events, please visit these links:

NHS England and NHS Improvement (NHSE/I):

Healthcare Safety Investigation Branch (HSIB)
https://www.hsib.org.uk/investigations-cases/page/1/

For further information please contact: safety@resolution.nhs.uk

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