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LETTERS

NEVER EVENTS

Details of "never" events should be generally accessible

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DW is a trustee of CORESS (Confidential Reporting System in Surgery).

Where can surgeons in UK hospitals, who are leading the delivery of services, easily find and learn from "never" events like the one reported by Dyer?[1]

Through its own voluntary reporting and publication system (www.coress.org.uk), the surgical profession provides a platform through which surgeons can share learning from less serious incidents and near misses. Although this system is valuable, there is a need for more widespread publication of the learning contained in serious medical accidents. In March 2014, the Royal College of Surgeons published an important report, "Building a Culture of Candour." This report makes it clear that a lack of general access to the details of "never" events and "serious untoward incidents" is holding back the wider dispersal of learning from these mishaps, and that trusts have a duty to close this vital section of the learning cycle. Until then, all of us—whether in practice or positions of leadership—remain vulnerable to making similar mistakes, and this is simply not good enough.

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1 Dyer C. Surgeon gives patient a vasectomy by mistake. *BMJ* 2014;348:g3180. (8 May.)

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