



# Never Events

Never events are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. These events indicate a real problem in the safety and credibility of a health care facility.

Some healthcare professionals use the terms Never Event and Sentinel Event interchangeably.

In 1996, the Joint Commission adopted a [Sentinel Event Policy](#). They define a Sentinel Event as a patient safety event that reaches a patient and results in death, severe harm (regardless of duration or harm), or permanent harm (regardless of severity of harm).

To be included on the National Quality Forum's (NQF's) list of "[never events](#)," an event had to have been characterized as:

- Unambiguous—clearly identifiable and measurable, and thus feasible to include in a reporting system
- Usually preventable—recognizing that some events are not always avoidable, given the complexity of health care
- Serious—resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- Any of the following
  - Adverse and/or, ◦ Indicative of a problem in a health care facility's safety systems and/or
  - Important for public credibility or public accountability.

The term "never event" started popping up around the year 2001 when Dr. Ken Kizer of the National Quality Forum used it to describe shocking medical mistakes.

As you read the [Patient Stories](#) on this website, you will see that some of those incidents meet the criteria to be classified as a Never Event. Did Sunrise Hospital report these events to the Joint Commission?

## Some states have laws about Never Events

Some states have enacted [legislation requiring reporting of these incidents](#). Here are a few examples:

In 2003, the **Minnesota** legislature, was the first to pass a statute requiring mandatory reporting of "never events." The law requires hospitals to investigate each event, report its underlying cause and take corrective action to prevent similar events. In addition, the Minnesota Department of Health publishes an annual report and provides a forum for hospitals to share reported information across the state and to learn from one another.

During the first year of Minnesota's mandatory reporting program, 30 hospitals reported 99 events that resulted in 20 deaths and four serious disabilities. In the second year, 47 hospitals reported 106 events that resulted in 12 deaths and nine serious injuries. These included 53 surgical events, and 39 patient care management events.

In 2004, **New Jersey** enacted a law requiring hospitals to report serious, preventable adverse events to the state and to patients' families, and Connecticut adopted a mix of 36 NQF and state-specific reportable events for hospitals and outpatient surgical facilities.

An **Illinois** law passed in 2005 will require hospitals and ambulatory surgery centers to report 24 "never events" beginning in 2008.

Several other states have considered or are currently considering never event reporting laws.

Never events are so forbidden, that even the government will refuse to make Medicare or Medicaid payments to hospitals to help cover expenses related to never events.

### **Leapfrog Survey results for Sunrise Hospital**

In the [2025 Leapfrog Survey results](#), Sunrise Hospital and Medical Center reported they have a Never Events policy, and they responded "Yes" when asked if they following each of the principles. However, news articles, legal documents, online patient comments, and patient stories never mention the Never Events principles were followed by Sunrise Hospital in response to medical errors.

The report also shows low ratings in several categories, and many items were marked as "Did Not Measure" or "Declined to Respond."

### **A systematic review of the literature**

A [2023 report](#) discussed a systematic review of the scientific literature regarding Never Events. Their analyses included 367 reports that identified 125 unique Never Events. The authors concluded that work needs to be done to improve collaboration and facilitate learning from errors.

### **A starting point for collaboration and learning**

One starting point would be for healthcare organizations to invite patients or family members to their conferences in order to tell their stories. This would provide an opportunity for further healing of the trauma of those events and provide detailed insight for the organizations so they could learn and improve and help to prevent Never Events in the future.

See the photos of the 2025 annual conference of the **Nevada Hospital Association**. They knew about the story of **Patient-1**, but they refused to step up and offer the patient a place on the agenda, missing a valuable opportunity to help the hospital CEOs learn from what happened (including the CEO of Sunrise Hospital who attended the conference).



This chart shows a sample of Never Events in England for a 10-year period from 2013-2023.

Based on 2018 data from Medicare, **25% (one in four) of Medicare patients experienced a harm event while hospitalized** and 12% experienced adverse effects leading to longer hospitalization, permanent harm, requiring life-saving intervention, or resulting in death.

## Principles for Handling Never Events

The Leapfrog Group is a nonprofit watchdog organization that serves as a voice for health care consumers and purchasers, using their collective influence to foster positive change in U.S. health care. According to Leapfrog, more than 200,000 lives are lost every year because of preventable medical errors.

Leapfrog established **the following principles** as the standard for handling Never Events. A hospital "fully meets standards" if they agree to all of the following if a Never Event occurs within their facility:

1. Apologize to the patient and family
2. Waive all costs directly related to the event
3. Report the event to an external agency
4. Conduct a root-cause analysis of how and why the event occurred
5. Interview patients and families, who are willing and able, to gather evidence for the root cause analysis
6. Inform the patient and family of the action(s) that the hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis
7. Have a protocol in place to provide support for caregivers involved in Never Events, and make that protocol known to all caregivers and affiliated clinicians
8. Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred
9. Make a copy of this policy available to patients upon request

Hospitals often fear that issuing a formal apology opens up a door for malpractice suits. Ironically, research indicates that malpractice suits are often the result of a failure on the hospital's part to communicate openly with the patient and apologize for its error.

Patients feel the most anger **when they perceive that no one is willing to take responsibility for the adverse event** that has occurred. But a sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient.

### **Adding Surgery Centers to Public Reporting**

In 2020, Leapfrog started publicly reporting on surgery centers as well including asking if they have a Never Events Policy in place.

### **A New Category Relating to Hospital Policies**

A **report was published in 2022** that proposed a new category of 5 hospital behaviors that should be rendered unacceptable.

- First, hospitals should never pursue aggressive debt collection tactics against patients who cannot afford their medical bills, such as suing them,<sup>1</sup> garnishing wages, placing liens on homes, and denying care due to owed debt.
- Second, a hospital should never spend less on community benefits (such as providing care to uninsured patients or funding public health programs) than it earns in tax breaks from its nonprofit status.

- Third, hospitals should never flout federal requirements to be transparent with patients about the costs of their care.
- Fourth, hospitals should never provide compensation worth less than a living wage for hospital workers, such as janitors and food-serving employees.
- Fifth, a hospital should never deliver racially segregated medical care, whereby it systematically underserves its surrounding communities of color.

**Consider that despite billions of dollars in tax breaks, 60% of nonprofit hospitals over the past several years spent less than 2 cents on charity care for every dollar of net patient revenue,** according to a July 25, 2022, *Wall Street Journal* article that included an analysis of recent Medicare cost reports.

In addition, although many hospital workers struggle to get by, some executives have benefited comfortably—as highlighted by an account of a technician in Missouri who was earning \$30 000 annually at a hospital that paid its CEO about \$30 million in compensation. Similarly, the employees of Sunrise Hospital are rallying for better pay and better working conditions, while the CEO of HCA Healthcare (which owns Sunrise Hospital) **was paid \$23 million in 2024**.

As **stated by Senator Bernie Sanders**, in his support of Sunrise Hospital employees: ***HCA made nearly \$5.8 billion in profits and spent \$6 billion on stock buybacks to make its wealthy shareholders even richer.***

Other organizations, such as insurance companies and medical device makers, undoubtedly create harms of their own that also merit dialogue.

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