The Faculty of
Intensive Care Medicine

Dean
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Mr. Ian Arrow
HM Senior Coroner, Plymouth
hmcoroner@plymouth.gov.uk

8th April 2016

Dear Mr. Arrow,

In response to Regulation 28 report relating to an inquest touching on the death of Peter Tye

Thank you for your letter involving this unfortunate case. The report has been discussed by the Faculty's Board and Professional Standards Committee.

We recognise that Mr. Tye's stroke was most likely caused by the misplacement and removal of the line and, as indicated in the report, acknowledge that the hospital has learnt from this case and has implemented changes to reduce the risk of the incident being repeated in the future.

The ICM training programme requires trainees to understand and recognise complications from line insertions however, the number of procedures required for sign off is not mandated nor do we believe that this type of complication would be prevented if this were the case. The spiral nature of our curriculum requires the trainee to demonstrate increasing levels of competence for this procedure resulting in a competence which would indicate that the trainee was capable of independent level practice. This is assessed by means of workplace based assessments, performed by consultant trainers who would also assess the trainee's knowledge of the indications for and complications of the procedure.

Trainees in ICM are also expected to have an understanding of the process of reporting of critical incidents, serious untoward incidents and root cause analysis and are expected to attend mortality and morbidity meetings throughout their training. As such, the ability to learn from incidents of patient harm must be demonstrated.

As acknowledged in the report the evidence base for dealing with inadvertent carotid artery puncture is not clear, but again we would expect this to be something that is discussed in order to demonstrate competence at this procedure. The authors of the report recognise that in Mr. Tye's case there was little they could do to mitigate the complication once it had occurred due to the instability of the patient. This is unfortunately the nature of intensive care medicine and when patients who are critically unwell develop iatrogenic complications of any kind, management of the complication will have to be considered on an individual patient basis.

The FICM and ICS Joint Standards Committee are currently discussing how to monitor incident reports and publicise the lessons learnt as a result of such incidents. Mr. Tye's case will be discussed at the next meeting where a mechanism for cascading this information will be agreed.

Yours sincerely,

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Dean of the Faculty of Intensive Care Medicine