Royal College of Anaesthetists

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Dear Dr Cummings,

Re: Regulation 28: Report to Prevent Future Deaths in the matter of Mrs Glenda May Logsdail

On 27 October 2021, we responded to your Regulation 28 Report highlighting your concerns regarding the tragic death of Mrs Logsdail. The Royal College of Anaesthetists (RCoA), in collaboration with the Association of Anaesthetists and the Difficult Airway Society (DAS), committed to an action plan in this response and this letter is to update you on the progress that has been made over the past year.

We launched a coordinated campaign to disseminate the key learning points from Mrs Logsdail's case to our specialty. This included the following actions:

- We launched a dedicated webpage www.rcoa.ac.uk/safety-standards-quality/patient-safety/prevention-future-deaths, which has been viewed over 12,000 times. This webpage also repromoted the original "No trace, wrong place" video, which has been viewed over 7,500 times since November 2021.
- There have been educational talks at more than ten events across the year to over 5,000 delegates. Of particular note is the session that we devoted to Mrs Logsdail's case at the RCoA's Winter Symposium 2021. This was carried out in the presence of representatives of Mrs Logsdail's family. We have made key talks freely available online on our webpage.
- Multiple articles across the year have been published in the RCoA's, the Association's and the Difficult Airway Society's members' magazines and newsletters, which are distributed directly to all our members.
- Articles and editorials have also been published in the speciality's most popular peer-reviewed journals the "British Journal of Anaesthesia" and "Anaesthesia".
- We have promoted the campaign on social media platforms as well. As an example, one Twitter thread on the topic of Mrs Logsdail's death had over 375,000 impressions.

To help embed the key messages of the campaign into practice, and recognising the critical importance of human factors in safe anaesthetic practice, we developed resources for multidisciplinary team training on the subject of oesophageal intubation. One of these resources were a set of flashcards, short scenarios that could be delivered with no need for theatre downtime. The flashcards have been downloaded over 2,000 times. Colleagues at the Royal United Hospital Bath developed a package of "tea trolley" training on the subject of oesophageal intubation, which has also been made freely available on our webpage.

At the end of 2021, we wrote to all Clinical Directors of departments of anaesthesia in the UK and asked them to promote the campaign and trial the use of the flashcards in their departments. Despite this period coinciding with another wave of the covid-19 pandemic, we received responses from 55% of departments. In those that responded, 80% had used multidisciplinary team training to disseminate the key messages to prevent unrecognised oesophageal intubation. We continue to promote the need for theatre teams to have sufficient time to train together through all of our guidance and quality improvement work.

Your report highlighted the variable configurations of monitors across the hospital as a systemic human factors issue. We continue to work with the Association of Anaesthetic and Respiratory Device Suppliers (Barema) to support the development of engineered solutions to the issue of variable and different configurations of the displays and alarms notifications of monitors.

Unrecognised oesophageal intubation is an issue that affects not just anaesthesia in the UK and we have shared the lessons to be learned from Mrs Logsdail's death with colleagues abroad as well through educational talks to organisations such as the European Airway Management Society, the Australian Safe Airway Society and to the International Anaesthesia and Acute Care Conference in the United Arab Emirates.

We have worked to ensure that other professionals involved in intubation are made aware of the key messages of the campaign. We wrote articles for the Faculty of Intensive Care Medicine's member magazine, the College of Operating Department Practitioners' newsletter and the National Freedom to Speak Up Guardian blog. We have also shared our resources with colleagues in intensive care and emergency medicine.

We recognise that there is still more that can be done:

- We will continue to regularly disseminate the key messages about preventing unrecognised oesophageal intubation to our members.
- In January 2022, the Association and the Difficult Airway Society launch their Human Factors guidance for Anaesthesia. We will work together to promote and embed the recommendations from this guidance in practice.
- We will develop more resources for multidisciplinary team training through the RCoA's simulation workstream.
- We will maintain our work to prevent unrecognised oesophageal intubation through the Safe Anaesthesia Liaison Group, which is a collaborative project between the Association of Anaesthetists, the Royal College of Anaesthetists and NHS England.

We hope that you can agree that we are taking appropriate steps to ensure that anaesthetists and the wider theatre team are aware of these issues and, most importantly, that these steps make future, similar tragedies less likely to occur.

We would be happy to respond to any questions that you might have.

Yours Sincerely

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President
Royal College of Anaesthetists

[redacted]

President
Association of Anaesthetists

[redacted]

President
Difficult Airway Society