Royal College of Anaesthetists

Churchill House
35 Red Lion Square
London WC1R 4SG
[redacted]
Email info@rcoa.ac.uk
Web www.rcoa.ac.uk
Twitter @RCoANews

27 October 2021

Dear Dr Cummings,

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

Thank you for giving the Royal College of Anaesthetists (RCoA) the opportunity to respond to your Regulation 28 Report highlighting your concerns regarding the tragic death of Mrs Logsdail. The RCoA has collaborated with the Association of Anaesthetists and the Difficult Airway Society (DAS) in the preparation of this response and action plan. It is of great concern to the RCoA, the Association and DAS that an avoidable death resulting from failure to identify and appropriately manage a misplaced tracheal tube has happened, despite the previous work of the speciality to try to ensure that oesophageal intubations are swiftly recognised and corrected.

We will seek to address the issues highlighted by Mrs Logsdail's case through a coordinated campaign to disseminate and embed the lessons to be learned into practice. Key aspects of the campaign are described below.

Your report highlights the critical importance of human factors in safe anaesthetic practice. Multidisciplinary team training has an important role to play in rehearsing emergency drills, embedding non-technical skills in practice and allowing teams to learn how to function well as a whole within a flattened hierarchy. Regular, multidisciplinary team training is one of the standards for our Anaesthesia Clinical Services Accreditation (ACSA) scheme. However, in practice, it is a standard that many departments find difficult to meet to an adequate level due to the pressure on theatre time. To support this, we will:

- Develop resources for multidisciplinary team training on the subject of unrecognised oesophageal intubation, including short scenarios to limit the need for theatre downtime
- Ask Clinical Directors in every UK anaesthetic department to confirm how they have used these resources, via an evaluation form
- Work with stakeholders to highlight the importance of theatre teams having sufficient time to undertake essential emergency drills training.

In situ multidisciplinary team training for emergency scenarios can also highlight systemic issues that can affect a team's response in an emergency. Your report highlights the variable configurations of monitors across the hospital as one such issue. We will 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.

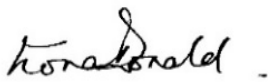
It is disappointing that both the anaesthetist involved in the case and the author of the incident investigation report were not aware of the "Capnography in Cardiac Arrest: No Trace = Wrong Place" video. This was published in 2018 and was widely promoted through the RCoA's, the Association's and DAS's communication channels. We recognise that much of this promotional activity was concentrated in a relatively short period of time. We plan for the following coordinated actions to take place over the next year. We will:

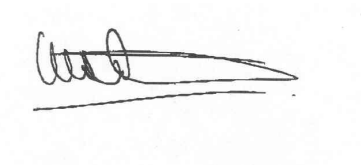
- Spread the key lessons to be learned through RCoA, Association and DAS journals, newsletters and social media
- Present the lessons to be learned at key educational events including the DAS Annual Conference, the Safe Anaesthesia Liaison Group Annual Conference, the RCoA Winter Symposium and the Association's Winter Scientific Meeting
- Work with stakeholders such as the College of Operating Department Practitioners and the Association for Perioperative Practice to ensure that the key messages are heard by the whole theatre team
- Work with other Royal Colleges to ensure that the key messages are shared with all medical professionals who undertake intubation.

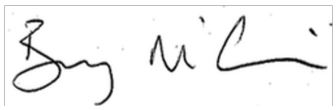
We hope that these proposed actions will satisfy you that we are taking appropriate steps to ensure that anaesthetists and the wider theatre team are aware of these issues and, most importantly, that these steps make future, similar tragedies less likely to occur.

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

Yours Sincerely







Dr [redacted]
President
Royal College of Anaesthetists

Dr [redacted]
President
Association of Anaesthetists

Dr [redacted]
President
Difficult Airway Society