11th September 2024

Dear Ms Voisin,

Re: Regulation 28: Report to Prevent Future Deaths in the matter of Mr Joseph Parker

Thank you for sending us a copy of your Regulation 28 Report regarding the sad death of Mr Joseph Parker. We have jointly reviewed the information available to us in the report via our Safe Anaesthesia Liaison Group (SALG). SALG is a collaborative project between the Association of Anaesthetists, NHS England's Patient Safety team and the Royal College of Anaesthetists. One of its core objectives is to analyse anaesthesia-related serious incidents and to share the learning with the specialty across the UK. We have also reviewed the information available with the Faculty of Intensive Care Medicine (FICM) in order to prepare this joint response.

As your report highlights, this is sadly not the first death as a result of unrecognised oesophageal intubation that has been referred to our organisations by your fellow coroners. It remains a great concern to our organisations that such incidents continue to take place, despite the work previously carried out by the specialty to try to ensure that oesophageal intubations are swiftly recognised and corrected.

Your report highlights that "capnography is the only reliable test, the gold standard, to confirm that a tracheal tube is in the right place and that no other test should override it." We agree entirely and this is made clear in the Association of Anaesthetist's "Standards of monitoring during anaesthesia and recovery"[1]. The message has been emphasised in our previous communications to members on the topic[2] and will continue to be at the heart of future communications. Our previous campaigns, in 2018 and again in 2021/22, have emphasised the "no trace = wrong place" message[3]. The Project for Universal Management of Airways (PUMA) consensus guidelines for the prevention of unrecognised oesophageal intubation's[4], emphasise "sustained exhaled carbon dioxide" as the test to exclude potential oesophageal intubation. This reflects the fact that in some cases of oesophageal intubation the capnograph trace has not been flat, but instead attenuated and abnormal. Our organisations are all supportive of the PUMA guidelines and plan to disseminate the key messages to our members through our safety communications and events. SALG publishes regular Patient Safety Updates, which are distributed to all members of the Association of Anaesthetists and Royal College of Anaesthetists. FICM publishes regular Safety Bulletins, which are distributed to all their members.

Guidelines are in place, but in order for them to be successful in preventing unrecognised oesophageal intubation, we also recognise the importance of human-factors based strategies to enable their use, as outlined in the Association of Anaesthetists' guidance "Implementing human factors in anaesthesia"[5]. In particular, multidisciplinary team training in the management of emergency situations is key in preventing unrecognised oesophageal intubation. As well as helping to ensure that individuals are familiar with the relevant algorithms, by rehearsing emergency drills, teams practise non-technical skills and learn how to function well as a whole within a flattened hierarchy, which contribute to safe and efficient task performance.[5] Regular, multidisciplinary team training is one of the standards for the RCoA's 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 have created and promoted resources that can be delivered regularly within the normal working day.[2,6]

The RCoA's Quality Improvement Network is currently undertaking a project to look at the implementation of airway-related recommendations across the country, including those related to unrecognised oesophageal

intubation. We will use the information gained from this project to focus our activity to support departments of anaesthesia to make improvements.

Your report mentioned that unrecognised oesophageal intubation was a suspended never event. We are aware that the never events framework is under review by NHS England. In our consultation response, we were clear that, whatever changes are made to the framework, we believe that unrecognised oesophageal intubation should be a nationally reportable incident, so that lessons can be learned from every tragic event to prevent its occurrence in the future.

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

Yours Sincerely

[redacted]
President,
Royal College of Anaesthetists

[redacted]
President
Association of Anaesthetists

[redacted]
Dean
Faculty of Intensive Care Medicine

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