Ms Maria Voisin
Senior Coroner
Avon Coroner's Office
37 Old Weston Road
Bristol
BS48 1UL

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

[redacted]

18 September 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Joseph Lawrence Parker who died on 16 April 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 July 2024 concerning the death of Joseph Lawrence Parker on 16 April 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Joseph's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Joseph's care have been listened to and reflected upon.

Your Report raises concerns that the Project for Universal Management of Airways (PUMA) guidelines for preventing unrecognised oesophageal intubation (including the use of capnography to confirm the correct placement of a tracheal tube) have not been widely endorsed or disseminated, and that there have been a number of Prevention of Future Death Reports written by Coroners in relation to concerns around this issue.

My response focuses on those areas of concern that fall under the remit of NHS England's national policy or programmes. NHS England notes that you have also sent your Report to the Royal College of Anaesthetists (RCoA), Faculty of Intensive Care Medicine (FICM), and the Royal College of Emergency Medicine (RCEM), who are better placed to respond to your matters of concern. NHS England will carefully consider their responses to the Coroner in due course.

We note that the RCoA does have a webpage dedicated to Patient safety: unrecognised oesophageal intubation which endorses the PUMA guidelines and highlights the previous Prevention of Future Death Reports. The page links to resources for the 'No Trace = Wrong Place' campaign launched by the RCoA and the Difficult Airway Society (DAS), which was intended to highlight the correct use of capnography to prevent undetected oesophageal intubation. This is aimed at all clinicians involved in airway management.

Your Report also raised the concern that unrecognised oesophageal intubation is no longer categorised as a "Never Event" by NHS England.

The use of capnography for intubation was included on the Never Events list in 2018. NHS England's national Patient Safety Team quickly received feedback that there were differing views on the type of capnography that should be used, depending on the age of the patient, and national guidance was required on how capnography should be interpreted, so the Never Event was suspended until this guidance became available. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) developed recommendations for standards of monitoring during anaesthesia and recovery in 2021 and a consensus guideline in 2022 'Preventing unrecognised oesophageal intubation: a consensus guideline from the Project for Universal Management of Airways and international airway societies', both of which make clear that 'waveform capnography is the mainstay for excluding oesophageal placements of an intended tracheal tube'.

The mitigations used to avoid oesophageal intubation, primarily the use of capnography, which is included in the 2021 AAGBI recommendations referenced above, does not meet the definition of a Never Event. As part of NHS England's current work to review the Never Events Framework and list of Never Events, we will be clarifying the future direction for the Never Events Framework. Since the completion of a widespread consultation in May 2024, a decision will be made on next steps which will determine if the current definition of a Never Event should change and whether this has implications for including oesophageal intubation on any future list. Further information on the consultation can be found here and NHS England can update the Coroner in due course if this would assist.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Joseph, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

National Medical Director