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NHS England

70 YEARS OF THE NHS 1948 - 2018

Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

Mr Sean Horstead
Assistant Coroner
Senior Coroner's Office
Cambridgeshire & Peterborough
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

4th June 2018

Dear Mr Horstead,

Re: Regulation 28 Report to Prevent Future Deaths following an inquest concerning the death of Peter Ian Saint (died 28.06.2016)

Thank you for your Regulation 28 Report to Prevent Future Deaths ("Report") dated 17 November 2011 concerning the death of Mr Saint on 28th June 2016. Firstly, I would like to express my deep condolences to Mr Saint's family. We would also like to apologise for the late response to your Report, your Report was not received in time for me to form a response within the 56 days' timescale.

Your Report concludes Mr Saint's death was a result of extensive hypoxic brain damage sustained when deprived of effective lung ventilation after an endotracheal tube was incorrectly located in his oesophagus whilst under general anaesthetic for routine knee replacement surgery.

Following the inquest you raised concerns in your Report to NHS England regarding:

a) a failure to understand capnography indications
b) a lack of on-going training for anaesthetists

NHS England is the national commissioning board for the NHS. We set national NHS priorities, provide direction and share out funds to local areas to deliver healthcare. Whereas, NHS Improvement has responsibility for overseeing foundation trusts and NHS trusts to ensure and to hold to account all providers on quality of care and on financial stability.

As a result, we do not communicate directly with NHS hospital trusts. However, we have contacted colleagues within the patient safety team at NHS Improvement who have contacted North West Anglia NHS Foundation Trust ("Trust") directly. The Trust has confirmed that a Serious Incident Investigation Report has been carried out. They concluded that: '*endotracheal tubes 1 and 2 were incorrectly placed in the oesophagus rather than the trachea. Contributing*

to this was the failure to recognise this resulted in prolonged loss of the airway, oxygenation and subsequent cardiorespiratory arrest and hypoxic brain injury. The leadership of the cardiac arrest was poorly managed due to loss of situational awareness and human factors. There was a reliance on the clinical signs of tube placement rather than on the monitoring equipment and capnography readings'. We also note that the Trust has contacted the family to notify them of this investigation.

NHS Improvement has also informed us that further action has been taken around this matter in that, as of February 2018, a new Never Event - '*undetected oesophageal intubation*' - has been included into their Never Event Framework. The Framework lists out a number of events that are defined as 'serious incidents' as they are deemed preventable as sufficient national guidance does exist and should be implemented by all healthcare providers. NHS Improvement is currently developing the national guidance required to support this proposed new Never Event, working closely with relevant national organisations, including Royal College of Anaesthetists ("RCoA"), the Association of Anaesthetists of Great Britain and Ireland ("AAGBI") and British Association of Paediatric Nephrology (the Renal Association).

In terms of training, the RCoA's continuing professional development[1] ("CPD") does include training on perioperative emergencies (including crisis training); emergency management and resuscitation; and human factors in anaesthetic practice. Consultants must undertake CPD training and this is used to assess revalidation, which every doctor practising medicine in the United Kingdom must do. We believe that the additional development of national guidance under the Never Events Framework will further support this.

Thank you for bringing these important patient safety issues to my attention and I hope the above information has provided you with assurances that NHS England is taking appropriate action to address your concerns. Please do not hesitate to contact me should you need any further information.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England

[1] https://www.rcoa.ac.uk/system/files/CPDMatrix2015.pdf