IN THE MILTON KEYNES CORONER'S COURT

Inquest into the death of

Glenda May Logsdail

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS. **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Milton Keynes University Hospital** **2. [redacted] Chief Medical Officer for England** **3. [redacted] President Royal College of Anaesthetists**
1	**CORONER** I am Dr Séan Cummings Assistant Coroner for the Coroner Area of Milton Keynes
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3	**INVESTIGATION and INQUEST** 1. On the 1st September 2020 the Senior Coroner for the coroner area of Milton Keynes commenced an Investigation into the death of Glenda May Logsdail who died at the Milton Keynes University Hospital on the 23rd August 2020. The Investigation concluded at the end of the Inquest on the 6th July 2021. 2. The conclusion of the inquest was that the medical cause of Mrs Logsdail's death was 1a Hypoxic-ischaemic encephalopathy, 1b cardio-respiratory arrest, 1c during general anaesthesia for acute appendicitis operation, II Acute appendicitis. 3. I recorded a narrative conclusion of: "Mrs Glenda May Logsdail was an otherwise healthy lady who developed an appendicitis and was admitted to Milton Keynes University Hospital on the 18th August 2020. She died on the 23rd August from hypoxic-ischaemic encephalopathy resulting from a failure to correct a misplaced endo tracheal tube. Her death was wholly avoidable and was contributed to in major part by neglect."
4	**Circumstances of the Death** Mrs Logsdail presented to the A and E department at the MKUH on the 18th August 2020. A diagnosis of acute appendicitis was made promptly and she was booked for emergency laparoscopic appendicectomy. She had signs of early sepsis. She was transferred to the operating theatre, specifically the anaesthetic room of theatre 1. The anaesthetist was Dr [redacted]. Following pre-oxygenation and induction of anaesthesia in an impromptu training session a Senior Theatre Practitioner was invited to attempt the initial intubation. This first attempt failed. This failed attempt used up around a minute or so of the oxygen reserve that had been built up by pre-oxygenation. After the failed attempt the endo tracheal tube was then placed in the oesophagus instead of the trachea by Dr [redacted]. This went unrecognised and Mrs Logsdail had a prolonged period of hypoxia culminating in a cardiac arrest at 15.00. The misplacement of the endo tracheal tube was not recognised until 15.11 when a tube was correctly placed by Dr

	[redacted], Consultant Anaesthetist who had attended to assist in response to the cardiac arrest bleep. Shortly afterwards there was a return of spontaneous circulation but tragically Mrs Logsdail had suffered irreversible brain damage and she died on the 23rd August 2020 at the MKUH.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) I was concerned to find that the anaesthetising Consultant Anaesthetist was not aware of the Royal College of Anaesthetists campaign video "Capnography in Cardiac Arrest: No Trace = Wrong Place". (2) I became even more concerned when towards the end of the Inquest when I was hearing evidence on the Incident Investigation Report the author, told me he had not been aware of the campaign himself until this incident. (3) As Mrs Logsdail's condition deteriorated there was no evidence that any confirmatory checks, notably looking for the presence of a capnography trace or expiratory misting, were done to check correct placement of the endo tracheal tube.

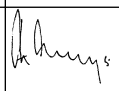
(4) As Mrs Logsdail deteriorated Dr [redacted] erroneously fixated on a diagnosis of anaphylaxis being responsible for the collapse. That fixation was contagious and appeared to compromise the assessments by other staff members who attended to help. Dr [redacted] did not go back to basics and consider A(airway), B (breathing), C (circulation) to work his way through possible correctable causes. He told me frankly that he became more and more fixated on anaphylaxis as the cause. Despite treatment for anaphylaxis and Mrs Logsdail's failure to improve he persisted with this as the diagnosis. His certainty in his diagnosis inhibited other staff members from effectively contemplating other causes until the arrival of another Consultant Anaesthetist. I accept entirely that he was not behaving in a dismissive or aggressive manner. He simply conveyed an infectious certainty which hindered other team members challenging him when several could see that Mrs Logsdail was increasingly cyanosed and in desperate straits.

(5) There was evidence of an inhibitory hierarchical structure which prevented others shouting out. This is despite the fact that I found Dr [redacted] to be a mild mannered, gentle and reflective witness.

(6) There was panic and chaos in the anaesthetic room. There was considerable confusion as to roles and there was an absence of a leader dealing with the emergency. Dr [redacted] was the natural leader but I found that he was effectively blind to what needed to be done – to check the capnograph and to reintubate. Individual staff members took on roles independently in the cardiac arrest. That is to be commended on an individual level but it betrays a fundamental lack of direction and control of the situation and bodes poorly for management of future life threatening emergencies. The team malfunctioned and did not operate as a team.

(7) The panic and chaos led to an inappropriate delegation of an irrelevant task to a Consultant Anaesthetist who attended to assist who eventually was the one to realise the ET tube was misplaced. This distracted her for a minute or two adding to the time when Mrs

	Logsdail was not ventilated. (8) I heard that there were variable and different configurations with respect to the displays on the ventilators in different theatres and anaesthetic rooms and ITU through the hospital. This was confusing for staff and had potential to put patients at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you: 1. [redacted], Chief Executive Milton Keynes University Hospital 2. [redacted] Chief Medical Officer for England 3. [redacted], President Royal College of Anaesthetists have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report,namely by 1st November 2021. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (1) The Logsdail Family (2) [redacted], Chief Executive of Milton Keynes University Hospital (3) [redacted] Chief Medical Officer for England (4) Dr [redacted], Chief Medical Officer for Scotland (5) Dr [redacted], Chief Medical Officer for Wales (6) Dr [redacted] Chief Medical Officer for Norther Ireland (7) [redacted],

	President of the Royal College of Anaesthetists. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this reported ot any persons who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9.	 **Sean CUMMINGS** HM Assistant Coroner **for** **Milton Keynes** **Dated: 06 September 2021**