

FROM THE DEPUTY CHIEF MEDICAL OFFICER

**Dr Ian Carson**

## **HSS(MD)26/2004**

Chief Executives, HSS Trusts

- to forward to Risk Managers and Clinical Governance Leads

Medical Directors, HSS Trusts

- to forward to Clinical Directors of Anaesthetics and Theatre Managers

Directors of Nursing Services, HSS Trusts

Directors of Nursing Services, HSS Boards

Directors of Public Health, HSS Boards

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Your Ref:

Our Ref: **HSS(MD)26/2004/iwc-058-2004**

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Dear Colleague

### **“PROTECTING THE BREATHING CIRCUIT IN ANAESTHESIA”**

You may recall that in England during 2001 there were several incidents in different hospitals in which an anaesthetic breathing circuit had become blocked by a small plastic object impacted within it. Tragically, two patients died as a result of these blockages. A linked Police investigation (Operation Orcadian) was set up in August 2001 to investigate these incidents. In July 2002 this investigation concluded that there was no evidence of a criminal offence. The Chief Medical Officer in England then set up an Expert Group to examine the incidents to establish what lessons the NHS might learn.

During the time that the Expert Group was meeting, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) was revising the Second Edition of its guidance document “Checking Anaesthetic Equipment” which had been published in 1997. The Expert Group was able to contribute to the revision of this guidance which was published by the Association as a Third Edition in January 2004 and circulated to all members.

The Report to the Chief Medical Officer of this Expert Group on blocked anaesthetic tubing was published in May 2004 as “Protecting the Breathing Circuit in Anaesthesia”. I would like to draw your attention to the conclusions and summary recommendations of the Report (Chapter 7) which are attached for ease of reference, along with a copy of the AAGBI document. Together these now represent best practice guidance in this area. A full copy of the Report can be accessed at:

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4081825&chk=rFCDhz](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4081825&chk=rFCDhz)

I would also draw to your attention, that in Northern Ireland any adverse incidents involving medical devices should be reported to the Northern Ireland Adverse Incident Centre (NIAIC), which has direct links with the Medicines and Healthcare Products Regulatory Agency (MHRA), which co-ordinates information across the adverse incident centres in England, Scotland, Wales and Northern Ireland for issues concerning medical device safety.

Also the recently published Circular HSS(PPM) 06/04, 'Reporting and Follow-up on Serious Adverse Incidents: Interim Guidance', issued on 7<sup>th</sup> July 2004.

Yours sincerely

**DR I CARSON**  
**DEPUTY CHIEF MEDICAL OFFICER**

**Encs.**

**Cc: CMO**  
**CNO**  
**CDO**