

8th January 2024

Dear Mr Merchant,

Re: Regulation 28: Report to Prevent Future Deaths in the matter of Maxwell Frame

Thank you for sending us a copy of your report regarding the sad death of Mr Maxwell Frame. 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 consulted with the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS).

Your prevention of future deaths report highlighted your concern regarding the "absence of a national policy on the placement of Central venous catheters (CVCs)."

In 2016, the Association of Anaesthetists published the guidance "[Safe Vascular Access](#)"¹, which was endorsed by the Royal College of Anaesthetists. Although this guidance does not contain a list of explicit recommendations for placement, information relating to how placement should be checked is included. The guideline does state "All hospitals should have clear, specific policies for insertion and documentation of CVCs (type, insertion site and tip position), and education on complications and their management." The guidance is currently being updated and we will ensure that it has more explicit recommendations for checking placement.

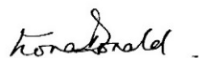
Since that guidance was published, the [National Safety Standards for Invasive Procedures](#) (NatSSIPs)² have been rolled out. As CVC insertion is an invasive procedure, NatSSIPs obliges every organisation to have a local standard (known as a LocSSIP), which would naturally include how placement should be checked. FICM and ICS published a [Central Venous Catheter Insertion Checklist](#) in 2017 (updated 2023)³, which can be used as the basis of the LocSSIP for individual organisations.

Additionally the ICS Standards and Guidelines Committee is currently developing a "Guideline for the management of inadvertent arterial puncture during central venous catheterisation in Critical Care", in conjunction with experts within the Vascular Surgery specialty.

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. Both publications have previously highlighted incidents related to CVC insertion and we will continue to do so to promote compliance with the guidance noted above.

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

Yours Sincerely



Dr Fiona Donald
President
Royal College of Anaesthetists



Dr Matthew Davies
President
Association of Anaesthetists



Dr Steve Mathieu
President
Intensive Care Society

References

1. Association of Anaesthetists of Great Britain and Ireland. Safe vascular access 2016. *Anaesthesia* 2016; 71: 573-585.
2. NHS England. National Safety Standards for Invasive Procedures (NatSSIPs), 2015 and Centre for Perioperative Care. National Safety Standards for Invasive Procedures (NatSSIPs) 2, 2023.
3. Faculty of Intensive Care Medicine and the Intensive Care Society. Central Venous Catheter Insertion Checklist, 2017 (updated 2023).