

# Medical Device Alert

Ref: MDA/2011/0096 Issued: 27 September 2011 at 14:30

## Device

Reusable laryngoscope handles

All models.

All manufacturers.



## Problem

The MHRA has received a coroner's report of an inquest which found that a patient death was caused by a failure to decontaminate a laryngoscope handle appropriately between each patient use. This led to cross infection and subsequently septicaemia.

## Action by

Healthcare professionals using these devices and staff responsible for reprocessing medical devices.

## CAS deadlines

Action underway: 11 October 2011

Action complete: 25 October 2011

## Action

- Review, and if necessary update, local procedures to ensure that reusable laryngoscope handles are decontaminated appropriately between each patient use, in accordance with the manufacturer's instructions.
- Be aware of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines, [Infection Control in Anaesthesia 2, 2008](#) (external link).

## Distribution

This MDA has been sent to:

- NHS trusts in England (Chief Executives)
- Care Quality Commission (CQC) (Headquarters) for information
- HSC trusts in Northern Ireland (Chief Executives)
- NHS boards in Scotland (Equipment Co-ordinators)
- Local authorities in Scotland (Equipment Co-ordinators)
- NHS boards and trusts in Wales (Chief Executives)
- Primary care trusts in England (Chief Executives)

### Onward distribution

Please bring this notice to the attention of relevant employees in your establishment. Below is a suggested list of recipients.

### Trusts

CAS and SABS (NI) liaison officers for onward distribution to all relevant staff including:

- A&E departments
- Adult intensive care units
- All wards
- Anaesthetists
- Coronary care departments
- Day surgery units
- ENT departments
- Infection control departments
- Intensive care units
- Maternity units
- Operating department practitioners
- Paediatric ITU
- Paramedics
- Resuscitation officers and trainers
- Risk managers
- Special care baby units
- Sterile services departments
- Supplies managers
- Theatres

### Primary care trusts

CAS liaison officers for onward distribution to all relevant staff including:

- Community hospitals
- Infection control teams
- Minor injury units
- NHS walk-in centres
- Resuscitation officers and trainers

### Independent distribution

#### Establishments registered with the Care Quality Commission (CQC) (England only)

This alert should be read by:

- Hospitals in the independent sector
- Independent treatment centres

Please note: CQC and OFSTED do not distribute these alerts. Independent healthcare providers and social care providers can sign up to receive MDAs directly from the Department of Health's Central Alerting System (CAS) by sending an email to: [safetyalerts@dh.gsi.gov.uk](mailto:safetyalerts@dh.gsi.gov.uk) and requesting this facility.

## England

If you are in England, please send enquiries about this notice to the MHRA, quoting reference number **MDA/2011/096** or **2011/009/006/291/003**

### Technical aspects

Douglas McIvor  
Medicines & Healthcare products Regulatory Agency  
Floor 4  
151 Buckingham Palace Road  
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Tel: 020 3080 7193  
Fax: 020 8754 3965  
Email: [douglas.mcivor@mhra.gsi.gov.uk](mailto:douglas.mcivor@mhra.gsi.gov.uk)

### Decontamination aspects

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### Clinical aspects

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## How to report adverse incidents

Please report via our website <http://www.mhra.gov.uk>  
Further information about **CAS** can be found at <https://www.cas.dh.gov.uk/Home.aspx>

## Northern Ireland

Alerts in Northern Ireland will continue to be distributed via the NI SABS system.  
Enquiries and adverse incident reports in Northern Ireland should be addressed to:

Northern Ireland Adverse Incident Centre  
Health Estates Investment Group  
Room 17  
Annex 6  
Castle Buildings  
Stormont Estate  
Dundonald BT4 3SQ  
Tel: 02890 523 704  
Fax: 02890 523 900  
Email: [NIAIC@dhsspsni.gov.uk](mailto:NIAIC@dhsspsni.gov.uk)  
<http://www.dhsspsni.gov.uk/index/hea/niaic.htm>

## How to report adverse incidents in Northern Ireland

Please report directly to NIAIC, further information can be found on our website <http://www.dhsspsni.gov.uk/niaic>

Further information about **SABS** can be found at <http://sabs.dhsspsni.gov.uk/>

## Scotland

Enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre

Health Facilities Scotland

NHS National Services Scotland

Gyle Square

1 South Gyle Crescent

Edinburgh EH12 9EB

Tel: 0131 275 7575

Fax: 0131 314 0722

Email: [nss.irc@nhs.net](mailto:nss.irc@nhs.net)

<http://www.hfs.scot.nhs.uk/online-services/incident-reporting-and-investigation-centre-irc/>

## Wales

Enquiries in Wales should be addressed to:

Dr Sara Hayes

Senior Medical Officer

Medical Device Alerts

Welsh Assembly Government

Cathays Park

Cardiff CF10 3NQ

Tel: 029 2082 3922

Email: [Haz-Aic@wales.gsi.gov.uk](mailto:Haz-Aic@wales.gsi.gov.uk)

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