Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Telephone: 01942 822196
Fax: 01942 822158

Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

Our Ref: AKF/JW/417063

10 February 2014

Mr AP Walsh
HM Deputy Coroner
Greater Manchester (West)
Paderborn House
Civic Centre
Howell Croft North
Bolton, BL1 1JW

Dear Mr Walsh,

Kenneth Smalley (Deceased)

Thank you for your letter dated the 19th December 2013 in relation to the inquest of the above named patient. I have noted the cause of death, the conclusions related to the circumstances of the death and your matters of concern.

I understand that under Regulation 28 (Report to Prevent Future Deaths) you have requested a response outlining details of action taken or proposed to be taken setting out the timetable for action to address your concerns which relate to:

I) The function of the operating tables and handsets particularly the review of all operating tables and handsets used at the Hospital following the incident on the 27th March 2013.

II) Pre-operation checks of equipment, particularly the function of handsets attached to operating tables with particular attention to the general condition of the handsets, the seals, and the position of the handsets at the side of the operating table to avoid the handsets being placed on the floor of the Operating Theatre to reduce the risk of fluid ingress.

III) The procedures relating to inspection of operating tables and handsets used at the Hospital particularly to identify any damage to the handsets to ensure the immediate replacements of any damaged handsets.

IV) The training of staff in relation to pre-operative checks of equipment in the operating theatres at the Hospital with the emphasis on operating tables and handsets including the correct positioning of the handsets with effective auditing of such inspections.

I wish to take the opportunity to respond to your request setting out clearly what action the Trust has taken to date, and also what actions will be continuing going forward, to reduce the risk of future deaths occurring.

I) **The function of the operating tables and handsets particularly the review of all operating tables and handsets used at the Hospital following the incident on the 27th March 2013.**

The Trust has four different types of powered operating theatre tables in use and a total of twenty-four units. All theatre tables are maintained via external maintenance contracts. Since this incident, the Trust has developed its own checklist for each type of table based on the Manufacturers User Manuals. The Trusts own qualified Medical Engineering Technicians have undertaken thorough checks of all operating tables against these checklists to confirm their safety for use. The completed checklists will be attached to work orders as evidence of the findings should remedial actions be required.

Following the investigation, the table involved in this serious incident has been taken out of service and is no longer in use at the Trust. There are two other Eschmann RX series tables in use (an RX500 and an RX600).These have been serviced in October 2013 and November 2013 respectively. A proposal to replace these tables has been taken to the Trusts Capital Medical Equipment Group and a business case is being prepared to secure approval to replace both tables.

II) **Pre-operation checks of equipment, particularly the function of handsets attached to operating tables with particular attention to the general condition of the handsets, the seals, and the position of the handsets at the side of the operating table to avoid the handsets being placed on the floor of the Operating Theatre to reduce the risk of fluid ingress.**

A Standard Operating Procedure for the preparation of Theatres prior to commencement of their daily list was ratified and disseminated in December 2013. Checks on the theatre tables must be performed as part of this SOP.

In addition we have developed a daily checklist for all critical equipment, in all theatres across the trust, which must be signed by the person performing the checks and audited on a monthly basis. The disciplinary procedure for non compliance is quite clear within the 'Preparation of RAEI & Leigh Theatres SOP'. This policy is currently under review to include Wrightington Theatres.

III) **The procedures relating to inspection of operating tables and handsets used at the Hospital particularly to identify any damage to the handsets to ensure the immediate replacements of any damaged handsets.**

As outlined above, all operating tables are covered by external maintenance contracts. The two RX Eschmann tables have been serviced since the incident by the contracted provider, Eschmann Group in addition to the Trusts own inspection outlined previously.

The checks required for the preparation of Theatres for their daily list should identify any damage to theatre equipment.

IV) **The training of staff in relation to pre-operative checks of equipment in the operating theatres at the Hospital with the emphasis on operating tables**

and handsets including the correct positioning of the handsets with effective auditing of such inspections.

We have reviewed our staff training and now have a more robust system and matrix for training theatre staff maintaining records of training compliance. Building on the self assessment packs developed within the Trust for medical devices we have expanded our data base within theatres to cover all medical devices including medium and low risk items. Staff are assessed on competence and knowledge of devices and further training given as required. The medical device packs also include manufacturer's user instructions and cleaning instructions.

We note in your letter your concerns about communications between the Medicines and Healthcare Products Regulatory Agency and the Trust. We have contacted the MHRA to request a discussion to strengthen communication and sharing of information in the future. We are pleased to confirm that this has been arranged for Monday 10 February 2014.

I hope that you are satisfied with the measures that the Trust has put in place since the issuing of your report and that I have provided you with sufficient assurance that procedures will continue to be monitored closely. If you feel there are additional measures that the Trust could be taking, I would very much welcome your comments.

Finally, I plan to share this letter with the family of Mr Smalley and I will be giving them the opportunity to attend the Trust to discuss its content.

I am very grateful to you for bringing your concerns to my attention.

Yours sincerely,

Andrew Foster
Chief Executive