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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Dr Séan Cummings
HM Assistant Coroner
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

29 September 2021

Dear Dr Cummings

Regulation 28: Report to Prevent Future Deaths

I write in response to the Regulation 28 report you issued on 06 September, following on from the Inquest you held into the death of Mrs Glenda May Logsdail (on 23 August 2020) which concluded on 06 July 2021. This report was issued to me, along with [redacted].

It is a matter of profound regret that this incident occurred in this organisation, and it is a seminal event for us. Our thoughts remain with Mrs Logsdail's family and friends.

I had hoped that we had been able to assure you at the Inquest of the steps we are taking *locally* to reduce the chance that an incident of this nature might recur in Milton Keynes (through the evidence of Trust employees and updates on progress against the actions articulated in the root cause analysis – RCA – report).

I will not duplicate the detailed content of our RCA action plan here other than to remind you that our actions fall into the following categories:

1. At the **practitioner level** we have managed, and continue to manage, the individuals involved in the incident in association with relevant regulators and Practitioner Performance Advice (NHS Resolution). Our primary emphasis is on patient safety, and appropriate levels of supervision and support are in place.

2. In relation to **systems and processes**, we have shared resources in relation to *'no trace, wrong place'* widely within the organisation, we have implemented the Association of Anaesthetists Quick Reference Handbook in our theatres, and we have ensured (as covered at Inquest) that monitor configuration across theatres is standardised.

3. In relation to **wider environment and culture** we continue with an extensive programme of simulation training and human factors work, both in our state-of-the-art skills laboratory and in-situ. This work is a mixture of in-house and collaborative – we have commissioned a bespoke theatre human factors programme with Cranfield University. We continue to work with all staff – including the multi-professional theatres team – on teamwork, raising concerns and flattening hierarchy. This work involves optimising team communication, advocating the freedom to speak up route, and a novel programme of 'appreciative inquiry' – a strengths-based change management methodology which engages staff in the workplace. Working with experts, this work is being implemented across maternity, ED and theatres.

4. Regarding **wider learning**, you have shared the Regulation 28 report with the Chief Medical Officer and the President of the Royal College of Anaesthetists (RCoA). You noted that the penetration of the 'no trace, wrong place' message (the campaign as opposed to the science / physiology) was incomplete. In our view, the effectiveness of this campaign is an area for RCoA to evaluate and optimise, rather than drawing conclusions specific to this organisation. You will recall from our RCA report and associated evidence that we attempted to refer this case to HSIB for further work. Whilst HSIB has not progressed the referral, we continue to believe that this would be the optimal approach. I hope that [redacted] will consider making additional representations to HSIB. We are in touch with the Association of Anaesthetists and remain committed to working with the association – and all other relevant organisations – to reduce the likelihood of a recurrence both here and elsewhere in healthcare.

We would be happy to share our RCA action plan with you again should that be helpful.

I hope that this response is helpful.

Yours sincerely,

[redacted]
Chief Executive Officer

Copies:
[redacted], Inspector, Care Quality Commission
[redacted]