REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health**
1	**CORONER** I am Catherine Mason, Senior Coroner, for the Coroner area of Leicester City and South Leicestershire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 21st December 2012 I commenced an investigation into the death of Lalitaben Jayantibhai Patel. The investigation concluded at the end of the inquest on the 11th March 2014. The conclusion of the inquest was a narrative conclusion which in summary recorded that inappropriate dissection during an elective cholecystectomy on the 4th May 2012 resulted in a series of complications which ultimately led to her death on the 20th December 2012 at the Leicester General Hospital.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Patel underwent elective laparoscopic cholecystectomy at the Leicester Royal Infirmary on the 4th May 2012. During the initial stages of the procedure the surgeon undertook inappropriate dissection leading to a damaged vessel near to the common bile duct which subsequently ruptured resulting in a massive secondary haemorrhage. This in turn led to Mrs Patel suffering problems after her surgery, hypoxic brain injury and her death on the 20th December 2012 at the Leicester General Hospital.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The surgeon who had responsibility for the elective cholecystectomy was a Locum Consultant Surgeon and was in the second week of his 4 weeks contract. Evidence was heard that he had been appointed via an agency following which he undertook two practical assessments at the University Hospitals Leicester. In summary, there were two main issues highlighted by both assessing Consultants on two separate days resulting in a decision to restrict the Locum Consultant Surgeon to conducting routine laparoscopic cholecystectomies. However, as this was a Consultant grade Locum, no other supervision was provided in respect of the cases under his clinical management.

	Evidence revealed that the systems in place at the material time for signing off a locum Consultant as competent to undertake independent practice were not as robust as they should have been. The inquest heard that University Hospitals Leicester have now changed their recruitment process for Locums and that Locums must be recruited by the 'Locum Bookers' team in accordance with Trust policy. In addition the processes for signing off a locum consultant as competent are more robust. However, it is understood that in other areas the practice for appointing locums is not so robust and mirrors the practice undertaken at the material time. Accordingly, there is a real risk that what happened in this case could happen elsewhere.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 8th May 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Chief Executive, University Hospitals Leicester I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**13/4/2014**