ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Medical Director of Leeds Teaching Hospitals NHS Trust**
1	**CORONER** I am Coroner David Hinchliff, senior coroner, for the coroner area of West Yorkshire (Eastern)
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. [redacted]
3	**INVESTIGATION and INQUEST** On 26 April 2012 I commenced an investigation into the death of Ann Bennett, age 61 The investigation concluded at the end of the Inquest on 22 April 2014. The conclusion of the Inquest was a [redacted] [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Ann Bennett was a married lady aged 61 who had suffered with biliary colic for six to eight months and was under the care of Professor Peter Lodge, Consultant Surgeon and Honorary Professor of Surgery at St James's University Hospital and was seen by him in his clinic at Wharfedale Hospital on Monday 16 April 2012 arising from which she was admitted for an emergency laparoscopic cholecystectomy which was carried out 18 April 2012 which resulted in a perforated bowel; poor post-operative care with a failure to act upon important obvious symptoms and clear deteriorating observations which meant that a serious post-operative complication was not detected quickly. Mrs Bennett's death was confirmed on the Intensive Care Unit at St James's University Hospital, Leeds at 1220 hours on 20 April 2012. A post mortem examination shows the cause of the death to be 1a) Multi organ failure due to b) Septic shock due to c) Peritonitis due to small bowel perforation complicating laparoscopic cholecystectomy for gallstones
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) I am entirely satisfied with the findings of the Trust Level 2 Investigation Report 02961 prepared by [redacted] a Consultant Physician dated March 2014 and the recommendations contained therein (2) Notwithstanding the above I regard this as a potentially avoidable death and I therefore wish to endorse those recommendations but I must incorporate them in this report to ensure that the Trust has due regard to the seriousness of these issues and in order to elicit their response in accordance with this report and Regulation 28, save and accept those issues which were changed by events in respect of the Foundation Year One Doctor [redacted] who is referred to as [redacted] in the report.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND your organisation have 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 4 July 2014, 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. 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	**[09/05/14]** **[SIGNED BY CORONER]**