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. The Chief Executive, Leeds Teaching Hospitals NHS Trust** **2. Secretary of State for Health, Department of Health**
1	**CORONER** I am Kevin McLoughlin, Assistant Coroner, in the coroner area of West Yorkshire (East)
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 1 December 2014 I commenced an investigation into the death of Pauline Taylor, aged 59. The investigation concluded at the end of the inquest on 3 December 2014. The conclusion of the inquest was a Narrative Conclusion, the medical cause of death being metastatic carcinoma
4	**CIRCUMSTANCES OF THE DEATH** The deceased underwent extensive medical investigation in 2010 without a firm diagnosis being established to explain her recurring medical problems. Having identified that her right kidney had ceased to function and her ureter was severely inflamed, the Consultant Surgeon decided that a nephroureterectomy was required. He envisaged this procedure would remove the kidney and the entirety of her ureter as far as the bladder wall. The surgery was assigned to another surgeon who performed a nephroureterectomy on 16 November 2010, in which approximately 5 cms of the ureter was removed, the remainder being left in situ. He believed that the term 'nephroureterectomy' left it to the discretion of the surgeon as to the proportion of the ureter to be removed. Persisting pain in the months after the surgery eventually led to further investigations and the realisation that not all the ureter had been removed. A tumour was identified at the junction between the distal ureter and her bladder which was considered to be inoperable. In August 2011 metastases were identified in her liver and lungs. She died at home on 12 May 2012.
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 surgical term 'nephroureterectomy' appears to lack sufficient precision to avoid any possibility of misunderstandings between clinicians as to the extent of the procedure to be performed. One surgeon gave evidence at the Inquest that the term involved the removal of a kidney and the entire ureter. Another surgeon, however, gave evidence that the term was sufficiently broad to allow the removal of only a portion of the ureter. By the time the difference in their understanding of this term of art became clear the deceased had an inoperable tumour located in the remaining portion of the ureter. (2) In this complex case, no firm diagnosis had been established. There was no one person in the clinical team whose role was to monitor progress, liaise with the patient and the various clinicians involved and ensure her significant ongoing problems were heard and heeded. Evidence was taken at the Inquest from an expert witness who described the benefits of a 'case manager' role, used in other NHS Trusts in cases characterised by uncertainty and complexity.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **Friday 6th March 2015.**. 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 via their solicitors: 1. The family of Pauline Taylor 2. [redacted] 3. [redacted] I have also sent it to The British Association of Urological Surgeons who may find it useful or of interest. 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	**9 January 2015** **Kevin McLoughlin, Assistant Coroner**