Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr Linda Pollard CBE, JP, DL** Chair, Leeds Teaching Hospitals NHS Trust Beckett Street Leeds LS9 7TF
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13/01/2015 I commenced an investigation into the death of Dorothy Cooper, 75. The investigation concluded at the end of the inquest on 21 October 2015. The conclusion of the inquest was Narrative conclusion - Dorothy Cooper underwent elective surgery on 29th September 2014. Complications from this surgery led to ischaemia of the liver with areas of infarction which had resolved by the time of her death. The operative procedures, complications there from and associated poor nutritional status, rendered Mrs Cooper more susceptible to developing infection which led to overwhelming sepsis, from which she died on 6 January 2015. The cause of death was: 1a. Sepsis; 2. Elective laparoscopic cholecystectomy and fundoplication; splenic injury; ischaemic and infarcted liver; poor nutritional status.
4	**CIRCUMSTANCES OF THE DEATH** On the 29th September 2014 Mrs Cooper underwent elective laparoscopic cholecystectomy and fundoplication. Splenic injury occurred at the time of surgery which required laparoscopic repair two days post operatively. Ischaemia to the liver led to infarction and areas of infection which resolved by the time of Mrs Cooper's death. However, post operatively she remained in a much weakened condition, she struggled to eat and had increasingly poor nutritional intake and also underwent investigations for carcinoma of the liver with ultimately the conclusion being abnormal changes seen on radiology were likely to be linked to an infective process. On the 4th January 2015 due to Mrs Cooper's extremely poorly state, she was readmitted to the Doncaster Royal Infirmary where she underwent an acute deterioration on the 6th September and she died in hospital on that date.
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.

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	The **MATTERS OF CONCERN** are as follows: During the course of the evidence it became clear that when Pinderfields Hospital (the Mid Yorkshire Hospital Trust) referred Mrs Cooper to the Leeds Hospital Trust to investigate the possibility of a liver carcinoma, there was a failure to provide key Information to the receiving team. The information omitted related to blood tests, full radiological evidence and key stages in Mrs Cooper's recent medical history. It was clear that had that information been provided, the clinical picture would have pointed more towards an infective process having been responsible for Mrs Cooper's condition rather than a cholangiocarcinoma and thus alternative management was indicated. The receiving team at Leeds identified in their first multi-disciplinary team meeting that there was insufficient information provided in team of clear clinical parameters but failed to proactively pursue this. My concern that if there is not effective training for junior doctors completing the referral form and systems for ensuring that key information is identified and transferred to the receiving team, and also that the receiving team have systems in place for ensuring any gaps in the knowledge are filled, then patients will continue to be at risk in the future where management and treatment plans are devised on the basis of an incomplete clinical picture. Matters of concern in summary are : 1. The absence of clear procedures for those in MDT meetings to proactively follow up inadequately completed referral forms. 2. Lack of procedures to proactively obtain information to complete gaps in clinical history
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, **Dr Linda Pollard, Chair,** 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 16 December 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: [redacted] Doncaster Royal Infirmary NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust. 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	Dated 21 October 2015 Signature_____ Senior Coroner for South Yorkshire (East District)

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