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. **Rt. Hon Jeremy Hunt, MP** **Secretary of State for Health** **Dept. of Health** **Richmond House** **79 Whitehall** **London** **SW1A 2NS**
1	**CORONER** I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire.
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 12 November 2014 I commenced an investigation into the death of Rosalind Jane Anne Bernadette Baird. The investigation concluded at the end of the inquest on 30 June 2015. The conclusion of the inquest was: - Medical cause of death: 1a: Bronchopneumonia 1b: Small Bowel Ischaemia requiring Small Bowel Resection 1c: Superior Mesenteric Artery Injury during Nephrectomy for Kidney Tumour - Coroner's Conclusion: Death due to an Accident On 20 October 2014 Rosalind Baird underwent a left nephrectomy at Queen Alexandra Hospital, Portsmouth, during the course of which a blood vessel supplying her bowel was cut. Thereafter her condition deteriorated and despite further surgery and other medical treatment, she died at the hospital at approximately 22.00 hours on 05 November 2014.
4	**CIRCUMSTANCES OF THE DEATH** See above.
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. –

	At the time of Mrs Baird's nephrectomy there was no formal scheme for the monitoring of inexperienced surgeons carrying out surgical procedures. Since that time, Queen Alexandra Hospital has adopted a formal scheme (see attached). I was told that such schemes are not widespread in England and no such scheme has been formulated at national level. To help prevent deaths in circumstances similar to those of Mrs Baird, consideration should be given to a national monitoring scheme for inexperienced consultant surgeons being compiled using the Queen Alexandra Hospital scheme as an example of good practice.
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 28 October 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] 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	**02 September 2015** **[SIGNED BY CORONER]** **David Clark Horsley**