Regulation 28: Prevention of Future Deaths report

Monique Susanna WHITBREAD (died 25.03.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Consultant Bariatric Surgeon** **University College Hospital** **University College of London Hospitals NHS Trust** **235 Euston Road** **London NW1 2BU**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 1 April 2014, I commenced an investigation into the death of Monique Whitbread, aged 49 years. The investigation concluded at the end of the inquest on 23 July. The determination I made at inquest was that Monique Whitbread died from a recognised complication of medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Ms Whitbread's medical cause of death was: 1a pulmonary aspergillosis and sepsis; 1b intra abdominal complications related to bariatric procedures; 1c laparoscopic gastric bypass on 09.01.14 for obesity; 2 diabetes mellitus, hypertension.

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. Ms Whitbread had a body mass index of above 50 and was referred for bariatric surgery. She also had a hernia. Her surgical options were: - gastric band - sleeve gastrectomy - gastric bypass. You performed a gastric bypass on 9 January 2014. At operation, you freed a plug of omental fat to perform the bypass, but it seems that this later allowed Ms Whitbread's hernia to strangulate, and she died ultimately from the consequences of this. You indicated to me at inquest that, in future, you will perform a sleeve gastrectomy rather than a gastric bypass on those patients who have a hernia. Although the surgery is not necessarily quite as effective, you believe it to be safer in this situation. It seems from your evidence that it would be helpful to disseminate your experience and observations nationally.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 29 September 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 following.

	• HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] brother of Monique Whitbread • Professor Dame Sally Davies, Chief Medical Officer for England 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 30.07.14