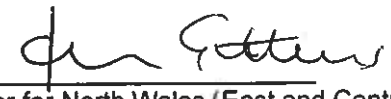
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 the 27th of October 2014 I commenced an investigation into the death of Arthur Price Hughes (DOB 26.9.33 DOD 24.10.14). The investigation concluded at the end of the inquest on the 6th of March 2020. The conclusion of the inquest was one of misadventure the Cause of Death being recorded as 1(a) Multi Organ Failure, (b) Intra-Abdominal Haemorrhage and Small Bowel Ischaemia (c) Vascular Injury following Right Hemicolectomy for Caecal Carcinoma
4	**CIRCUMSTANCES OF THE DEATH** The Deceased underwent an emergency operation on the 20th of October 2014 and this was initially carried out by a locum consultant surgeon. During the procedure, the patient began to bleed significantly either as a result of complications of surgery or due to an error on the part of the locum and another consultant took over the operation. Despite further surgical interventions, the injury which had been sustained resulted in his subsequent death. The locum had only been in post since the 11th of August of 2014 and during the short period which he had been at the hospital, a number of concerns had been raised by staff regarding his confidence and/or competency with the result that he had been placed under restrictions by the Health Board.
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 appointment of locum staff is a necessary requirement within the Health Board to provide continuity of service and the recruitment process in relation to locums ensures that they have the appropriate qualifications to undertake the roles for which they are appointed, However, there does not appear to a recognised protocol or policy by which their work is initially observed, assessed or evaluated in practice, with the result that locum staff could be required to undertake tasks or roles which are at the limit or beyond their capabilities thus creating a risk to patients which may include a risk to life. A more rigid or defined approach to observing and assessing (and where necessary mentoring) new recruits to ensure that their skills and working practices match their apparent qualifications could be beneficial in ensuring a quality of service.

	2. Whilst it would appear that the process by which the taking up of references has improved significantly for the appointment of locums since 2014, evidence provided at the inquest appears to indicate that there is a marked reluctance at a managerial level for references to be supplemented by telephone calls to the referees.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 4th of May 2020 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 Family of the Deceased and 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	Dated 9th March 2020 Signature  Senior Coroner for North Wales (East and Central)

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