IN THE WEST YORKSHIRE (WESTERN) CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Judith VARLEY
A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
1 Managing Partner – Wilsden Medical Practice

1 CORONER

I am Mary Burke, Assistant Coroner for the area of West Yorkshire Western Division jurisdiction

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

Date investigation opened 11th December 2019.
Date inquest concluded 21st April 2021.

Conclusion Narrative –On 2nd December 2019 Judith Varley underwent right hip replacement surgery at The Yorkshire Clinic Bingley West Yorkshire.

During the course of the operation she suffered sudden catastrophic bleeding which despite all appropriate medical and surgical efforts resulted in her death during the procedure.

It is likely that the bleeding was from a tear to the femoral vein which occurred when her treating surgeon undertook a necessary manipulation of her hip joint during the operation.

4 CIRCUMSTANCES OF THE DEATH

In March 2009 Mrs Varley suffered an accident sustaining extensive burns to the left side of her body, despite hospital treatment she developed complications leading to an above knee left leg amputation.

During this time she was also diagnosed with peripheral vascular disease and underwent a right sided ileo-femoral bypass graft to improve the blood supply to her right leg.

In 2013 she underwent further vascular procedures namely an angioplasty and patch repair at the sight of her previous by-pass graft.

In 2019 she developed right hip pain, she consulted your practice and was referred by letter to Mr Thomas consultant orthopaedic surgeon, who recommended right hip replacement surgery.
During the course of surgery undertaken at The Yorkshire Clinic Bingley on 2nd December 2019, Mrs Varley suffered a catastrophic bleed, which despite both medical and surgical intervention led to her death in the operating theatre a short time later.
During the course of the inquest, it was established that the coding given and entered on the computer system of the Wilsden Practice for Mrs Varley's Surgery in 2013 was not in fact an accurate description of the surgery which she had undergone at that time.

This led to an inaccurate description of this surgery within the referral letter submitted by Wilsden Practice at the time of Mrs Varley referral in 2019 for her right hip pain.
In the inquest evidence [redacted] from the practice.

1. she was unable to clarify if there was in fact an alternative coding in 2013 which would have accurately reflected the surgery performed.
2. She was not familiar with the system to know if the coding can be overrided so as to ensure an accurate description of a procedure can be recorded, when the coding options available do not provide an accurate description
3. As she is not the designated doctor within the practice, she was not aware of what auditing / reviewing systems operated within the practice so as to ensure the accurate inputting of information into the practices computer system

I would wish to stress that there was no evidence at the inquest which indicated that this issue in any way caused or contributed to Mrs Varley's death. However I consider that this issue does potentially pose a risk which could impact on the lives of others, hence the reason for reporting this matter to you.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. The computer coding entered by the practice in respect of Mrs Varley's 2013 procedures did not accurately describe the procedure undertaken.

2. It was unclear whether the operating coding computer system in 2013 had facility to be overrided to ensure an accurate description was entered on the system.

3. It was unclear if there was /is an auditing / quality control system in place in the practice to ensure accurate inputting of information within the coding process.

6 ACTION SHOULD BE TAKEN

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 August 2021. 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 who may find it useful or of interest.

[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.

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Dated: 21/6/21