REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], consultant trauma and orthopaedics surgeon via his legal representative at DWF.
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner for the coroner area of Berkshire.
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** I conducted an inquest into the death of Peter William Frederick Lawrence, which concluded on 15th March 2023. Mr Lawrence was 79 at the time of his death. I recorded a short narrative conclusion : complication of necessary surgery. His cause of death was: 1a Septic Shock 1b Gluteal and Hamstring Abscess 1c Spinal Decompression 2 Type 2 Diabetes Mellitus, Ischaemic Heart Disease, Cerebrovascular Disease

4	**CIRCUMSTANCES OF THE DEATH** In brief terms, Mr Peter Lawrence underwent spinal surgery at Spire Hospital in Portsmouth on the 11th January 2022. He had had several other spinal operations before then. He developed infection and abscesses, and the evidence showed that the most likely origin of that infection was the surgery that he had in January. He died at the Royal Berkshire Hospital on the 3rd March 2022. As part of the investigation, I reviewed the medical records. These included medical records from the time of his surgery at Spire Hospital in Portsmouth, but also included outpatient appointments (as a private patient) with [redacted] on (inter alia) 29th December 2021 (by telephone), 26th January 2022, and 23rd February 2022. My investigation revealed that [redacted] made no formal medical records of the outpatient appointments. It is right to point out that [redacted] did send letters dictated and typed up by his secretary (to the patient and his GP), and some of this correspondence is relatively detailed. It was advanced on his behalf that this correspondence effectively represents a medical record and it is entirely appropriate to make 'records' in this way. I did not accept that this correspondence is as full as a medical record would be. Much of the correspondence relates predominantly to plans and proposed courses of action, rather than a record of the patient's condition at that time. In questioning, [redacted] accepted that much of the further information which he gave at the inquest (and referred to in a witness statement) is not recorded anywhere other than his own personal memory. Even leaving aside GMC requirements in relation to record-keeping, it is plainly the case that records are important for patient safety, and storing information about a patient in an individual doctor's memory is clearly unacceptable. Leaving aside the issue of protection for the clinician, this approach carries a risk for patients. I was clear at the inquest that I had no reason to disbelieve the additional evidence which [redacted] brought to the inquest – both in his oral evidence in court and in his witness statement – but I am concerned about the risks of this continued approach for other patients. In questioning, [redacted] clarified that his intention is to continue practising in this way.

	Adequate medical records are fundamental to patient safety, particularly when patients are receiving treatment from numerous clinicians and organisations both in the private sector and in the NHS. I did not find that the record-keeping approach in this case contributed to Mr Lawrence's death, but I remain concerned of a risk to other patients, in adopting this approach.
5	**CORONER'S CONCERNS** The issue about which I have concern is clear. [redacted] should review his record-keeping approach, perhaps with the benefit of legal advice and reference to GMC guidance. An approach of 'storing' information in an individual clinician's memory carries a risk (including a risk of death) for future patients.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you and/or 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 16th June 2023.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Mr Lawrence's family. I have also sent a copy to the Spire Hospital in Portsmouth, and to the senior coroner in Hampshire, given the location of these events. To be clear, I have included the Spire Hospital in this regulation 28 report, not because I had concerns about record-keeping within the hospital setting. However, they are involved in recruiting and relying on private consultants to carry out operations for patients under their care.

	I do not require a formal response from Spire Hospital.
9	**21st April 2023**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**