Regulation 28: Prevention of Future Deaths report

Chamali BIBI (died 04.03.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **National Medical Director** **NHS England** **Wellington House** **133-135 Waterloo Road** **London SE1 8UG**
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 7 March 2023 I commenced an investigation into the death of Chamali Bibi, aged 39 years. The inquest was listed for 15 August 2023, but the investigation was not concluded until the end of the inquest on 25 September 2024. I made a narrative determination at inquest, which I now attach.
4	**CIRCUMSTANCES OF THE DEATH** Ms Bibi underwent a right periacetabular osteotomy (PAO) on 01.03.23, during which she suffered haemorrhagic shock that led to a stroke that evening.

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. As you will see from the narrative determination attached, there were several matters requiring attention at the Royal London Hospital. However, I do not intend to make a prevention of future deaths (PFD) report to Barts Health, because I was given undertakings in court that these matters have already been addressed. The issue that I bring to your attention is this. At inquest, I heard evidence that PAOs should only be conducted by surgeons expert in this procedure. I heard that only those undertaking this procedure frequently, with mentor feedback on the surgery taking into account the post operative imaging, can gain the necessary experience to become expert. However, the majority of the surgeons on the specialist register are the only practitioners within their trust performing the surgery and the majority undertake fewer than ten per annum each. Further, the register is voluntary. Outliers do not appear to have been flagged. It is not clear to me whether all trusts recognise that the PAO is a different procedure, rather than simply being a different technique.
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 2 December 2024. 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. • [redacted], husband of Chamali Bibi • [redacted], Chief Medical Officer for England • HHJ Alexia Durran, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 09.10.24 *ME Hassell*