Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Martin Kuper Medical Director Homerton University Hospital Homerton Row London E9 6SR
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 19 October 2017, Senior Coroner Mary Hassell commenced an investigation into the death of Paliben Dullabh (87 years). The investigation concluded at the end of the inquest which was conducted by me on 11 October 2018. The conclusion of the inquest was a narrative conclusion which is attached. The medical cause of death was:

	1a intestinal perforation 1b caecal volvulus
4	**CIRCUMSTANCES OF THE DEATH** Mrs Dullabh initially presented to the Accident and Emergency Department at the Homerton University Hospital on 9 October 2017. X-rays established that she had gas filled loops of small bowel but did not show radiographic features of bowel obstruction or perforation. Plans were made for further investigations to be undertaken as an outpatient and she was discharged. She returned to the hospital the following evening with increasing pain. A CT scan established sigmoid diverticular disease and a distended stomach. No signs of obstruction were seen. A decision was made to discharge her from hospital but the ward manager of the ACU decided that she should remain in hospital until she was reviewed by the surgical team. A number of requests were made by the ward for Mrs Dullabh to be reviewed as her levels of pain were increasing. Mrs Dullabh was not reviewed by a member of the surgical team until 1am on 12 October 2017. The on-call surgical registrar requested an urgent x-ray in order to rule out bowel perforation. At 5.30 am a radiographer advised that Mrs Dullabh needed to be reviewed urgently by the on-call surgical registrar as the x-ray showed clear signs of bowel perforation. The on-call surgical registrar's view was that Mrs Dullabh required an urgent laparotomy. When he discussed the case with the on-call surgical consultant, he was advised to seek further information from the radiologist. The on-call surgical registrar found that there were no arrangements in place to obtain a radiologist's opinion during the early hours of the morning. Nursing observations made at 6 am showed that Mrs Dullabh was in a state of hypovolaemic shock. Mrs Dullabh was handed over to the daytime on-call surgical team at 8 am. She continued to deteriorate and the daytime on-call surgeon's view was that surgery was very high risk and Mrs Dullabh was unlikely to survive. Attempts were made to resuscitate her in order that surgery could be performed. Mrs Dullabh did not respond to these measures and died on the afternoon of 12 October 2017. Since Mrs Dullabh's death, the hospital has taken steps to increase the level of out of hours surgical cover.
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 could 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) Whilst the Hospital has arrangements in place to obtain out of hours reports from radiologists in relation to CT and MRI scans, there is no similar arrangement for x-rays.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 6 February 2019. 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: [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.
	Sarah Bourke **Assistant Coroner** **11 December 2018**