MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 16304181

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB [redacted] • The Rt Hon Thérèse Coffey MP, The Secretary of State for Health & Social Care 39 Victoria St, Westminster, London SW1H 0EU [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 8th December 2021, this court commenced an investigation into the death of Shahan Abu Aman, The investigation concluded at the end of the inquest held on 31st August 2022. I made a determination of a narrative conclusion incorporating a finding of neglect; "*Shahan Abu Aman died in hospital on the morning of 8th December 2021.* *Aman had attended the same hospital on the previous evening, 7 December 2021.*

	A lack of communication between the nursing and medical team led to an inappropriate discharge from hospital, had Aman remained in hospital that evening, it is likely, on the balance of probability, that a different outcome would have followed. *Neglect contributed to Aman's death."* *Aman's medical cause of death was determined as;* *1a Systemic Inflammatory Response Syndrome (SIRS)*
4	**CIRCUMSTANCES OF THE DEATH** Shahan Abu Aman was a three year old boy born who was presented to his local ED on the evening of 7th December 2021 with symptoms of vomiting and diarrhoea. After assessment, observation and a fluid challenge he was discharged home. The following morning Aman was found unresponsive by his mother, despite the best efforts of his family and emergency services he was declared deceased later that morning in hospital.
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. A series of miscommunications between; nursing staff, junior and consultant paediatric medical staff resulted in concerns regarding Aman not being properly considered prior to discharge. Staff relied on assumptions that others understood the factors affecting Aman and had a plan to resolve them, this was not the case. Had effective communication occurred it was unlikely that Aman would have been discharged. 2. The doctor who authorised discharge did not satisfy himself of the most recent set of clinical observations and associated Paediatric Early Warning Sign (PEWS) score prior to discharge. 3. The Paediatric Emergency Department was particularly busy that evening, with a combination of high patient numbers and severe acuity of symptoms. The accounts provided by Trust witnesses was that resulted in a pressurised environment and that this was a situation that occurred with an increasing level of frequency over the last two years.
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 **25th November 2022**. 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 the family of Aman, the Care Quality Commission, the General Medical Councill CDOP. I have also sent it to the local Director of Public Health who may find it useful or of interest. 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. 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.
9	**[DATE] 30 September 2022 [SIGNED BY CORONER]**