

Zafar Siddique Senior Coroner  
Joanne Lees Area Coroner



THE BLACK COUNTRY CORONERS  
COURT  
Jack Judge House  
Halesowen Street  
Oldbury, B69 2AJ

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Date: 29 December 2023

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO: Sandwell and Birmingham NHS Trust**

**CORONER**

<sup>1</sup> I am Michael James Pemberton HM Assistant Coroner for The Black Country Coroners Jurisdiction

**CORONER'S LEGAL POWERS**

<sup>2</sup> 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>

**INVESTIGATION and INQUEST**

<sup>3</sup> On 26 September 2022 an investigation was commenced into the death of Karmchand GULZAR. The investigation concluded at the end of the inquest on 13 December 2023. The findings and conclusion of the inquest were

Mr Karmchand Gulzar died at Sandwell hospital on 24 September 2022 during the course of an emergency operation to treat dilated large bowel. There had been a delay in obtaining a CT scan which showed the extent of the condition, meaning that the prospects of surviving surgery had reduced significantly by the time of the operation. Other warning signs of the significance of the surgical abdomen obstruction were not noted including a lactate level of 5 showing that Mr Gulzar was deteriorating. An immediate surgical review was not undertaken. These matters contributed more than minimally to Mr Gulzar's death.

Natural Causes contributed to by neglect.

1a Multiorgan Failure

1b Sigmoid Tumor causing Large Bowel Obstruction

1c

II Schizophrenia

## **CIRCUMSTANCES OF THE DEATH**

On 23rd September 2022, Karmchand was taken from his secure care home where he was a resident under a Mental Health Act Section to Sandwell Hospital with features of abdominal distension and pain. A member of staff was with him. On arrival he was triaged at 11:01 and assessed by a physician associate at 13:34. This was reviewed by the Emergency Medicine Consultant and a diagnosis of acute intestinal obstruction was made based on the clinical assessment and x-ray of the abdomen which showed distended bowel loops. He was deemed stable and was referred to the nurse co-ordinator on the Surgical Assessment Unit (SAU) at 14:30. Evidence was provided at the inquest that the NELA (National emergency laparotomy audit) risk of death score was 2.3% at this time of referral.

4 Crucially no CT scan was undertaken which would have provided better resolution and information on the presenting condition. Evidence was given at the inquest that this would form basic medical treatment for an acute intestinal obstruction and consideration of an abdominal emergency laparotomy. Later under examination from the trust representative, the witness recanted slightly on this stating that more junior doctors may not be minded to seek a CT scan, and commented surprisingly that requesting a scan by a consultant in the Emergency department could not be guaranteed.

I received evidence in the form of the serious incident report that there were nursing shortages on that day and that the department was under considerable pressure. No surgical referral had been made. Concerns were raised that observations were not completed on time and I heard evidence from family members that their concerns about Karmchand and the pain he was suffering were not taken on board by staff. The SI report noted that there were difficulties in assessing his condition due to his mental health difficulties meaning that he could

not express pain to staff as easily. His family and staff who knew him raised concerns, but adequate notice does not appear to have been taken..

At 20:30 Karmchand Deteriorated with decreasing level of consciousness and oxygen saturations and was escalated to the ED registrar and transferred to the resuscitation area where he was intubated and taken for CT scan at 22:00. The CT scan demonstrated dilated large bowel and a decision was taken for him to have urgent surgery

The delay in seeking a CT scan, which did not occur until that evening meant that surgery to treat the bowel distention only occurred much later into the evening and into the early morning of 24 September 2022. By this time, the NELA risk assessment had increased from 2.3% to 52% in other words, death was more likely to occur at that point of surgery than earlier in the day.

Mr Gulzar died during surgery in the early hours of 24 September 2022.

### **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. –

- 5 (1) Karmchand was referred to the surgical nursing team instead of the surgical registrar or surgical on-call team, as required by the Emergency Department to surgical registrar referral pathway from a previous SI where it had been identified as an issue. This was not followed in this case, leading to a delay in surgery and increased risk of death. I am concerned that the surgical registrar referral pathway is not being utilised despite previous incidents in which its use was highlighted as necessary.
- (2) No CT scan was undertaken as required by the acute abdominal pathway and guidance as part of the initial assessment. I was concerned by evidence that a CT scan would not be undertaken urgently as part of an acute abdominal presentation and that the necessity for a scan may not be known by junior (or some consultant) doctors.
- (3) The deterioration in Karmchand's condition was not recognised due to difficulties in communication of pain due to his mental health condition. Concerns raised by his carers and family who knew him best and his presentation were not given adequate weight. A previous SI was reported to have raised this issue, but no action point or plan was provided in the current report to set out how staff could improve the assessment of patients with communication difficulties, by using observations and relying on people who better knew their demeanour and presentation.

## **ACTION SHOULD BE TAKEN**

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

## **YOUR RESPONSE**

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 February 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.

## **COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

1 – [REDACTED] – Brother on behalf of the Family

2 – Sandwell and Brimingham NHS Trust.

8 I have also sent it to NHS England who may find it useful or of interest.

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.

29 December 2023

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Signature



Michael Pemberton Assistant Coroner for The Black Country Jurisdiction