MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

1. CORONER

I am Louise Slater, Area Coroner for South Yorkshire (East) District

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 5 July 2024 I commenced an investigation into the death of Khadija Kerri. The investigation concluded at the end of the inquest with a Narrative conclusion of:

Khadija Kerri died primarily as a result of heart disease, but her death occurred on a background of traumatic injuries sustained in an unwitnessed fall and other co-morbidities.

. The medical cause of death :

1a Acute Coronary Event

1b Ischaemic Heart Disease, Cardiomegaly, Left Ventricular Hypertrophy

1c

II Fall, Multiple Fractures, Dementia, Type II Diabetes Mellitus

4. CIRCUMSTANCES OF THE DEATH

Khadija Kerri was admitted to Doncaster Royal Infirmary on the 19th June 2024 with a head laceration and multiple traumatic injuries following an unwitnessed fall downstairs at her home. CT scans were undertaken and reported by Everlight Radiology (a remote third party). These scan were reported on the 19th June 2024. Following a routine peer review the next day, a discrepancy in radiological report was identified and the original CT report had missed two cervical fractures and a rib fracture. An addendum report was issued and a telephone call made to Doncaster Royal Infirmary to advised of the new findings.

Despite the addendum report being uploaded on the shared system and a telephone call being made to the Emergency Department at Doncaster Royal Infirmary on the evening of the 20th June 2024, this information was not communicated to or acted acted upon by the clinical team caring for Ms Kerri until the 23rd June 2024. Following the full extent of her injuries being identified, the fractures were immobilised. Ms Kerri remained in hospital until her death on the 3rd July 2024.

The third party provider identified the missed fractures within 24 hours and communicated this to Doncaster Royal Infirmary, however, this was not acted upon until the 23rd June 2024 due to there being no clear internal policy of disseminating an addendum report and/or it contents to the treating team. This lead to a delay in appropriate care.

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. -

1. There is no clear internal policy/procedure within Doncaster Royal Infirmary for disseminating either an addendum report and/or the information contained within the addendum report from the external third party radiology service to the treating clinical team. If this is not addressed there is potential for similar delays and incorrect management of patient care.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 **Tuesday 22nd April 2025**. 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], Khadija's daughter. I have also sent it to the [redacted], Secretary of State for Health and Social Care and Everlight Radiology 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.

25 February 2025

Mrs S L Slater, Area Coroner

for South Yorkshire East