Regulation 28: Prevention of Future Deaths report

Shalini GANESH-RAM (died 11.08.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Acting Medical Director** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London** **E1 1BB**
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 17 August 2015, I commenced an investigation into the death of Shalini Ganesh-Ram. The investigation concluded at the end of the inquest on 17 December 2015. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Ms Ganesh-Ram died in the Royal London Hospital on Tuesday, 11 August 2015, having suffered a perforated caecum.

	On Thursday, 6 August, she underwent a Caesarean section. Unbeknown to anyone at the time, she immediately developed Ogilvie's syndrome, a very rare complication of Caesarean section. On Saturday, 8 August, this acute pseudo obstruction of the bowel led to a perforated caecum. And on Monday, 10 August, the perforation was diagnosed and a left hemi colectomy was performed. However, she was by then in extremis, and died the following day.
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. I heard at inquest that Ogilvie's syndrome is an extremely rare complication of a Caesarean section, and it would be highly unlikely that any clinician would suspect this in the first instance. However, when Ms Ganesh-Ram's caecum perforated, which with hindsight was probably two days post operation, the perforation was not diagnosed and a surgical consultation not sought until four days post operation. From the evidence I heard, it seems that a number of issues would benefit from your consideration. 1. Whilst Ms Ganesh-Ram underwent many consultant reviews, a raised pulse, abdominal pain and lack of urine output on Saturday the 8th and the morning of Sunday the 9th did not prompt a CT scan. Reassurance was drawn from the fact that her pain was controlled, but I wonder whether this was false reassurance, given that it was controlled by Oramorph, dihydrocodeine and paracetamol. (Abdominal distension was not noted until the middle of the day on Sunday the 9th, probably because it was masked by a high body mass index.) 2. When a plan was made at 1.30pm on Sunday the 9th for a CT scan, this was not performed and reported on until approximately 7.30pm that evening.

	3. Several obstetric registrars were aware that the CT scan revealed a large volume in the peritoneum, but did not then seek a surgical consult, perhaps because the radiology registrar described no bowel wall defect having been demonstrated. I heard that the report of the radiology consultant the following day was felt to provide a clearer warning of perforation. 4. Your own serious incident report has already identified other issues around service delivery, most particularly that the modified obstetric early warning score tool was not used appropriately to identify Ms Ganesh-Ram's sepsis. It seemed from the evidence I heard at inquest, that Ms Ganesh-Ram's sub optimal care was not the result of the actions of one individual, nor even of several individuals, but of many individuals and the system within which they were working. Optimal care may not have saved Ms Ganesh-Ram's life. Indeed, given a body mass index of 55, I was told that death was a likelihood from the moment her caecum perforated. However, earlier diagnosis and appropriate treatment would have afforded her a greater chance of survival than she had on Monday, 10 August.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 29 February 2016. 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.

	• HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] husband of Shalini Ganesh-Ram • [redacted], consultant obstetrician and gynaecologist 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 22 December 2015