In the South London Coroner's Court

Inquest touching the death of Madhumita Mandal

Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: **1. Croydon Health Services** **2. Virgin Care Wandle LLP** **3. Croydon Clinical Commissioning Group**
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South 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.
3	**INVESTIGATION and INQUEST** On 16th September 2013 the Senior Coroner Dr Roy Palmer (now retired) commenced an investigation into the death of Madhumita Mandal . I took conduct of the investigation in April 2014. The investigation concluded at the end of the inquest on 23 September 2015. The conclusion of the inquest was that Madhumita Mandal died from multiple organ failure due to sepsis due to ruptured endometriotic ovarian cyst (recently treated with laparotomy). I recorded a narrative conclusion as follows: *Mrs Mandal suffered from an endometrial cyst and was awaiting surgical removal. She became unwell and attended Croydon University Hospital at about 7.20 a.m. on 7th September 2013. There were several cumulative delays in the Urgent Care Centre and Emergency Department in assessing and treating her, the Registrar did not appreciate the seriousness of her condition in spite of concerns raised by the junior doctor, and the consultant did not supervise his juniors or make himself aware of what was happening in the department. There were missed opportunities to take urgent steps that may have prevented Mrs Mandal's death, but the evidence does not disclose whether her death would have been prevented by earlier appropriate assessment and treatment.*
4	**CIRCUMSTANCES OF THE DEATH** Please see the narrative conclusion set out in paragraph three, which sets out the circumstances leading to the death. The subject of this report relates to events in the Urgent Care Centre, as set out in paragraph 5.
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 **MATTER OF CONCERN** is follows:- Mrs Mandal was taken to Croydon University Hospital by her husband. Virgin Care was contracted by the Croydon Clinical Commissioning Group to provide urgent care

	services, and to stream adult patients arriving at the emergency department. A streaming model was followed by a receptionist who had no medical training and who performed no medical observations. This led to a delay of about an hour before Mrs Mandal was seen by any qualified healthcare professional, by which time her condition was critical. The streaming model had been approved and commissioned in the contract as recommended by an NHS body called the Emergency Care Intensive Support Team. The system at Croydon has changed since Mrs Mandal's death but concerns remain about the level of qualification for assessment of patients, and there may be lessons for other Trusts who contract out the provision of urgent care. Mrs Mandal's' death also raises questions about the use of ambulance services. A difference in assessment of patients based upon their mode of transport to the emergency department may encourage patients to err on the side of calling an ambulance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd 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 Chief Coroner and to the following Interested Person: [redacted] (for the family) I have also sent it to Sir Bruce Keogh, National Medical Director, 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.
9	**DATE** 8th December 2015 **SIGNED** Imma Lynch