MR GRAEME IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex RM7 0AG
Email:</td></tr>
<tr><td>1</td><td>CORONER

I am Graeme Irvine, acting senior coroner, for the coroner area of East London</td></tr>
<tr><td>2</td><td>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</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 9th March 2020 this Court commenced an investigation into the death of Juliet Saunders, 25 years old. The investigation concluded at the end of the inquest on 30th April 2021. On 9th March 2020, this court commenced an investigation into the death of Juliet Saunders. The investigation concluded at the end of the inquest on 30th April 2021.

I made a determination of a short form conclusion of death arising from natural causes contributed to by neglect. The medical cause of death was:
1a Small Bowel Perforation
1b Volvulus
1c Intestinal malrotation
II Cornelia de Lange Syndrome</td></tr>
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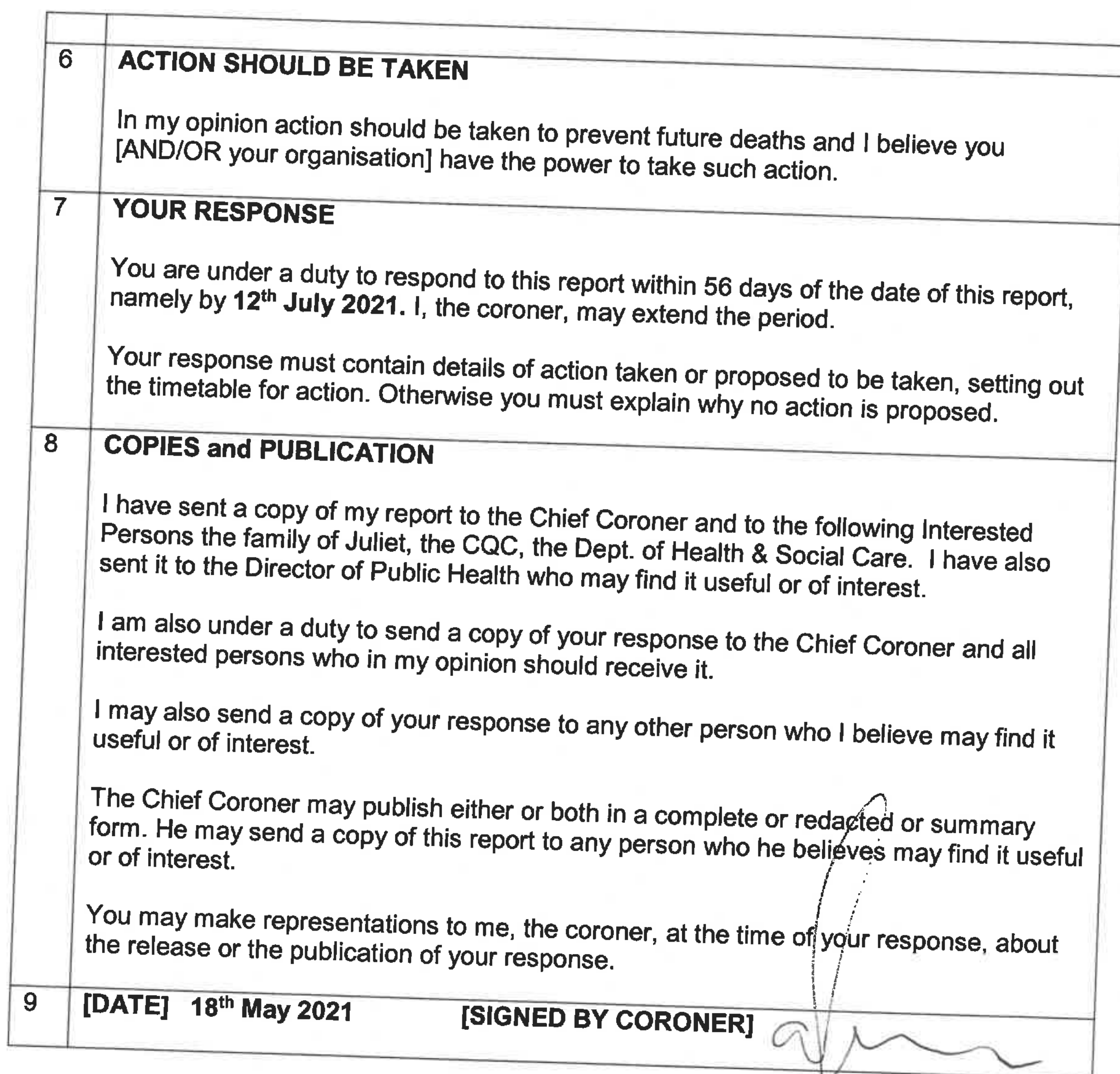
4	**CIRCUMSTANCES OF THE DEATH** On 7 March 2020 Miss Juliet Saunders a 25 year old woman with a genetic condition known as Cornelia De Lange Syndrome was admitted to the emergency department with abdominal pains and vomiting. Ms Saunders had a complex medical history, her congenital disorder caused a number of factors including a profound learning disability, and an increased likelihood of contracting an intestinal obstruction. Ms Saunders had also undergone abdominal surgery that increased the likelihood of intestinal herniation. Due to Ms Saunders' learning disability, no direct history could be taken from the patient. The Trust's trained learning disability nurses were not available to advice or assist staff as they do not work at weekends. The emergency department registrar examined Ms Saunders, arrived at a single queried diagnosis of gastritis and commenced a treatment plan. Abdominal x-rays showing signs of an intestinal blockage were misinterpreted by both the registrar and a hospital radiographer. The images were not escalated to a consultant. Blood test results which cast doubt on Ms Saunders' queried diagnosis of gastritis were not given sufficient consideration. Hospital policies for discharge were not properly followed which allowed Ms Saunders to be transferred to an observation unit without an assessment from a consultant. Miss Saunders was discharged from hospital, without safety-netting advice, she died at home on 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. 1. The absence of any support for staff within the emergency department during weekends, in dealing with patients with learning disability. 2. The poor standard of medical record keeping and documentation within the emergency department and observation unit. 3. The failure of systems within the department to allow for the supervision of junior doctors to ensure that complex cases are escalated to more experienced staff. 4. Consecutive failures by medical and radiological staff to recognise abnormal findings within an abdominal radiograph, impacted upon by diagnostic overshadowing. 5. A lack of clinical curiosity, combined with diagnostic overshadowing meant that there was a reluctance to depart from a queried diagnosis of gastritis which led to the failure to diagnose an acute intestinal obstruction. 6. A departure from established procedures to ensure the safety of transfers out of the emergency department onto the observation unit. 7. The absence of safety-netting advice to patients leaving the hospital. 8. Ineffective identification of significant care delivery problems through the Trust's own Serious Incident Investigation process, leading to a finalised report of poor quality.



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 **12th July 2021.** 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 Juliet, the CQC, the Dept. of Health & Social Care. I have also sent it to the 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] 18th May 2021** **[SIGNED BY CORONER]**