Regulation 28: Prevention of Future Deaths report

Lita SERKES (died 24.07.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Medical Officer** **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 27 July 2016 I commenced an investigation into the death of Lita Serkes, aged 80 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest that Lita Serkes died from a complication of a hysterectomy undertaken for endometrial cancer, being a devastating bleed, the gravity of which was not immediately recognised. I recorded a medical cause of death of: 1a intra abdominal haemorrhage 1b total abdominal hysterectomy and bilateral salpingo-oophorectomy for endometrial adenocarcinoma, on 22.07.16 2 diabetes mellitus, hypertension, right cerebral infarct

4	**CIRCUMSTANCES OF THE DEATH** The surgery performed at Whipps Cross Hospital on Friday, 22 July 2016, was unremarkable. However, the following morning, Mrs Serkes suffered a stroke and was transferred to the Royal London Hospital. By that evening she was extremely unwell, and she died on Sunday, 24 July.
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 Whipps Cross medical notes record normal observations, most specifically that Mrs Serkes was "alert" at 9.50am on Saturday, 23 July 2016. However, by that time, her son had been at her bedside for nearly an hour and had himself realised that Mrs Serkes had suffered a stroke. He saw no nurse conducting any observations at this time. Some five months on, no member of staff has yet addressed this discrepancy with the nurse who recorded the observations. 2. When Mrs Serkes' treating consultant gynaecological surgeon attended her at 10.30am on Saturday, 23 July, he formed the impression that he was the first person to diagnose the stroke. In fact, her son and another doctor had already discussed the stroke, and her son was under the impression that they were simply waiting for an ambulance to transfer to the Royal London Hospital. (He was already making arrangements to drive his father there.) None of this is recorded in the medical notes. 3. The decision was made by, at the latest 10.30am, but quite possibly an hour before then, to transfer Mrs Serkes to the Royal London Hospital for specialist care, but transfer was not effected until 2.07pm. Stroke is an emergency. 4. Patient controlled administration of pain relief was arranged for Mrs Serkes, but she remained in pain. It was quite some time before it was recognised that the device was not connected and so was not delivering any analgesia.

	5. Mrs Serkes' surgeon went to the Royal London Hospital to see her at 10.30pm on Saturday, 23 July. He described in court palpating her abdomen and there being no rigidity, guarding, or further distension. However, he made no record in the medical notes of his attendance and examination. 6. The same surgeon described in court his view that [static] imaging did not disclose any active bleeding and so there was no indication to return to theatre. However, later in evidence he agreed that the scans simply showed a collection of blood and could not demonstrate whether the bleeding was active. When I asked about the haemoglobin, he responded that at 3.04pm that afternoon, it was recorded as 7 (he said 7, not 70), having dropped from a normal level of 120. He explained that this result might have been available earlier, but the computers were down in the middle of the day. After further discussion, the surgeon told me that, given the 8cm haematoma he had diagnosed at the beginning of the day (Saturday, 23 July), he now believes that more efforts should have been made to review the blood results earlier, and in any event before Mrs Serkes was transferred to the Royal London Hospital. He said that if he had considered the blood results earlier in the day, he would have recognised a much bigger bleed than he actually appreciated. He said that he would probably have advised a further laparotomy – though of course there is no way of knowing if Mrs Serkes would have survived that. 7. The surgeon suggested that perhaps bloods should be taken routinely at 6am so that they are available for the ward round, though he was unsure whether the laboratory would be able to accommodate this.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 13 February 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], obstetrician and gynaecologist • [redacted], husband and son of Lita Serkes 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** 16.12.16