MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Medical Director, Barts Health NHS Trust, The Royal Hospital, Whitechapel Rd, London, E1 1BB [redacted] 2. The Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU [redacted] 3. [redacted], Chief Executive Officer, The Royal College of Surgeons, 38-43 Lincoln's Inn Fields, London WC2A 3PE [redacted] 4. [redacted], Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London, WC1R 4SG [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. 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 3rd October 2018 I commenced an investigation into the death of Mrs Surekha

	Pandharinath Shivalkar aged 78 years. The investigation concluded at the end of the inquest on 24th December 2021. The conclusion of the inquest was that Mrs Shivalkar, died from; 1a. Multi-organ Failure 1b. Complications arising during anaesthesia and hip revision surgery leading to hypotension and hypoperfusion in a woman with ischaemic heart and chronic obstructive pulmonary disease. A narrative conclusion was arrived at incorporating a finding of unlawful killing.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Surekha Pandharinath Shivalkar Was a 78-year-old woman who was scheduled for elective total hip replacement revision surgery. Mrs Shivalkar had a number of serious debilitating comorbidities including ischaemic heart disease, osteoporosis, and chronic obstructive pulmonary disorder. No formal assessment tool was used in the calculation of risk of death, consequently, an inaccurate risk of mortality was assessed as being less than 5%. Mrs Shivalkar was deemed suitable for surgery at a surgical centre that did not have high dependency unit facilities suitable for dealing with the critically ill patient in recovery. On 28 September 2018 Mrs Shivalkar underwent revision total hip replacement surgery under combined regional and general anaesthesia. The surgery was estimated to last 4 to 5 hours. The surgery was completed after a period greater than 7 ½ hours. During surgery, allowed Mrs Shivalkar to sustain a prolonged and dangerous period of hypotension. The anaesthetist failed to communicate this fact to the surgical team. After six hours of surgery, the anaesthetist was specifically asked if there was any reason that surgery ought not to be prolonged, the anaesthetist assented to the delay. Mrs Shivalkar was returned to recovery where she was found to be in a dangerously hypotensive state. The consultant anaesthetist assessed Mrs Shivalkar and failed to recognise her critical state, the patient was discharged from the recovery room. Upon being returned to the surgical ward, Mrs Shivalkar sustained a cardiac arrest, CPR was commenced and steps were taken for transfer to the local intensive treatment unit. Due to the remote location of the surgical centre there were delays in this transfer. Upon admission to the intensive treatment unit Mrs Shivalkar was found to be in multiorgan failure with a profound metabolic acidosis. Despite the efforts of the intensive treatment team Mrs Shivalkar sustained a further cardiac arrest and died.
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 could 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. No formal risk assessment tool was adopted to assess preoperative risk prior to Mrs Shivalkar's total hip replacement revision surgery. Despite policy changes at Barts Heath NHS Trust since 2018, there remains no

	requirement to utilise such a tool. 2. Poor communication between the orthopaedic surgical team and the anaesthetist during surgery led to a collective failure to identify a critically ill patient. General and non-specific questions regarding the patient's welfare passed between the two teams but no targeted questions requiring clear factual responses were asked. Had such questions been put, a different outcome may have arisen. 3. The Senior Consultant surgeon left the surgery prior to its conclusion, lengthening the procedure. The Consultant did not effectively communicate his reasons for leaving the surgery to the other members of the surgical team, neither did the surgical notes refer to his early departure. The Consultants statement to the court did not indicate that he had left the surgery before its conclusion. No system was in place to; assess whether a decision to leave surgery was appropriate, or to effectively monitor when a surgeon leaves theatre.
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 **4th March 2022**. 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 Mrs Shivalkar and to the CQC. I have also sent it to the local 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] 7th January 2022 [SIGNED BY CORONER]**