Barts Health NHS
NHS Trust

Chief Medical Officer
Trust Executive Offices
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
London
E1 2ES

Coroner ME Hassell
Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

6 February 2017

By special delivery

Dear Ma'am,

Inquest touching the death of Lita SERKES

I write in response to a Regulation 28, Report to Prevent Future Deaths, dated 16 December 2016, which was made at the conclusion of the inquest into the death of Lita Serkes. Barts Health NHS Trust takes Coronial investigations very seriously and I am sorry you have had to make Preventing Future Death recommendations and I am grateful to you for highlighting your concerns.

I note Lita Serkes died from a complication of a hysterectomy undertaken for endometrial cancer, that being a devastating bleed, the gravity of which was not immediately recognised. You have raised a number of concerns relating to the treatment received by Mrs Serkes.

The seven concerns you have raised in the Preventing Future Death report are:

1. The discrepancy in the observation charts relating to Mrs Serkes being 'alert' has not been addressed with the member of staff who recorded them.

2. There was incomplete documentation in Mrs Serkes medical records. Mrs Serkes' treating consultant believed that he was the first person to diagnose the stroke, however, Mrs Serkes son had already discussed this with another doctor. This conversation was not recorded in the medical records.

3. There was inadequate urgency in transferring Mrs Serkes to The Royal London Hospital on Saturday 23 July 2016. The decision was made to transfer Mrs Serkes at 10:30am but this was not effected until 02:07pm.

4. Mrs Serkes Patient Controlled Analgesia (PCA) system was not connected and this was not recognised for some time; leaving Mrs Serkes in pain.

POSITIVE ABOUT DISABLED PEOPLE

5. Mrs Serkes surgeon described in court a physical examination that he carried out at The Royal London Hospital at 10:30pm on Saturday 23 July 2016 – the details of this were not documented in the medical records.

6. You felt that there was an inadequate urgency in chasing the blood results; if these had been reviewed earlier in the day the surgeon would have recognised that Mrs Serkes bleed was much bigger than he originally appreciated and he may have advised further surgery.

7. The surgeon suggested that routine bloods 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.

We have investigated the above concerns and I can confirm:

1. The requirement of making contemporaneous and accurate recording of patient observations has been reiterated to all nursing staff via the Safety Huddle. The discrepancy in this instance has been discussed with the nurse in question and they have been asked to reflect on this incident and have been given appropriate training.

2. All medical staff have been briefed on the requirement for complete and contemporaneous recording of all events in a patient's medical records.

3. The Trust recognises that stroke is an emergency and that you feel there was inadequate urgency in managing Mrs Serkes stroke. As a result the Trust is currently in the process of reviewing the hospital policy for the management of stroke and is also reviewing the checklist of advice given by the Hyperacute Stroke Unit. The Trust is hoping that this will be completed by 01 April 2017.

4. To ensure that this doesn't happen again, the pain team is giving on-going training to all nursing staff in the use of PCA machines.

5. It has been reiterated to the surgeon in question the importance and the requirement for complete and contemporaneous recording of all events in a patient's medical records. He has also been instructed to reflect on this incident, to add it to his appraisal documentation and to discuss the incident at his next appraisal.

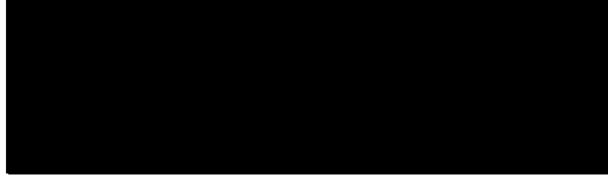
6. Again, the surgeon in question has been asked to reflect on this incident, to add to his appraisal documentation and to discuss at his next appraisal.

7. The Trust has reiterated to all medical staff the availability and option of using point of care tests when managing deteriorating patients. These are tests that can be carried out at the point of care ie. without having to send the sample to the laboratory. The Trust feels that by highlighting this option to all staff will ensure that investigations will be performed with the appropriate degree of urgency in the future.

We can provide you with a copy of the SI report once it is completed upon request; this will highlight the areas that we as a Trust felt could be improved upon in future and the steps that we are taking to do so.

I am once again grateful to you for bringing this case to my attention and I hope this letter fully answers the concerns you have raised.

Yours faithfully



Chief Medical Officer