Mid Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 28 February 2024
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Kent and Medway Integrated Care Board

1. CORONER

I am Catherine Wood, Assistant Coroner for Mid Kent and Medway

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 2 September 2022 I commenced an investigation into the death of Kerri Louise MOTHERSOLE. The investigation concluded at the end of the inquest . The conclusion of the inquest was:

Narrative "She died as a consequence of endometrial cancer, the diagnosis of which was delayed due to a number of factors."

1a Endometrial Cancer with Brain Metastases

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Kerri Mothersole was a 44 year old woman who had a past medical history of asthma,

labyrinthitis, depression and back pain. In May 2020 she was seen with symptoms of possible early menopause and blood tests requested. In October 2020 she was noted to be suffering from tiredness and had irregular periods and again blood tests were requested. Blood tests taken in January 2021 noted a low haemoglobin and ferritin so iron was prescribed as well as follow up in 2 months. In March 2021 she complained of having per vaginal bleeding for 6 weeks and she was referred for an ultrasound. Due to her underlying ill health she had difficulty in attending appointments and missed a number of different appointments. She was seen in the surgery on 21 June 2021 by her General Practitioner who noted abdominal tenderness and weight loss and he again referred her for an ultrasound. An ultrasound was undertaken by a private firm HEM Clinical Ultrasound on 28 June 2021 but the report was never sent to her General Practitioner. A second ultrasound on the 1 July 2021suggested a diagnosis of adenomyosis but noting that serious pathology could not be ruled out. Only the second report was sent to the General Practitioner which led to a routine gynaecology referral, she had however already been referred to the colorectal team on the urgent two week wait pathway. Had the earlier scan report been seen this would have led to an urgent referral to gynaecology.

There were a number of missed appointments and a colonoscopy took place on 20 October 2021. The procedure was negative but the endoscopist thought he could feel something in the pelvis and a CT scan was arranged. The CT scan on 28 October 2021 demonstrated a large pelvic mass and she was referred to the gynaecology team in early December and a multidisciplinary team meeting discussion on 17 December 2021 led to a request for an MRI scan. Appointments were made for 31 December 2021, 25 January 2022 and again in February but not attended and she eventually underwent an MRI on 1 May 2022 which revealed a large mass. She was again discussed at the multidisciplinary team meeting on 6 May 2022 and referred to the gynae-oncology surgeons at Maidstone hospital. She was seen on 1 June 2022 and booked for surgery on 27 June 2022. She was, however, far too unwell for surgery on 27 June 2022 and further investigations revealed brain metastases. She was admitted to hospital and treated with steroids and referred to the Oncologists as surgery was deemed no longer appropriate. She was prescribed hormone treatment but she was, by now, too unwell to receive even palliative radiotherapy. She was taken to Medway Maritime hospital on 19 August 2022 and was struggling as she had been so unwell at home. Whilst plans were being made to provide some care at home she remained overnight but sadly died on 20 August 2022 as she was so unwell she could not return home.

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 two reports from HEM Clinical Ultrasound Ltd on 28 June 2021 and 1 July 2021 and any images associated with the reports were not provided to any of the deceased's treating clinicians. Only the second report from 1 July 2021 was sent to her General Practitioner and not the first report from 28 June 2021. Neither report was uploaded to her clinical notes at Medway Maritime hospital or Maidstone hospital. Had the images and the reports been available to her treating clinicians then a more urgent referral would have been warranted by her General Practitioner and she may have been investigated and treated at a much earlier stage.

(2)The court heard that most of Kent have a system whereby imaging taken can be seen at more than one Trust and is even linked to tertiary referral centres in London. The system used

was referred to as the PACS system. Clinicians told the court that they could look up images for their patients taken at another hospital and this would impact on their decision making for a patient. Images taken in the community by private providers are not uploaded to the system but can be requested however this relies upon knowing that there were any images to access in the first instance.

(3) The managing partner at HEM Clinical Ultrasound Ltd gave evidence that she had been requesting that the imaging they took be made available on the central system. She was unable to explain why this had not been requested or set up or commissioned by the Integrated Care Board. All gave evidence that the lack of imaging being available meant that issues could be missed and this created a risk to patients, which at its extreme would include a risk of future deaths.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Integrated Care Board 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 30 April 2024. 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 Kerri Mothersole's son and her partner, Medway Maritime NHS Trust, Maidstone and Tunbridge Wells NHS Trust, HEM Clinical Ultrasound Ltd and Green Porch Medical Centre.

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.

5 March 2024

Signature 

Catherine Wood Assistant Coroner for Mid Kent and Medway