Walsall Healthcare NHS
NHS Trust

Our Ref: 2017/18552
Your Ref: Regulation 28 Report

Date: 11th October 2017

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Dear Mr Siddique,

Re: Dorothy Webb (Deceased)

Date of Birth: 05/03/1933
Date of Death: 05/05/2017
Date of Inquest: 16th August 2017

I am writing in response to your report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The conclusion of the inquest was natural causes but evidence emerged during the inquest of a missed opportunity to assess a scan which would have resulted in further identification of a "mass" and a failure to note a fracture from an x-ray during a previous admission. The investigation was unfortunately not complete at the time the inquest was held and I apologise for this. The report has now been completed and the findings and resulting actions have been used in my response to you. The Serious Incident investigation process has been amended with an expectation that investigation reports will be completed wherever possible before future inquests.

Circumstances of Dorothy Webb's death

1. Around December 2016, Mrs Webb's health began to decline and she was experiencing dizziness and had lost consciousness. She was admitted to Walsall Manor Hospital with a suspected stroke and a diagnosis of hyponatraemia (low sodium levels) and syndrome of inappropriate secretion of antidiuretic hormone diagnosed. She was later discharged on the 27 January 2017.
2. On 2 February 2017, she attended the same hospital after a fall. An x-ray was done and no fracture noted at the time.
3. The next hospital admission came in April 2017, when she presented with a history of expressive dysphasia and a transient ischaemic attack (TIA) was suspected. She

was treated and also commenced on antibiotics for a urinary tract infection before discharge.

4. She was re-admitted back to hospital on the 25 April after a further fall and on this occasion a fracture (wedge fracture at T12) was identified. Two CT scans were done but only one scan was examined by the Radiologist and consequently a right para-vertebral soft tissue mass on the CT scan wasn't identified.
5. On the 2 May she complained of chest pain and troponin levels were mildly elevated. She was found to be hypertensive and this was treated.
6. On the 4 and 5 May, she had several episodes of coffee ground vomit and at around 20:40 hrs. on the 5 May, she deteriorated rapidly and had vomited a round 500ml of coffee ground vomit which she immediately aspirated.
7. An emergency response was initiated and the suction machine used was ineffective but the Doctor treating her at the time does not believe she would have survived even if the suction machine had been effective because she was very frail and had very poor physiological reserves.
8. She sadly passed away a short time later.
9. After post-mortem, the tissue mass identified in the scan was confirmed as small cell carcinoma of Right Lung with Liver Metastases. This type of cancer is particularly aggressive and very difficult to treat and had spread from the lungs to the liver.
10. The immediate cause of death was heametemisis (vomiting of blood) in conjunction with aspiration blood-stained vomit/gastric contents into the blood. There was evidence of a small distal oesophageal mucosal tear from episode of retching and vomiting. The low blood sodium levels and the development of inappropriate antidiuretic hormone secretion can be caused by the small cell carcinoma.

Coroner's concerns

During the course of the inquest the evidence revealed matters giving rise to concern and a risk that future deaths will occur unless action is taken.

The **MATTERS OF CONCERN** were identified as follows. –

1. Evidence emerged during the inquest that there was a missed opportunity and failure by the Radiologist to assess the scan which would have resulted in further investigation of the "mass" that was identified. Although this may not, on the balance of probability prevented the outcome, it may well have resulted in further medical investigation and treatment.

2. There was also a failure to note a fracture from the x-ray during the admission in February 2017 and consequently the patient and family were unaware of its existence until the re-admission in April 2017

Preventing Future Deaths – Action for Walsall Healthcare NHS Trust

Specific areas for action were identified at the conclusion of the Inquest and a Preventing Future Deaths report has been issued to the Trust:

1. In relation to the failure to note the scan results, you may consider re-visiting your procedures and systems to ensure that this is not replicated as part of your internal serious incident investigation.

As part of the Serious Incident Investigation (provided with this letter) we identified the following issues and contributory factors:

Issues Identified

- Individual reporter errors in failure to review previous investigations with a high degree of suspicion to aid in identification of issue.
- Presentation of images and reports discrepancy between CRIS and PACS causing images of T-Spine to not be reviewed by reporter.

Contributory Factors

- Failure to use urgent red flag notification on CT spine 02/02/2017 regarding depression of T12 in spine to alert clinicians to report.
- Composition of images making interpretation difficult due to patient factors such as positioning.

Another finding relates to the delay in providing a Serious Incident report before the inquest. From now onwards, where a complaint letter suggests that a case might also be an incident; this will be taken to the next SI meeting for a decision. Whenever there is a multi-stemmed case, for example a complaint is also an incident and has been listed for an inquest, we will hold an initial meeting to work out the timeline and responsibilities for each team so that there is a plan to deliver the investigation and report without unnecessary gaps. Our aim is to complete an investigation before the Inquest is held so that we can discuss the findings with the family and also provide the completed report to you in good time.

Actions Taken

The following are the key actions taken in response to this incident in order to improve the reliability and safety of our systems and minimise the risk of further incidents:

- To ensure the system for imaging discrepancy and error rate monitoring is robust to assure that individual errors in reporting are monitored to ensure they are in accordance with Royal College guidelines and identify individual training issues which require further support we have established individual Consultant Radiologists error and discrepancy monitoring rate to highlight practice issues and where training and development is required.

- The CRIS and PACS records presented in a different order – CRIS (the Radiologist's reporting system) shows the images in newest to oldest order while PACS (the system that holds the images) shows in the oldest to newest order. The PACS manager investigated whether the system could be configured to reverse the order of image presentation to match CRIS. It cannot so additional training has been provided to all reporters.

- To ensure that the red flag system is used where it is required regardless of referrer or modality, colleagues have been provided with feedback from this incident and reminded to follow the policy.

- A review of the individual's practice was undertaken and the error rate was below that which requires remedial action.

- A 'Lessons Learned' bulleting has been produced to use this incident to remind clinicians across the trust of their professional responsibility to review and act on all requested investigations regardless of if they are identified as being urgent.

Finally, and on behalf of the Trust, I would like to take the opportunity to offer our sincere condolences to Dorothy Webb's family for their loss and apologise for both our failure to assess the scan which would have resulted in further investigations and the failure to note the fracture from the x-ray taken during the admission in February 2017.

I trust that the actions set out in this letter will provide you with the assurance that we have responded constructively and with the seriousness required to improve the care we provide.

Yours sincerely

Richard Kirby
Chief Executive