MEDICAL DIRECTORS OFFICE

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PRIVATE & CONFIDENTIAL

Ms Patricia Harding
Senior Coroner for Mid Kent and Medway
Kent Register Office
The Archbishop's Palace, Palace Gardens
Mill Street
Maidstone, Kent
ME15 6YE

Dear Ms Harding,

Regulation 28 Report to Prevent Future Deaths – Betty Tadman

We now respond to the Assistant Coroner's concerns set out in the Regulation 28 Notice dated 1st February 2021. The events took place in early November 2018 and the Trust is committed to sharing any learning which arose from the events and the inquest heard on 21 January 2021, as set out below.

1. Coroner's Matters of Concern

1.1. Mrs Tadman had dementia and a long term catheter and was admitted to hospital with a pre-alert for suspicion for urosepsis that was treated appropriately. However, urine dipstick tests were only positive for blood and consideration was not given to the circumstances in which she was found with a history of a fall.

1.2. Evidence was heard at the Inquest that ambulance crew noted and handed over that Mrs Tadman's left leg was rotated but not shortened. Mrs Tadman could not stand or mobilise to use the commode in hospital. No consideration was given to a potential fracture injury.(*The Trust wishes to point out that in fact the ambulance record documented shortening but no rotation)*

1.3. Mrs Tadman was an elderly lady with a medical history of osteoporosis who fell from a standing height. No imaging was conducted on admission to hospital to establish if Mrs Tadman had sustained an injury.

1.4. Swelling in the calves gave rise to a suspicion of potential deep vein thrombosis and Dalteparin was prescribed. Physical examination was over reliant on the lack of complaints of pain in a patient with dementia in the absence of imaging.

1.5. There was not consideration of potential fracture or internal bleeding in the presence of dropping of haemoglobin and continued deterioration.

1.6. The Trust did not conduct a serious incident investigation following Mrs Tadman's death when the post mortem cause of death established a pelvic fracture with severe haemorrhage. Evidence heard at the Inquest confirmed that this case was not discussed at the Trust's morbidity and mortality review or any other forum giving rise to concerns that lessons had not been learned.

2. Trust Response to points 1.1-1.5

2.1. The Trust accepts there were multiple opportunities where symptoms of a traumatic injury and occult haemorrhage were missed despite repeated blood tests showing a decreasing haemoglobin level. These appear to be at individual nursing and medical assessments which failed to consider a differential diagnosis as the clinical focus was on possible uro-sepsis and DVT symptoms. There was an incorrect interpretation of the D-Dimer test which could have also been explained by an undiagnosed fracture and haemorrhage. The vast majority of pelvic fractures are managed conservatively with analgesia and physiotherapy: however it is accepted that the post mortem indicated a rare Young-Burgess AP1 fracture. Investigations should have been undertaken to explore the possibility of an underlying traumatic injury.

2.2. Prior to the Covid pandemic, extensive staff teaching and training had already been undertaken on improving trauma care of the elderly with a focus on the emerging evidence-based pathway of "silver trauma" care. This training programme, which included simulated exercises, is currently suspended but will be resumed shortly.

2.3. The Trust is committed to implementing the "silver trauma" screening system in ED for frail patients presenting with 'low energy' trauma with an assessment led by a senior clinician (ST 4 +) if there are any red flag signs for escalation.

2.4. The facts and identified failures in this matter will be presented as a case study at a Multi-disciplinary Grand Round session, as soon as they resume, for teaching purposes when clinicians will be reminded that D-Dimers are not to be used in isolation but in conjunction with the recognised screening tool.

2.5. The Trust plans to adopt the London Major Trauma System; Management of Elderly Major Trauma Patients – Second Edition whereby trauma units use an effective screening triage tool on elderly patients who self-present or arrive by ambulance and this prompts an immediate senior doctor (ST4+ level) review for assessment. Since November 2018, we have already introduced a "front door" team of specialist nurses to assess elderly frail patients upon arrival in ED to expedite their transfer to the ward or escalate for medical advice or discharge as appropriate.

Trust Response to point 1.6 above

2.6. Since publication in July 2018 of the National Quality Board (NHSE) Learning from Deaths Guidance, the Trust Board is committed to embedding a culture of learning and ensuring effective implementation of all aspects of learning from death. The Trust Mortality Team has initiated a system with the local Coroners Court to ensure all post mortem reports are now disclosed promptly following any patient's death in hospital. The Medical Examiner also now reviews PM Reports, to ensure that any concerns are highlighted through the Trust's Patient Safety programme via a link with the Trust Learning from Deaths Team. All post mortems will now be shared with the doctor making the referral to the Coroner and the responsible Consultant.

Yours sincerely,

Dr [redacted]
Chief Medical Officer

Best of care
Best of people