National Medical Director
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Ms Patricia Harding
Senior Coroner
Coroner Service Team,
Cantium House,
Sandling Road,
Maidstone
ME14 1XD

5th October 2020

By email: KentandMedwayAdmin@kent.gov.uk

Dear Ms Harding,

Re: Regulation 28 Report to Prevent Future Deaths – Lynda Pedersen

Thank you for your Regulation 28 Report dated 15th May 2020 concerning the death of Ms Lynda Pedersen on 7th September 2018. Firstly, I would like to express my deep condolences to Ms Pedersen's family.

The regulation 28 report concludes Ms Pedersen's death was a result of complication of an undiagnosed but untreatable adenocarcinoma of the oesophagogastric junction. The Matters of Concern arising from that inquest are as follows:

1) Lynda Pedersen was admitted to William Harvey Hospital on 6th September 2017 with dysphagia. A gastroscopy conducted two days later identified a stricture within the oesophagus with the appearance of the mucosa suggestive of a submucosal infiltration. A CT scan did not identify a malignancy but indicated that the area of concern could not be evaluated as it had not been distended by the orally ingested contrast. Lynda Pedersen had a number of further gastroscopies to attempt to dilate her oesophagus between 2017 and 2018 some of which reported a benign appearance but the cause of the stricture was never investigated despite the risk of variceal bleeding having been significantly reduced by a TIPS procedure having been conducted on 11th October 2017. It was accepted that a biopsy should have been undertaken but the need for investigation as to whether there was a malignancy was lost in that the clinicians' focus was on attempting to improve her nutritional status and quality of life. The reason for the loss of the need for an investigation was twofold: there was no pathway in place for dysphagia presentation caused by a stricture and the fact of multiple presentations. It was agreed by the treating clinicians and an independent expert that had there been a pathway in place, the investigation for cancer was less likely to have been lost. The clinicians who gave evidence at the Inquest were of the view that this was a matter most appropriately addressed by NHS England and NHS Improvements.

2) Fluid balance charts were not correctly completed in the period leading to Lynda Pedersen's death. The evidence from the fluid balance charts showed that she was carrying fluids forward until the time of her death; there being an imbalance to the tune of some 3 1/2 litres. That there was a significant fluid overload was also evident from the pathology. That she had a fluid overload was only identified by the hospital at a time that she was temporally close to death. It was accepted at the inquest that the charts were deficient in their completion, that nursing staff had not recorded output properly or reconciled the balance as required.

While it is not the role of NHS England and Improvement to develop clinical pathways for conditions such as oesophageal stricture, other national bodies have done this. For example, the British Society of Gastroenterology 2018 guideline on managing dysphagia states: "*obtain biopsies from all strictures to exclude malignancy*" and "*repeat biopsy after cross-sectional imaging in cases where biopsies are negative but clinical or endoscopic features are atypical or suspicious of malignancy"*.

It is common practice for multidisciplinary team meetings to be held to discuss patients with complex presentations, such as Ms Pederson, who had dysphagia but also presented a bleeding risk in view of her liver disease. I would hope that this case has been used at the Trust as the basis of reflection, learning and action to reduce the risk of a similar situation arising again in the future.

Thank you for bringing these important issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

Professor [redacted]
National Medical Director