REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. EAST KENT UNIVERSITY HOSPITAL NHS TRUST** **2. NHS ENGLAND NHS IMPROVEMENTS**
1	**CORONER** I am Patricia Harding, Senior Coroner, for the Coroner area of Central and South East Kent
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.
3	**INVESTIGATION and INQUEST** On 19th September 2018 I commenced an investigation into the death of Lynda Pedersen age 60. The investigation concluded at the end of the inquest on 26th February 2020. The conclusion of the inquest was a narrative conclusion that Lynda Pedersen died of a complication of an undiagnosed but untreatable adenocarcinoma of the oesophagogastric junction
4	**CIRCUMSTANCES OF THE DEATH** Lynda Pedersen died on 7th September 2018 on Oxford Ward William Harvey Hospital from aspiration pneumonitis, pneumonia and fluid overload due to a stricture caused by an adenocarcinoma of the oesophagogastric junction against a background of alcoholic liver disease. During the course of her admission she received necessary intravenous fluids but became overloaded with fluid which impacted on lung function. The adenocarcinoma was not identified on this admission or at any earlier time whilst she was under the care of medical practitioners following an admission in September 2017 for dysphagia. The stricture was identified
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 could 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) 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **13th July 2020**. 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 Graystons Solicitors representing the family, King's College Hospital NHS Foundation Trust. I have also sent it to who may find it useful or of interest. 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.
9	**[DATE] 10th March 2020 Revised 15th May 2020 [SIGNED BY CORONER]**