ABIOLA DOSUNMU DECEASED: INQUEST 16.04.14
RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Matters of Concern

1 The 3+ proteinuria discovered in A&E was not communicated to the ward.

There is both a training issue and an issue regarding the use of electronic patient records at the Trust (raised as a recommended action in the SI report at item 1b).

a) Training issue: Whilst it is not uncommon to have a trace/+ proteinuria on a urinalysis in a patient with a systemic infection, 3+ proteinuria on a urine dipstick should be recognised as abnormal and needing further investigation. In this case, the result was transcribed to the paper version of the medical admission proforma but not relayed to the inpatient team or noticed by them. The doctors involved in relaying this information no longer work at the Trust, but the Trust will refer the case to be included, as a reminder of the significance of this finding, in the formal teaching of Foundation doctors. The incident has already been shared at departmental governance meetings.

b) Electronic records: The Trust supports the initiative from the Emergency Department (ED) to introduce point of care testing (POCT) to allow a faster turnaround of results and also an electronic transfer of results from ED to the ward. POCT has been planned for some time and subject to issues around assurance of the results and the IT interface, this should be in place by December 2014. In the interim, and in response to this incident, ED has revised the transfer checklist for patients being admitted to include results of tests done in ED. The checklist is appended to this report.

2 The Trust failed to communicate the significance of the persistently raised ESR and CK to the patient and family

The medical records (in particular the clinical noted dated 09.03.12 at 13.25 hours) suggest that the Trust communicated the significance of Abiola's illness as it was understood at the time and did its best to dissuade her from leaving hospital. The Trust is satisfied that it acted appropriately by warning Abiola and her mother of the serious consequences of self-discharging. Nonetheless, with immediate effect consultants will be notified within 12 hours that their patient has discharged themselves from hospital to minimise the potential risk to the patient or others (see also paragraph 5 below).

3 The Trust failed to send the GP a discharge summary or communicate to the surgery the significance of the raised ESR and CK and the need for further monitoring.

a) *Failure to send a discharge summary*: A discharge summary should have been completed when Abiola self-discharged. As a result of this case, the Trust conducted an audit which showed that it is not consistent practice to issue discharge summaries for self-discharging patients. This issue was

discussed with the Medical Director at the Trust's Serious Incident Committee on 26.06.14 and with immediate effect, discharge notifications will be produced for patients who self-discharge.

b) *Failure to communicate the significance of the raised ESR and CK and need for further monitoring to Abiola's GP*: The Trust contacted the GP by telephone informing the GP that Abiola had self-discharged, recommending oral antibiotics and stressing the importance of IV antibiotics and need for her to attend ED if her condition deteriorated. The Trust also notes that ED generated, and the GP received, a 4 page discharge summary which included (because it was generated on 9 March 2013) the abnormal results identified during Abiola's admission.

Had a discharge summary been produced by the inpatient team associated with her self-discharge, this would also have included these results and any recommendations about further investigations/monitoring. Please see 3(a) above for the action proposed by the Trust to address this concern.

4 Despite the exceptionally high ESR, elevated CK of which no cause was found and proteinuria, a diagnosis of cellulitis was preferred to that of a connective tissue disorder. The opportunity to treat her SLE was missed due to failure to diagnose the condition, whilst recognising that diagnosis was hampered by her self-discharge.

Had the consultant been aware of the proteinuria at the post-take ward round, further tests would have been carried out.

The actions that the Trust proposes to take in relation to this concern are set out in response to your first concern.

5 Before discharge neither the patient nor the imminent self-discharge were known to the consultant, who would have wished to be informed and would have sought further investigations and communications.

It is not currently standard practice for Trust consultants to be informed of self-discharging patients. This issue was raised with the Medical Director at the Serious Incident Committee on 26.07.14 and it is now agreed that with immediate effect, consultants will be notified within 12 hours that their patient has discharged themselves from hospital, to minimise the potential risk to the patient or others.

6 Concerns (2), (3) and (5) above were not considered by the Serious Untoward Incident Investigation.

(2) The SI report concluded that a working diagnosis of cellulitis was reasonable. On that basis, your second concern was not considered a concern for the reasons set out above.

(3) A discharge summary was generated by ED and sent by email to Abiola's GP. The SI report should have addressed the failure to send a second discharge summary to the GP. This has now been addressed under 3 above.

(5) The SI did not identify this as a concern because it is not currently standard practice for Trust consultants to be informed of self-discharging patients. The Trust has now addressed this concern at paragraph 5 above.