East Kent
Hospitals University
NHS Foundation Trust

FAO:
Patricia Harding
Senior Coroner
Cantium House
Maidstone, Kent
ME14 1XD

Dear Madam,

Regulation 28: Prevention of Future Deaths Report arising from the inquest into the death of Lynda Pedersen who died on 7th September 2018

Thank you for your Regulation 28 Report dated 10th March 2020, revised 15th May 2020 pursuant to paragraph 7 (1) of Schedule 5 to the Coroners and Justice Act 2009, setting out your concerns.

I would like to begin by expressing to Mrs Pedersen's family my condolences and on behalf of everyone at East Kent Hospitals University NHS Foundation Trust (EKHUFT) for Mrs Pedersen's death.

I hope that this reply will be helpful in detailing the consideration given and actions taken to address the matter of concern in your report, and the ongoing work to make improvements within our services.

Our response to your concern details the actions taken or to be taken. The implementation and auditing of this work will be the responsibility of the Trust Board's Quality and Safety Committee.

Matter of Concern

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.

Our response

The Trust is focused on improving how we monitor fluid balance through the completion of fluid balance charts in all areas of the Trust. We have addressed this through supporting our clinical leadership teams in understanding their roles and responsibilities to ensure best practice in their wards by medical and nursing teams. We have undertaken multi-disciplinary education programmes on the importance of accurate fluid balance monitoring and regularly audit of the completion of fluid balance charts.
Our Deteriorating Patient Group leads on monitoring audit results regarding accurate completion of fluid balance charts with ward managers taking responsibility for their results and making improvement where required.
In addition, all our clinical staff complete clinical induction days to ensure they understand the importance of completing fluid balance charts and reviewing these daily and our critical care outreach teams provide support and teaching to ward staff on the importance of completing fluid balance.
This concludes our response to your concern.

We will learn wherever possible from concerns such as this and we will continue working to improve the services we offer to the population we serve. I can assure you that East Kent Hospital University Foundation Trust Board will be receiving regular updates on the progress of the actions set out in this response.

My thoughts and those of my colleagues at East Kent Hospitals remain with Mrs Pedersen's family and we are very sorry for our failings in her care.

Yours sincerely

Chief Executive