East Kent Hospitals University
NHS Foundation Trust

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[redacted]

PRIVATE & CONFIDENTIAL
Sonia Hayes
HM Assistant Coroner
Cantium House
Maidstone
ME14 1XD

16 December 2022

Dear Madam

Mr Keith Dimond - PFD Response

Thank you for your Prevention of Future Death Report dated 22 October 2022 sent pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 concerning the death of Mr Keith Dimond on 24 November 2021.

I understand that during the course of the inquest you heard evidence that revealed matters giving rise to various concerns that need to be addressed by the Trust to prevent a future death. I will address your concerns in chronological order:

1. **Treating Clinicians stated they were not aware of the diagnosis of Iliac Artery Aneurysm previously made at the Trust in August 2019 even though this was set out in the medical records and made at the same time as the diagnosis of Aortic Abdominal Aneurysm that was known. Abdominal surgery and anticoagulation were undertaken without consideration of this information.**

   The treating clinical teams should be aware of any previous medical conditions. This should be part of clinical history taking and a review of previous medical conditions available in the Trust patient document.

   The Trust has become more digitally mature as an organisation; there have been several developments which have significantly improved the clarity and accessibility of our medical records. In October 2020, we launched Sunrise which provides ordering and viewing of test results. This was followed by the introduction of moving the documentation of the A&E clinical notes onto this system. Following on from this in June 2021 Sunrise was launched onto the wards for all clinical documentation and now includes patient clinical observations (blood pressure, heart rate etc). These significant improvements enable the clinical teams to access digitally the clinical notes and important results in one place which are accessible from anywhere within the organisation. We continue to strive to improve the Sunrise system to support the quality of our record keeping and patient safety and are revisiting training to ensure all clinicians know how to access all parts of the clinical record.

In addition, our surgical site leads are ensuring all the clinicians in the department including seniors, understand their responsibility regarding accessing of medical records in line with GMC good medical practice and this will also be part of our induction for new staff. This case will be discussed at departmental morbidity and mortality meetings Trust wide for additional learning and the individual clinicians involved to include their personal reflection and learning within their annual appraisal.

2. **The patient was discharged on 19 October 2021 with a new diagnosis of Atrial Fibrillation and prescription of Direct Oral Anticoagulant Apixaban was prescribed. The patient was not given any written advice on the risks as to bleeding on this medication and the risks were not shared with family on discharge. This led to advice being sought from 111 and a long delay before 999 was called when the patient deteriorated on 22 October 2021.**

   I can confirm that the Trust is in the process of creating and implementing a generic anticoagulant patient leaflet, which will be provided to patients upon discharge from hospital. The leaflet will cover information around risks of bleeding, signs and symptoms to look for in terms of bleeding and when to seek medical attention. The leaflet is due to be finalised by the end of March 2023.

3. **Anti-coagulation on readmission was considered complex and the advice of a Consultant Haematologist was sought but not followed on two occasions:**

   a. **Beriplex and Vitamin K was administered. There was no rationale noted as to why advice to withhold Beriplex was not followed.**

   b. **There was no record as to why advice to give prophylactic clexane was not administered.**

   It is good practice for all clinical teams to seek advice from the haematologist regarding anti-coagulants if considered complex. Since this incident, we have communicated the importance of documenting who made the decision and the rationale behind withholding treatment that has been advised by the haematologist, for example in response to a rapidly changing clinical picture or additional information coming to light, to all clinical teams. This has been through via training and written communications from the clinical director. This element will also be included within the team learning review at the morbidity and mortality meetings for shared learning.

   In addition, we will be providing further training to all clinical teams on how to use Careflow effectively and ensure that the clinicians monitor this platform. Careflow is an online system which logs advice and notifications from the clinical team about a specific patient. As well as providing training, our clinical directors have disseminated the importance of reviewing Careflow to the clinical teams in our morning meetings and followed up in writing.

4. **The Consultant Haematologist confirmed that if information of the existence of an Iliac Artery Aneurysm had been shared, they would have sought the advice of a Consultant Vascular Surgeon.**

   We accept that the importance of any referral made by a clinician should contain accurate information so that it is understood and acted upon by the responsible clinician. This has been communicated with the clinical directors who have disseminated this information to their clinical teams. In addition to this, it is also being communicated through the training sessions which are delivered to the clinical teams regularly.

I hope I have provided you with the relevant assurance that the Trust has taken your concerns seriously and we will continue to strive to offer high standards of clinical care to our patients.

Yours sincerely

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Chief Executive