United Lincolnshire Hospitals NHS
NHS Trust

HMC Mr Paul Cooper
Assistant Coroner for Lincolnshire
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Boston
Lincolnshire
PE21 7TQ

Legal Services Department
Trust Headquarters
Lincoln County Hospital
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[redacted]

Date: 31 August 2023

[redacted]

Dear Mr Cooper,

Inquest Touching the death of Elizabeth Oluwatofunmi AGBEJIMI

Thank you for providing us with a copy of the Regulation 28 Report to Prevent Future Deaths (**'the Report'**). This document is the response from the United Lincolnshire Hospitals NHS Trust (**'the Trust'**).

At the outset, the Trust would like to express our heartfelt condolences to Elizabeth's family and friends for their loss.

Response to issues raised by the Report

The Trust was not granted interested person status at the inquest, and as such did not have the opportunity during the inquest itself to provide the additional information to the Court and the family to provide the reassurances understandably now sought. It is however hoped that this information below will reassure the Coroner that the findings have been given serious consideration by the Trust and appropriate reflection and learning undertaken.

In writing this response, without direct access to the full content of your report, we have made the following positive assumptions:

- Your concern is that the abnormalities found on the venous blood gas sample taken on 12 June 2021 showed evidence of respiratory compromise that may have been a sign of the pneumonia which was diagnosed on Elizabeth's second admission and that the abnormalities found on the venous blood gas sample was not related to possible chronic but relatively stable problems.

- That the pneumonia was the consequence of immobility arising from injuries sustained from the falls which are attributed as the direct cause of death.

We note that the matters of concern in Paragraph 4 of the report relate to evidence given by the intensive care consultant [redacted] that the abnormalities demonstrated on the venous blood gas sample undertaken on 12th June 2021 were not investigated further. You have asked us whether there was or still is a training or communication issue.

We have taken the time to review the case notes carefully to address your concerns and identify potential learning points.

On 12 June 2021, the initial blood gas was taken at 13:17. A signature was placed on the results report. The signing of blood gasses by ED clinicians is standard practice as this denotes that a clinician has seen the gas results and acknowledges any abnormalities so that any further action required can be taken. There is no evidence of identification of the potential acute type 2 respiratory failure with chronic metabolic compensation documented in the clinical records. For context, an acute Type 2 respiratory failure is where arterial oxygen levels are low and carbon dioxide levels are high along with a low blood pH. The metabolic compensation refers to the bicarbonate levels which elevate to correct the reduction in pH caused by the high carbon dioxide levels. In this case, the venous blood gas test cannot however categorically diagnose an acute Type 2 respiratory failure as the oxygen levels are always lower on a venous sample, and arterial oxygen levels are always higher.

High carbon dioxide levels in a patient's blood can manifest as symptoms of drowsiness and confusion, which were documented symptoms in Elizabeth's case. We acknowledge that there was no documentation either on the gas result or in the notes requesting that the sample taken on 12 June 2021 be repeated after treatment to ensure this is not a spurious result or to demonstrate that treatment had been successful in correcting the abnormality.

We acknowledge that there is no documented plan to investigate the result further. Such investigations would include a chest x-ray which may have been helpful to identify an infection earlier. This may well be compounded if the clinician checking the gas is not the clinician seeing for the patient and therefore, they do not have the benefit of a full clinical picture of the patient's symptoms as they have not been adequately documented

A decision to admit Elizabeth under the medical team was made at 14:45. Review of the notes from the Emergency Department ('ED') doctor who saw Elizabeth do not refer to the blood gas result at any point but did make a provisional diagnosis of an infection as a cause of her symptoms. The ED doctor recorded Elizabeth's low blood pressure and noted that this may constitute infection despite the normal blood values. They also made note of Elizabeth's lethargy which is then subsequently commented on by the medical team. Antibiotic therapy was commenced which would typically cover both the suspected urinary symptoms and a respiratory infection which was suspected as the cause of her symptoms.

It was noted that Elizabeth was to be seen by the medical team at 16:30 and again at 20:00. They note an increasing level of consciousness returning closer to baseline, but a venous gas taken at about 17:00 demonstrates a worsening of the original values. The notes indicated that the medical team identified issues which would require input from the orthopaedic team. There is then discussion in the notes which ends with the medical team concluding that there was no further medical input required to treat the potential infection identified by the emergency team and Elizabeth was transferred to the orthopaedic ward. Elizabeth was discharged from the orthopaedic ward at 00:45 following a stay of 12 and a half hours.

Learnings and Actions

Upon reviewing the case we can see that there are two main areas of learning which we are committed to improving.

1. <u>Ensure better documentation of the identification of the abnormalities on the blood gas results</u>

   All ED clinicians who are acknowledging blood gas results are now required to document:
   - any abnormality that needs further management and
   - the planned further management for example by prescribing medications, documenting an x-ray request or documenting a request for a repeat gas.

2. Ensure clinicians recognise the potential altered response to infection seen amongst those affected by Trisomy 21.

   We see this as an educational opportunity to ensure that clinicians recognise the potential altered response to infection seen amongst those affected by Trisomy 21. A significant infection can manifest very differently in this group and a lower threshold for investigation and admission for these patients is prudent.

   This will be communicated onto the ED Team and other teams involved in this case along with a reminder to admitting teams to fully review the ED notes.

In order to assure that these processes have been embedded, the clinical audit team in both ULHT departments will undertake an audit of blood gas results and the documentation in them to review the learning and actions have been embedded.

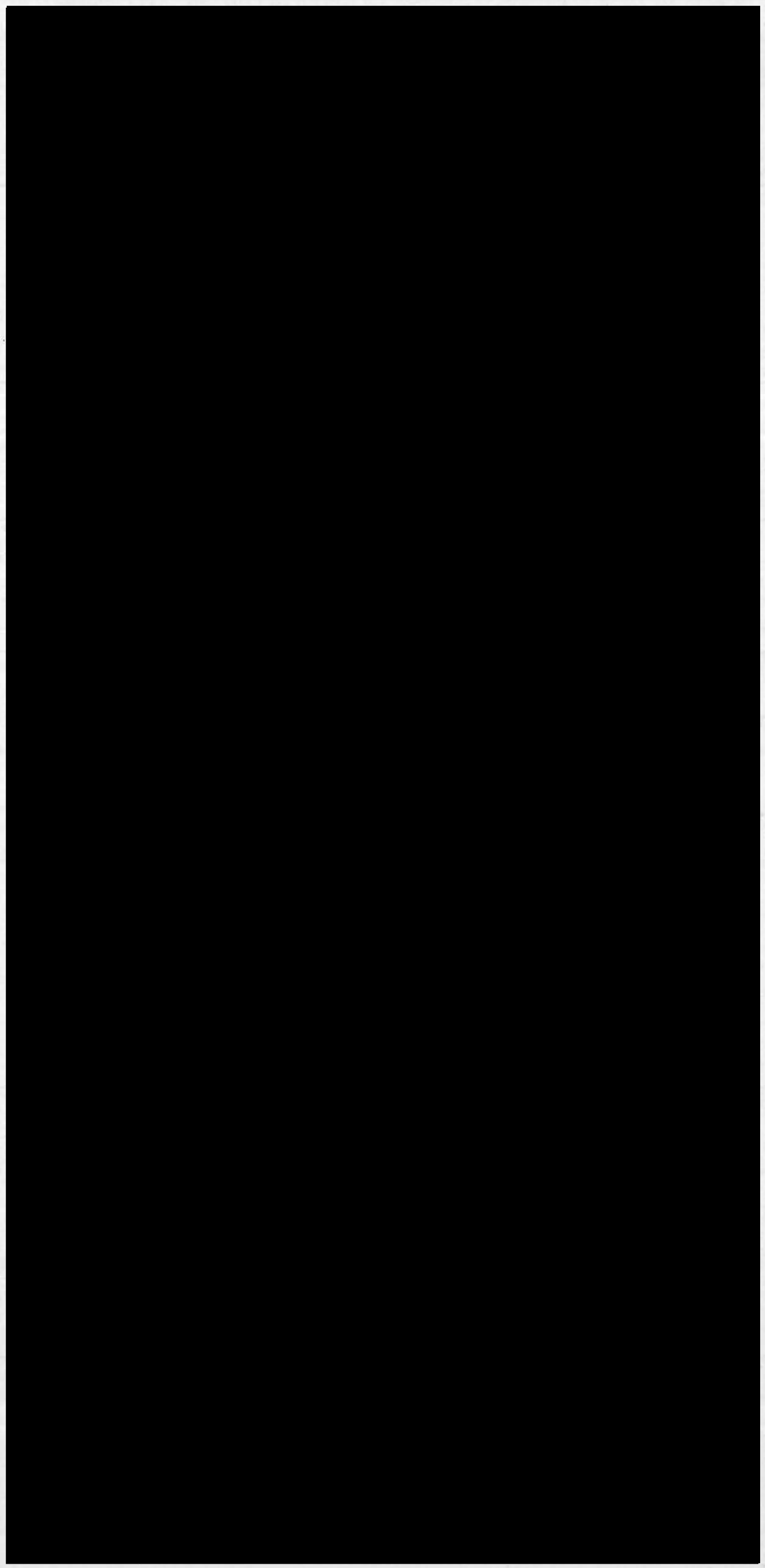
We understand that documentation and communication between clinicians is incredibly important for patient safety and we are committed to continue to use adverse events as learning opportunities to ensure ongoing patient safety and continual improvement.

We hope that this response is satisfactory and addresses the concerns you have outlined.

Yours Sincerely,

[redacted]

Medical Director



[redacted]

Subject: Fw: Draft PFD response - 25_8_23.DOCX

Pleas see attached - for governance input

Need to audit blood gas results in 6 months

- look at all VBG taken
- Highlight abnormal
- Look at documentation of abnormal
- Present results please

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OUTSTANDING CARE *personally* DELIVERED