NHS
Hampshire Hospitals
NHS Foundation Trust

Management Offices
Basingstoke and North Hampshire Hospital
Aldermaston Road
Basingstoke
Hampshire
RG24 9NA

By e-mail only to: hampshirecoroners@hants.gov.uk

12 March 2018

Chief Coroner
Coroner's Office
Castle Hill
Winchester
SO23 8UL

Dear Sir

Inquest in relation to the death of Mrs Joan Betteridge

I acknowledge receipt of the Prevention of Future Deaths Report dated 26 January 2018 (the "Report"), issued by the Assistant Coroner for Central Hampshire Ms Harrold to Hampshire Hospitals NHS Foundation Trust (the "Trust"), under paragraph 7, schedule 5, of the *Coroners and Justice Act 2009* and regulations 28 and 29 of the *Coroners (Investigations) Regulations 2013*.

Firstly, on behalf of the Trust, I offer my condolences to the family of Mrs Betteridge, to whom I am very sorry for their loss.

I note the two concerns raised by the Assistant Coroner in the Report, the second of which requires a response from the Trust and the other of which is to be responded to by Park & St Francis Surgerys. I set out below the concern which relates to the Trust, together with our response.

"Trust to explore potential IT changes to automatically capture an Xray request made by an ED doctor"

My understanding of the issue raised by the Assistant Coroner is that it relates to how the location of x-ray requests are recorded when made though the electronic reporting system ICE.

There are two ways to make such requests:

1. ICE via the electronic patient record (ePR). The clinician will need to manually select a location for the request, for example the emergency department. This is because there is no default location.

2. A desktop version of ICE. There is a default location set for desktop computers based on their physical location, for example the emergency department. At log-in, the clinician is prompted to check the default location and ensure the correct location is selected.

A factual finding at the inquest was that the request for Mrs Betteridge's hip x-ray on 31 May 2017 was incorrectly mapped to [redacted] a short stay in-patient ward next to the emergency department in Winchester). The request should have been mapped to the emergency department because this affected the timing of radiological review and reporting.

The Assistant Coroner heard evidence at the inquest from Mr [redacted] Director of Surgical Services, about some possible reasons as to how the incorrect request location might have come about. Subsequent investigation by Mr [redacted] Chief Information Officer, has confirmed that the request for Mrs Betteridge's x-ray on 31 May was made through a desktop version of ICE on a computer in the emergency departmet which had a default location of [redacted]

The default location on that computer has since been changed to the emergency department. I am pleased to confirm that the other computers in the emergency department that are used for accessing ICE were already set to the correct default location.

[redacted] Clinical Lead for Emergency Medicine, has also confirmed that the clinicians working in the emergency department have been educated on the importance of correctly recording the location of the requests, since this directly affects the timeframes for radiological review and reporting of images.

I am confident that these changes will mitigate the risk of a similar incident occurring in the future.

I trust that this provides assurance that the concerns raised by the Assistant Coroner have been investigated and promptly addressed by the Trust. Should there remain any further concerns, I would welcome the opportunity to address these for you.

Yours faithfully

Alex Whitfield
Chief Executive