NHS
City Hospitals Sunderland
NHS Foundation Trust

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***Private & Confidential***

Derek Winter DL
Senior Coroner for the City of Sunderland
Civic Centre
Burdon Road
Sunderland
SR2 7DN

Dear Mr Winter,

**Regulation 28 Report – Ms Susan Joan Elliott**

I write further to your correspondence dated 6th August 2018 regarding your concerns identified during the inquest into Ms Susan Joan Elliott's death.

I enclose with this letter an action plan which confirms: a) the actions that will be taken by the Trust in response to your concerns; b) the target dates for completion of those actions; and c) the Officers with responsibility for progress of the actions.

You will recall that one of the witnesses in his evidence at Ms Elliott's inquest, suggested that Ms Elliott's radiograph of 4th August 2017 was "reported and ignored". I would like to reassure you that following a thorough internal investigation, I can confirm that both the radiograph and the associated radiology report were viewed on our electronic system (Meditech) between 4th and 5th August 2017 by three different members of medical staff who considered the report alongside Ms Elliott's clinical presentation and status.

The radiology report was also viewed during the Emergency Department (ED) consultant's routine review of abnormal results on 9th August 2017. He immediately rang Ms Elliott's medical team to discuss the report with them who in turn contacted the Trauma & Orthopaedic (T&O) team, who advised that as Ms Elliott was at that stage mobilising well and not reporting pain, she could be discharged home as planned, but if she developed worsening pain she should return to hospital and have a CT scan. This advice was clearly outlined in Ms Elliott's discharge letter.

Our investigation has highlighted that interpretation of the radiology report was influenced by a falsely reassuring clinical picture, as Ms Elliott's examination and radiographic findings were not a typical presentation of a hip fracture and were therefore falsely reassuring to all those involved in her care. Additionally, undisplaced intracapsular fractures of the proximal femur are notoriously difficult to diagnose on initial radiograph and the early discomfort felt by the patient can improve if the fracture is not grossly unstable, which can lead to false reassurance that no fracture is present.

Ms Elliott appeared to improve in terms of her mobility and pain during her hospital stay, so no further investigations or imaging/CT scan were arranged prior to her discharge from hospital, as they were not thought to be necessary based on her clinical presentation. However, in hindsight, the clinicians have acknowledged that Ms Elliott should have had definitive imaging (CT) performed in the ED on 4th August 2017, as both the radiograph and the clinical history were suggestive of hip fracture at that time, despite her physical presentation.

At the inquest, the same witness also made reference to new protocols about the treatment of patients presenting with similar conditions such as Ms Elliott, but did not produce any documents. I would like to assure you that we do have an "Emergency Department Injured Elderly Non-Weight Bearing (NWB) Guideline/Pathway", which was developed in 2015. This guideline provides clear recommendations for cross sectional (CT) imaging and reporting, where pain or dysfunction suggests an occult fracture. I have provided a copy of this guideline.

The guideline is now included in the T&O junior doctor induction programme and the importance of all referrals being discussed at the trauma x-ray meeting is also stressed within this training. Our internal investigation has acknowledged that we need to review and relaunch this pathway across the Trust in order to raise clinicians' awareness and this has been addressed within the action plan.

Our investigation has acknowledged that there were missed opportunities early in Ms Elliott's admission to diagnose her hip fracture, despite the clinicians involved recognising that she had suffered a fall with subsequent hip pain requiring significant opiate analgesia and a reduction in mobility. This meant that the ED Injured Elderly NWB Guideline was not followed, early definitive cross-sectional imaging was not arranged, and the lack of clinical suspicion of a fracture meant that Ms Elliott's hip fracture remained undiagnosed by a number of clinicians throughout her first hospital stay in August 2018.

There was also a delay in the initial abnormal radiology report being reviewed by the ED team, as well as differing interpretations of the contents by clinical staff involved in the patient's care. When specialist advice was requested from the T&O team, telephone advice only was given, with no clinical examination or senior review of the imaging.

Therefore, our investigation has acknowledged that surgery was an earlier possibility for Ms Elliott, had there not been a delay in diagnosing her hip fracture. The Trust has a clearly defined Hip Fracture Pathway which would have meant that had Ms Elliott's fracture been confirmed on 4th August 2017, she would have proceeded to theatre for definitive surgery either on that day or the following day. She would also have been considered for a fascia iliaca compartmental block in ED, for more effective pain management. This would have reduced the amount of time she suffered pain and mobility problems, but was unlikely to change the unfortunate outcome for her.

As you will note from the enclosed action plan, the Trust is addressing the shortfalls highlighted during our investigation and the inquest, in order to prevent future deaths in similar circumstances. Progress of the actions detailed within the action plan will be overseen by [redacted] Executive Director of Nursing, Midwifery and Allied Health Professionals, who will keep me briefed and report to the Trust's Clinical Governance Steering Group.

I trust this information provides assurance to you that the Trust has taken appropriate action to mitigate any future patient safety issues with regards to the diagnosis and management of hip fractures.

I would also like to take this opportunity to offer my sincere condolences to Ms Elliott's family on behalf of myself and the Trust.

Yours sincerely

**Ken Bremner**
**Chief Executive**

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