NHS
County Durham
and Darlington
NHS Foundation Trust

Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington,
DL3 6HX
E-mail: [redacted]

Our Ref: [redacted]

25th July 2025

Janine Richards,
Assistant HM Coroner,
County Durham

Dear Ms Richards,

Re: Esther Byrne

We are writing in response to your request for the Trust to take action in relation to concerns as detailed below:

(1) Poor communication and liaison with family generally, and in particular with a family member who held a health and welfare power of attorney, led to important information being incorrect, including about such issues as the deceased's baseline presentation which was pertinent to safe discharge planning and risk assessment. It was accepted that there was no communication with the family member who held power of attorney regarding diagnosis and treatment options, the rationale for these, or the discharge plan.

(2) There were numerous discrepancies in the evidence demonstrating a misunderstanding by various medical staff as to the deceased's baseline presentation, and the extent to which she had or had not mobilised whilst an inpatient which were pertinent to care planning upon discharge and to any handling required to be risk managed by care home.

(3) It was accepted that a follow up appointment should have been arranged for the deceased after discharge and there was no explanation for why this was not arranged.

(4) The treating consultant physician expressed considerable doubt as to the quality and accuracy of radiological reporting provided by the outsourced out of hours service (which is understood to be outside the UK) and accepted that this issue, amongst others, contributed to his doubt that the deceased had sustained a fracture. The Inquest heard that there was no ability to discuss the findings with the reporting radiologist.

The Trust would like to offer its sincere condolences to Ms Byrne's family for their loss. We take very seriously the concerns which you have raised and have provided a response below.

Poor communication and liaison with family generally, and in particular with a family member who held a health and welfare power of attorney, led to important information being incorrect, including about such issues as the deceased's baseline presentation

which was pertinent to safe discharge planning and risk assessment. It was accepted that there was no communication with the family member who held power of attorney regarding diagnosis and treatment options, the rationale for these, or the discharge plan.

On review of the care the ward team were unaware that a family member had Power of Attorney for health and welfare. However the trust acknowledges that communication with the family was poor. On review of this issue the Orthopaedic team will ensure that a member of multi-disciplinary team is allocated on the ward round to update the family regarding all issues of the patients care. To provide assurance to the organisation of meeting this standard, regular audits will be completed by the relevant ward manager by a retrospective clinical record review.

There were numerous discrepancies in the evidence demonstrating a misunderstanding by various medical staff as to the deceased's baseline presentation, and the extent to which she had or had not mobilised whilst an inpatient which were pertinent to care planning upon discharge and to any handling required to be risk managed by care home.

Communication failures resulted in conflicting information regarding mobility status and the ability to transfer from bed to chair. On 4th November and 6th December 2024, Ms Byrne's baseline mobility was documented as having the ability to walk short distances with a wheeled Zimmer frame with supervision in the care home. This information was provided by the care home staff and the patient's granddaughter. On the 5th November 2024, the patient was only able to transfer from the bed to chair with assistance of 2 staff and using a wheeled Zimmer frame. During the patients second admission hospital (3rd December 2024) Ms Byrne was not able to stand with assistance and the plan was to nurse in bed/hoist. Although there was a plan for the patient to be discharged back to her care home, the physiotherapists were planning to complete further mobility assessments including considering using a hoist for transfers. Unfortunately this assessment did not take place prior to Ms Byrne's discharge back to the care home. The patient had not returned to her baseline level of mobility and therefore a further discussion with the family care home should have taken place to ensure the care home could meet Ms Byrne's care needs.
As a result of this the ward has made adjustments to ensure the physiotherapy team attend orthopaedic ward rounds and have access to electronic clinical records to ensure they are involved in decision making and contribute to discussion regarding the mobility status of patients.
As a further action physio and occupational therapist will input to patient's discharge letter to record patients mobility status.

It was accepted that a follow up appointment should have been arranged for the deceased after discharge and there was no explanation for why this was not arranged.

The accountable doctor, [redacted] accepts that the lack of a scheduled follow up appointment was an error on his part. A discharge process is in place to include scheduling a follow up appointment for every patient (if required) and confirmation is documented in the patient records. To ensure compliance with this process regular ward audits will be completed to provide assurance.

The treating consultant physician expressed considerable doubt as to the quality and accuracy of radiological reporting provided by the outsourced out of hours service (which is understood to be outside the UK) and accepted that this issue, amongst

others, contributed to his doubt that the deceased had sustained a fracture. The Inquest heard that there was no ability to discuss the findings with the reporting radiologist.

The Trust acknowledges that there may be occasions when contacting the out-of-hours radiologist proves challenging. In such cases, the duty radiologist should be contacted as the next point of escalation.
To ensure all clinical teams are fully informed of this protocol, a flow chart detailing the contact process has been circulated. This has also been shared directly with the orthopaedic consultants to support consistent application across relevant departments.

Conclusion
We trust that the responses detailed in this letter are sufficient to address the concerns you have highlighted. However, please feel free to contact us if you need any additional information or have further queries.

Yours sincerely

[redacted]

[redacted]

[redacted]
Executive Director of Nursing

[redacted]
Executive Medical Director

cc. [redacted], CEO
[redacted], Associate Director of Nursing, Patient Safety and CNIO