Oxford University Hospitals
NHS Foundation Trust

The John Radcliffe Hospital
Trust Headquarters
Academic Centre
Headley Way
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22 July 2024

PRIVATE AND CONFIDENTIAL

Mr Nicholas Graham
HM Area Coroner for Oxfordshire
[redacted]

Dear Mr Graham

Following the death of Mrs Beryl Dandridge, and subsequent inquest hearing on 10 June 2024, I write as CEO of Oxford University Hospitals NHS Foundation Trust (OUH), to provide a response to your Regulation 28 Report dated 12 June 2024.

I would like to start by expressing to Mrs Dandridge's family how sorry I am for their loss. Mrs Dandridge underwent a surgical repair of a periprosthetic fracture (a fracture associated with a previous orthopaedic knee implant) of the left distal femur at the John Radcliffe Hospital on 27 January 2024.

You recorded a narrative conclusion which states *'There is insufficient evidence to establish whether the combined delay in her admission to hospital and in undergoing surgery contributed to her death."*
The cause of death was:
1a) ST elevation Myocardial Infarction
1b) Periprosthetic distal femur fracture
2) Dementia, Atrial Fibrillation, heart failure, chronic kidney disease

Prior to the inquest hearing, the Trust's Structured Mortality Review (Ulysses ID 353853) dated 7 February 2024 was disclosed to your office which had been discussed at the Trust's Mortality Review Group, on 18 April 2024.

You set out the following areas of concern:
1. Application of the most appropriate clinical guidelines
2. Description of the process for obtaining an urgent echocardiogram.
3. Assurance that OUH Mortality Review process includes a clinician with the relevant subject expertise.

We reviewed these points and convened a Learning Multi-disciplinary Team meeting and response under the Patient Safety Incident Response Framework (PSIRF):

1. Application of appropriate Clinical Guideline

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines on the management of hip fractures (2020) are not explicitly for the type of fracture that Mrs Dandridge experienced (distal peri-prosthetic femur fracture). However they are used as a guide for all fragility femoral fractures by the Orthogeriatrician Team.
We convened a group of experts at the Learning Multi-disciplinary Team meeting including the Orthogeriatrician team and the Anaesthetist involved in this case and have agreed that whilst the same principles of the AAGBI guidelines apply to patients with periprosthetic fractures as to other femoral fragility fractures, these cases present a more complex risk / benefit analysis due to the increased length of operation and complexity of the surgery and therefore each patient will require an individualised risk assessment.

2. OUH urgent Echo-Cardiogram request process

We already have a process for requesting urgent echocardiograms within the Trust. This process was reviewed and clarified at the Learning Multi-disciplinary Team meeting. This clarification included the rationale and criteria for requesting the urgent echocardiogram, who is responsible for making the request, acceptable timescales, the need for early multidisciplinary discussion, and an escalation process for when any delay through the normal route would be unacceptable. This process has been agreed with the Consultant Cardiology team and the escalation will go through the on call Consultant Cardiologist.
Some members of the Orthogeriatrics team will also undergo training in focused bedside echocardiography to provide further capacity for urgent echocardiograms.

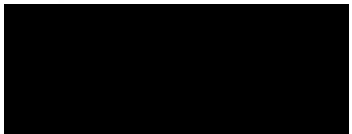
3. OUH Mortality Review Process

The OUH Mortality Review Process includes dedicated training for senior clinicians in conducting Structured Mortality Reviews (SMR). SMRs are presented to the Trust Mortality Review Group which is composed of a range of consultants. The SMR discussion for this case did involve an anaesthetist when it was presented at MRG. We have strengthened the SMR training, guidance and report template to include a requirement to discuss any concerns about poor clinical care raised in the SMR with the appropriate clinician involved and to include their views within the SMR as necessary. The Mortality Review Group will ensure that subject matter expertise is included in all cases, especially where there are concerns about the quality of care provided and if necessary a wider Learning MDT meeting with a range of subject matter experts will be convened to explore any differences of opinion.

The learning from this case will be presented at the Trust Safety Learning and Improvement Conversation (SLIC) meeting, the Trust Mortality Review Group, and the Clinical Governance meetings for Anaesthetics, Trauma and Orthogeriatrics.

I hope that this response will reassure you that we have taken your concerns very seriously and worked quickly to implement appropriate changes to our processes as a result of this inquest.

Yours sincerely



Chief Executive Officer