East Lancashire Hospitals NHS
NHS Trust

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PRIVATE AND CONFIDENTIAL
Mr M J H Singleton
Coroner's Office
Blackburn Enterprise Centre
Furthergate
Blackburn
BB1 3HQ

Dear Mr Singleton

Re: Regulation 28 report in relation to the death of Mr Alfred Grimshaw

I am writing in response to your Regulation 28 letter of 28th October 2016 in which you identify several specific concerns relating to the care of a specific patient. I apologise for the delay in replying; this is due in part to exceptional clinical workload and delays in obtaining case notes.

The case involved a failure to diagnose a fracture of the femoral neck during the initial admission of this patient despite a number of opportunities to do so. This patient was subsequently re-admitted (four days after discharge) and received the correct surgical management but unfortunately suffered post-operative complications and died.

I will deal with each of your concerns in the order you raise them:

1. The failure to perform an x-ray of the hip given the history and clinical findings.
   I have reviewed the Emergency Department notes of this patient and the clinical picture presented to the Doctor did not suggest a fractured femoral neck as the patient was moving all limbs and not complaining of specific hip pain. An alternative diagnosis to explain the reduced mobility was felt to be more appropriate.

2. The x-ray report of 27th May (abdominal x-ray to exclude intestinal obstruction) failed to report the evident right hip fracture. The Radiologist who undertook this report is currently under restricted practice, and subject to a clinical review. I am unable to comment further on this matter but specific measures have been put in place to ensure that the risk of further errors is reduced.

3 & 4. The processes around communication relating to discharges of complex frail patients has been significantly strengthened in the past six months with specific emphasis upon the role of the Multidisciplinary Team. There have also been developments between primary and secondary care to ensure that discharge documentation and transfer of information is improved.

I would point out that [redacted] initial statement stated that the discharge summary print out that you refer to was printed on 1st June, whereas your letter suggests 28th May. Having reviewed the case notes if the case that the letter printed out on 28th May does not contain a handwritten note. It is the copy printed on 1st June which does. I have been unable to identify who wrote this note.

As a result of the receipt of this Regulation 28 notice this case has been used as a learning case for teaching of Junior Doctors and used in feedback meetings to the Ward Team involved.

Yours sincerely

Ian Stanley.

[redacted]
Deputy Medical Director – Quality & Education
Consultant – Anaesthetics & Critical Care