University Hospitals of North Midlands NHS Trust

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5 May 2023

STRICTLY PRIVATE & CONFIDENTIAL
Mr D Ritchie
H M Assistant Coroner
Stoke on Trent and North Staffordshire

Dear Mr Ritchie

Sara Anest JONES

Further to my letter dated 16 March 2023, I am pleased to provide a response to your report under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Sara Anest Jones.

Recorded Circumstances of the Death
Sara Anest Jones died at the Royal Stoke University Hospital, Stoke on Trent on 2 April 2021 of complications of a bowel injury sustained in a road traffic collision on 30 March 2021. Miss Jones was treated for her injuries at the Royal Stoke University Hospital, Stoke on Trent. Those responsible for Miss Jones' care at the Royal Stoke Hospital did not identify that she had sustained a bowel injury and consequently it remained untreated. Miss Jones developed peritonitis because of the untreated bowel injury, from which she later died.

Concerns
During the course of the inquest you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows:

1. The patient was admitted to Royal Stoke University Hospital, Stoke on Trent as a "polytrauma" patient who had sustained serious injuries in a road traffic collision. Following her admission, she was treated by doctors from several different specialisms, but it was apparent that some doctors involved in her care concentrated on only the injuries that fell within their speciality and did not consider the patient as a whole. At an important stage in her treatment the general surgeons thought that the orthopaedic surgeons would alert them to any intervention which was needed from their speciality, whilst the orthopaedic surgeons expected the general surgeons to regularly review the patient.

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Partly as a result of the doctors concentrating only on the injuries which fell into their speciality signs of a bowel injury which the patient sustained were missed. The patient subsequently died as a result of complications of the undiagnosed bowel injury.

Evidence was given during the inquest that a major trauma consultant role was in the process of being developed at the Royal Stoke University Hospital, Stoke on Trent to address issues like this, but that the role was only 50% filled at the current time.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Action Taken
The University Hospitals of North Midlands NHS Trust has taken the issues highlighted during the inquest of Sara Jones seriously and indeed, I am grateful that you have raised your concerns.

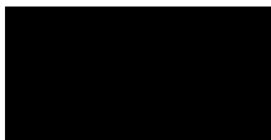
1. At the time of the inquest the Court heard that the current trauma rota was 50% filled and that the Trust were seeking to appoint further consultant cover so that all trauma patients are reviewed by a trauma consultant within 24 hours of their admission. In order to progress this, the Trust requires a further 6 consultants to be included on the rota.

   In order to fulfil this, an internal recruitment process has already been initiated. One additional consultant is now in post, and negotiations are underway with a further three consultants which will fill our Monday-Friday rota. We intend to have this rota staffed by the beginning of August 2023. Approval for the development of a business case is under consideration for the expansion of the Major Trauma service, to include weekend and out of hours cover. We intend to remove any potential confusion around team responsibilities by redefining the Major Trauma Service. This will mean that the Major Trauma Consultant is primarily responsible for the whole patient review and will liaise with specialty teams as appropriate. The timescale for this redesign is within the next 12 months.

I do hope that the above information provided assurance that the Trust has taken the concerns raised at the inquest seriously.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely



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