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22 January 2024

**STRICTLY PRIVATE & CONFIDENTIAL**

Mrs Emma Serrano  
H M Area Coroner  
Stoke on Trent and North Staffordshire

Dear Mrs Serrano

**Kathleen BOOTH**

Further to your letter dated 22 November 2023, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013, addressing your concerns surrounding the death of Kathleen BOOTH.

**Recorded Circumstances of the Death**

Mrs Booth was admitted to hospital as an emergency following a fall in her own garden on Friday 9 June 2023. She was transported by ambulance to the Royal Stoke University Hospital, Stoke on Trent. Hip x-rays confirmed a displaced intra-capsular neck of femur fracture on the left.

On admission, Mrs Booth was taking Apixiban, an anticoagulant medication, that required stopping for 24 hours before any surgery could be.

Provisional plans were made to carry out surgery over the weekend when able to do so, considering her anticoagulation.

Between 9 June and 12 June, we had many trauma admissions requiring emergency surgery and over the weekend of 10 June and 11 June 2023 we surgically treated 21 trauma cases. These included 3 Paediatric, 3 Spines and 15 Orthopaedic cases and some very complex cases within that. Under exceptional circumstances such as this it means that cases have to be clinically prioritised, i.e. those requiring emergency treatment were managed first before less urgent cases. This inevitably meant that some cases were postponed.

On Monday 12 June 2023, a decision was made to operate but was delayed to the following day due again to a large amount of trauma patients in the hospital. On 13 June 2023, the surgery was performed and was

uneventful. After surgery Mrs Booth was found to be alert and comfortable in the recovery area. Around 9pm, she suffered a sudden deterioration and passed away.

## Concerns

During the course of the inquest you felt that evidence revealed matters giving rise for concern. The issues raised were:

1. There was a 4 day delay in her receiving surgery due to NHS wide under staffing and underfunding; and wards having to undertake elective and emergency work at the same time. Additionally, the fact that the injury happened on a Friday, meaning less staff and experience was available.
2. Earlier intervention is associated with better outcomes.
3. Patients can be disadvantaged by not receiving treatment if an injury is sustained on a Friday as cover over the weekend is limited.

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.

In your opinion, action should be taken to prevent future deaths.

## Action Taken

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

1. UHNM is a major trauma centre (MTC) and provides a very high quality service for a population of over three million. As a MTC the trust is required and does have the ability to perform major trauma surgery 24 hours a day, seven days a week for all days of the year. There are exceptional occasions when demand outstrips capacity, and these cannot always be foreseen or planned for. However, when they occur the management teams work with the clinicians to review job plans and reallocate work to ensure the urgent and emergency patients get seen as soon as possible.

It is acknowledged that there was a delay of 4 days between presentation on 9 June 2023 and surgery being undertaken on the morning of 13 June 2023. However, as Mrs Booth was on Apixaban for AF the very earliest she could have undergone surgery was 24 hours later on the morning of 10 June 2023, as the last dose of Apixaban was on the morning of 9 June 2023. Mrs Booth would have been optimal for surgery within 24-36 hours of coming off Apixaban and a 24-36 hour delay for Mrs Booth would have been clinically appropriate.

Please see the response to question 3 regarding weekend cover and access to services.

2. It is agreed that earlier intervention is associated with better outcomes for patients requiring emergency (and urgent) surgery following injury. As a Trust with a significant major trauma unit, we endeavour to treat patients with a fragility fracture within 36 hours of presentation where clinically appropriate. However, the data within the NHFD (National Hip Fracture Database) does not link a delay in theatre with an increased risk of mortality.

However, the trust does annually review capacity and demand for all its services and based on one of these reviews and subsequent business case, on the 6 November 2023, the Trauma Directorate introduced a dedicated fragility fracture theatre list, 5 days per week. This has seen a reduction in time to theatre for this cohort of patients since its inception. Capacity and demand also include the weekend provision and the division are preparing a business case to see if the demand over the weekend period requires the same on a Saturday also.

3. Routinely, over the weekend there is provision for 2 all-day trauma theatre lists which provides shared theatre capacity for orthopaedic, spinal and neurosurgical emergency/urgent cases. This is a reduction in theatre capacity compared to the weekday provision and in exceptional circumstances can lead to surgery delays, dependent on the clinical prioritisation of the caseload.

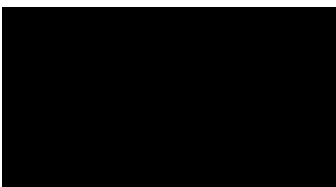
If emergency admissions are high, patients are prioritised clinically based upon their presenting clinical issues. If the number of trauma admissions is particularly high, this can affect the trauma surgical service throughout the week and as previously advised, clinical and managerial teams work together to ensure emergency work is prioritised. This can sometimes lead to the cancellation of planned elective work.

The trust is also reviewing whether there is a need for a dedicated fragility fracture theatre over the weekend. As referenced in the response to question 2, this is a matter which is being reviewed and will be dependent on available clinical and financial resources.

I do hope that the above information provides 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



**CHIEF EXECUTIVE**