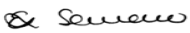
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England;** **2. Royal Stoke University Hospital, Stoke-on-Trent**
1	**CORONER** I am Emma Serrano, Area Coroner, for the coroner area of Staffordshire & Stoke-on-Trent
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 7th July 2023, I commenced an investigation into the death of Mrs Kathleen Booth. The investigation concluded at the end of the inquest on 24 October 2023. The conclusion of the inquest was a narrative conclusion of complications following a fall. The cause of death was: 1a) Stroke 1b) Fractured neck of femur 1c) Low blood pressure II) 4 day delay in operating on the fractured neck of femur
4	**CIRCUMSTANCES OF THE DEATH** Mrs Booth had been admitted to hospital as an emergency following a fall in her own garden on 09 June 2023. She was transported by ambulance to the Royal Stoke University Hospital, Stoke-on-Trent. A hip x-ray confirmed displaced intra-capsular neck of femur fracture on the left. On Monday 12 June 2023, a decision was made to operate. The operation was due on the 12 June 2023 but was delayed until the following day due 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.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 January 2024. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. Family of the deceased. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	22 **November 2023**  **Miss Emma Serrano** **Area Coroner** **Staffordshire and Stoke-on-Trent**