Mr Brendan Joseph Allen
Area Coroner
Coroner's Office for the County of Dorset
BCB Civic Centre
Bourne Avenue
Bournemouth
BH2 6DY

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

24 December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Christine Rita Booker who died on 24 February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 October 2024 concerning the death of Christine Rita Booker on 24 February 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Christine's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Christine's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to respond to your Report, and I apologise for any anguish this delay may have caused to Christine's family or friends. I realise that responses to Coroner's Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raised the concern that there is no out of hours interventional radiology at Dorset County Hospital and that patients requiring this intervention who reside in the area must be transferred to the Royal Bournemouth Hospital, exposing patients to a potentially significant delay in the provision of urgent and life-saving treatment.

In preparing this response, colleagues within the Clinical Reference Group (CRG) for Vascular Disease have been consulted.

Orthopaedic procedures do sometimes lead to life-threatening complications such as bleeding, as they sadly did for Christine. They are also often being carried out in private hospitals where there is no vascular cover. It is important to identify such complications early, resuscitate and arrange transfer to a site where definitive and life-saving vascular intervention can be performed. The transfer should be to a site (usually a vascular hub) where 24/7 vascular intervention is available, and this should include both interventional vascular radiology and vascular surgery.

Based on the information provided in your Report, NHS England is unable to provide further comment on the care provided to Christine following her procedure, and her transfer to Royal Bournemouth Hospital. It is not clear to NHS England whether the hip replacement procedure had been commissioned and funded by the NHS.

My South West regional colleagues have been engaging with NHS Dorset Integrated Care Board and NHS England Direct Commissioning South West, to gather further information in this matter.

Dorset Integrated Care Board advise that there is a well-practiced hub and spoke model with the Royal Bournemouth Hospital for vascular services, as well as clear pathways for private provider transfer. They advise that a full interventional radiology service at Dorset County Hospital would likely be unsustainable.

NHS England continues to seek further details on the issues surrounding Christine's care and the matters raised in your Report from colleagues in the South West. We are happy to update the Coroner on the information received in due course. However, we remain of the view that the concerns raised by the Coroner in respect of the circumstances of Christine's death are more appropriate for the Trusts to address.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Christine, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director