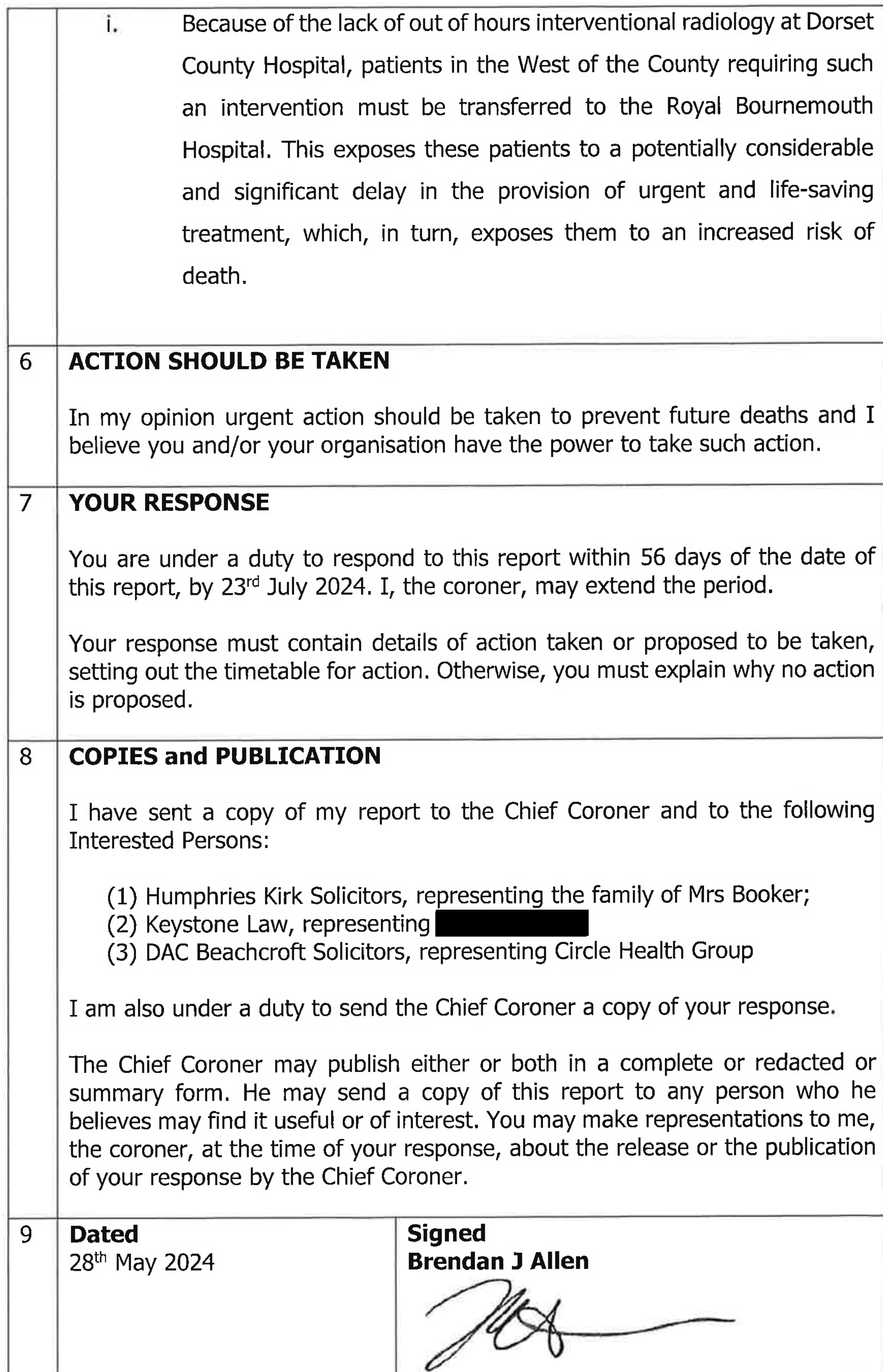
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Dorset County Hospital NHS Foundation Trust**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 8th March 2023, an investigation was commenced into the death of Christine Rita Booker, born on the 6th October 1943. The investigation concluded at the end of the Inquest on the 17th May 2024. The Medical Cause of Death was: 1a Haemorrhagic shock 1b Iatrogenic injury of right pelvic blood vessels 1c 2 The conclusion of the Inquest recorded that Christine Rita Booker died as a consequence of a complication of elective hip replacement surgery.
4	**CIRCUMSTANCES OF THE DEATH** Christine Rita Booker underwent an elective right total hip replacement at the Winterbourne Hospital, operated by Circle Health Group, on 23rd February 2023. During the procedure, and in order to adequately secure the acetabular cup to her hip socket, the consultant orthopaedic surgeon, [redacted], drilled

	a hole in the socket to accommodate a 20mm screw. Blood flowed from the drill hole, which stopped upon the insertion of the screw. Mrs Booker lost approximately 500ml of blood in the operation, which is at the upper level of the expected blood loss. Mrs Booker initially appeared to recover as expected following such a procedure, but became severely unwell at approximately 18.55 when her blood pressure became unrecordable. Measures were taken to resuscitate and stabilise Mrs Booker and she was transferred to Dorset County Hospital for ongoing treatment and imaging. The imaging demonstrated extensive intraperitoneal and extraperitoneal blood, likely as a consequence of the surgery. Following a conversation with a vascular surgeon it was determined that Mrs Booker required embolization of the bedding vessels. However, there is no out of hours interventional radiology at Dorset County Hospital. Therefore, Mrs Booker was transferred to the Royal Bournemouth Hospital for the embolization of the bleeding vessels by interventional radiology. Following the embolization, she initially stabilised, but deteriorated again on 24th February 2023. Christine Rita Booker died at the Royal Bournemouth Hospital on 24th February 2023.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. There is no out of hours interventional radiology at Dorset County Hospital and that patients requiring this potentially urgent and life-saving intervention that live in the West of the County require transfer to the Royal Bournemouth Hospital for treatment. 2. I have concerns with regard to the following:



i. Because of the lack of out of hours interventional radiology at Dorset County Hospital, patients in the West of the County requiring such an intervention must be transferred to the Royal Bournemouth Hospital. This exposes these patients to a potentially considerable and significant delay in the provision of urgent and life-saving treatment, which, in turn, exposes them to an increased risk of death.

6 **ACTION SHOULD BE TAKEN**

In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, by 23rd July 2024. I, the coroner, may extend the period.

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) Humphries Kirk Solicitors, representing the family of Mrs Booker;
(2) Keystone Law, representing
(3) DAC Beachcroft Solicitors, representing Circle Health Group

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	**Dated** 28th May 2024	**Signed** **Brendan J Allen**