IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Hilda Florence Thompson
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: East Surrey Hospital Trust
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 30/1/14 I opened the inquest into the death of Hilda Florence Thompson, who at the date of her death was 101 years old. The inquest was resumed and concluded on 27/8/14 I found that the cause of death to be: 1a – Subdural Haemorrhage 1b – Head Injury 2 - Congestive Cardiac Failure I concluded with a narrative conclusion as follows: On 1/1/14 Hilda Florence Thompson who had a history of cardiac ill health and asthma was admitted to A&E at East Surrey Hospital with breathlessness, for which she was treated. Subsequently on 19/1/14 she suffered a witnessed collapse causing her to sustain a subdural haemorrhage to which she succumbed and died on 22/1/14.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Thompson who had limited mobility and a history of falls was admitted to A&E at East Surrey Hospital on 1/1/14 suffering with breathlessness, where she was treated for possible worsening heart failure and renal function. She was moved from the acute medical unit to Holmwood ward on 8/1/14 where she was identified as a high falls risk. On 19/1/14 she was seen in the corridor adjacent to her room calling for help and holding onto a chair, but had a collapse before the senior nurse could reach her, and she struck her head on the floor. CPR was immediately commenced and she was restored to consciousness. Subsequently a CT scan showed that she had suffered an extensive intracranial injury to which she succumbed and died on 22/1/14.
5	**<u>CORONER'S CONCERNS</u>** During the inquest the following concerns arose: - • Upon her admission to hospital, her management plan was not completed and she was wrongly identified as not being a falls risk. • There was no further review of Mrs Thompson and it was not until 11/1/14 when a full falls risk assessment was made and preventable measures put into place. • Poor note taking of 2/1/14 to account for this. • This left a gap of some 10 days during which she was not properly risk assessed for falls. I would ask that you consider giving further consideration to the procedures and systems to ensure that there is no further repetition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that East Surrey Hospital Trust has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8	**COPIES** • [redacted] • The Chief Coroner
9	**Signed: Mr Martin Fleming** **DATED this 3rd September 2014**