Regulation 28
REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive Officer; and**
2. **Head of Nursing; of**

County Durham and Darlington NHS Foundation Trust

1 CORONER

I am Jeremy Chipperfield, Senior Coroner for the area of Durham and Darlington

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 Twentieth August 2019 I commenced an investigation into the death of

Agnes Gwenllian SANSOM, aged 95

The investigation concluded at the end of inquest on 6th January, 2020. The conclusion of the inquest was:

I a Hospital Acquired Pneumonia
I b Fractured Neck of Femur (Repaired)
I c Frailty of Old Age

II Left Ventricular Systolic Dysfunction, Stroke

4 CIRCUMSTANCES OF THE DEATH

The deceased was admitted to University Hospital of North Durham on 15th July 2019. She was known to be at risk of falling and of suffering serious injury or death in the event of falling.

The deceased was obliged to share a zimmer frame with another patient on the ward.

On 18th July, a physiotherapist assessed the deceased and observed that she (i) was likely to rise from her bed and mobilise unaided (contrary to nursing advice); and (ii) required supervision when mobilising. These observations were recorded in the deceased's "Patient Health Record" (a paper document).

Had the physiotherapist's observations been known to nursing staff or to the Ward Manager, action should have been taken to prevent unaided mobilisation.

Nursing staff relied only upon the Electronic Patient Record System (EPRS) for information about the deceased. The EPRS contained none of the physiotherapist's observations and no alert as the importance of the same. Neither nursing staff nor Ward manager acted to prevent unaided mobilisation.

Unaided mobilisations continued after the physiotherapist's assessment and during one such incident, on 20th July, the deceased fell, thereby sustaining the injury which led to her death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows

The following circumstances create the risk of other deaths:

(i) existing patient record systems fail to ensure that important and urgent information is brought, in a timely way, to the attention of those who need it; and

(ii) vulnerable patients are obliged to share walking aids on hospital wards

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 03 March 2020. 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: The 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.

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Jeremy Chipperfield
Senior Coroner for
Durham and Darlington
7.1.20