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

The Inquest Touching the Death of Douglas Nickols
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Sussex Healthcare NHS Trust Trust Headquarters East Surrey Hospital Canada Avenue Redhill RH1 5RH
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Nickols' death was opened on 18 April 2023. The inquest was resumed and concluded on 25 September 2023. The medical cause of Mr Nickols' death was: 1a. Bronchopneumonia 2. Fractured Left Neck of Femur (Operated 5 March 2023), Frailty of Old Age With respect to where, when and how Mr Nickols came by his death it was recorded at Box 3 of the Record of Inquest as follows:

	Mr Nickols was an elderly man who suffered an unwitnessed fall at his care home on 28 February 2023, as a result of which he sustained a fractured left neck of femur. On the same day he was admitted to East Surrey Hospital and on 5 March 2023 he underwent fixation surgery. He subsequently deteriorated with Bronchopneumonia, resulting in his death at East Surrey Hospital on 11 March 2023. The inquest concluded with a short form conclusion of 'Accident' together with the following short narrative conclusion: Following his admission to East Surrey Hospital on 28 February 2023 Mr Nickol's surgery did not take place until 5 March 2023. Mr Nichols therefore remained immobile for a number of days prior to the operation taking place, which contributed to his death. There was no clinical reason for the surgery not taking place until 5 March 2023.
5	**CIRCUMSTANCES OF THE DEATH** During the course of the inquest the court heard that the NICE Guideline on the Management of Hip Fractures recommends that hip surgery take place on the day of the injury or the day thereafter and that this is because early mobilisation is recommended for hip fracture patients to reduce the risk of complications, including pneumonia. The Court heard evidence that Mr Nickols was clinically fit for surgery following his admission to East Surrey Hospital on 28 February 2023 but that his surgery did not take place because other trauma patients were prioritised ahead of him based upon their relative clinical need. The Court heard that East Surrey Hospital has a dedicated list and operating theatre for trauma patients but that on some occasions demand outweighs capacity, meaning that patients have to be prioritised according to clinical need, meaning that is not possible to perform all operations with the timeframe set out in the NICE guidelines.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: On some occasions at East Surrey Hospital it is not possible to perform operations on patients with fractured hips on the day of admission or the day thereafter, which is the timeframe set out in the NICE Guidelines on the Management of Hip Fractures. Early mobilisation is recommended for hip fracture patients to reduce the risk of complications, including pneumonia. The Coroner is concerned that in failing to comply with the NICE guidelines in this way, the Trust is placing such patients at risk of early death.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**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.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Nickol's family

10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 29th day of September 2023**