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

The Inquest Touching the Death of Bavaniammah Theiventhiran
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 Ms Theiventhiran's death was opened on 20 April 2023. The inquest was resumed and concluded on 9 November 2023. The medical cause of Ms Theiventhiran's death was: 1a. Congestive Cardiac Failure 1b. Valvular Heart Disease, Ischaemic Heart Disease and Acute on Chronic Kidney Disease 2. Fracture Neck of Femur due to Fall on 26 February 2023 (Operated 2 March 2023) The inquest concluded with a narrative conclusion as follows:

	Ms Theiventhiran was 80 years old. Her past medical history included Ischaemic Heart Disease, Valvular Heart Disease and Chronic Kidney Disease. On 26 February 2023 Ms Theiventhiran tripped over a suitcase at her home address and was admitted to East Surrey Hospital on the same day and diagnosed with a fractured left neck of femur. On her admission to hospital Ms Theiventhiran was placed on the trauma list for surgery. However, the surgery did not place until 2 March 2023. There was no clinical reason to delay her surgery. Following the surgery Ms Theiventhiran developed an Acute Kidney Injury and on 6 March 2023 she died at East Surrey Hospital. Her death was due to Congestive Cardiac Failure caused by a combination of her Chronic Heart Disease and Acute on Chronic Kidney Disease. The fall and fracture, along with the amount of time that elapsed between the fracture and the surgery taking place, placed prolonged stress on Ms Theiventhiran's already compromised heart, exacerbating her congestive cardiac failure and thereby contributing to her death.
5	**CIRCUMSTANCES OF THE DEATH** 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 on the basis that early surgery for hip fractures is the most appropriate form of pain relief, potentially quickening rehabilitation and reducing complications. The Court heard evidence that Ms Theivanthiran was clinically fit for surgery following her admission to East Surrey Hospital on 26 February 2023. However, her surgery did not take place until 2 March 2023 because other trauma patients were prioritised ahead of her, either because they had been admitted on an earlier date, or because they had been assessed as having a higher clinical need. The Court heard evidence that the most recently monthly figures recorded by East Surrey Hospital indicate that fewer than 50 per cent of its neck of femur patients had been operated upon with the timeframes set out in the NICE Guideline on the Management of Hip Fractures.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: 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 in order, amongst other things, to reduce complications. The most recent monthly figures indicate that East Surrey Hospital it is not meeting this timeframe for over half of patients who present to the hospital with a fractured neck of femur. The Coroner is concerned that in failing to comply with the NICE Guideline 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. Ms Theiventhiran's family

10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 13th day of November 2023**