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

The Inquest Touching the Death of Anne Johnston Rowland
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** Ms Susan Ridge, 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 Mrs Rowland's death was opened on 20 April 2023. The inquest was resumed on 24 January 2024 and concluded on 20 March 2023. The medical cause of Mrs Rowland's death was: 1a. Aspiration Pneumonia 1b. Dementia 2.Neck of Femur Fracture (repaired 3 March 2023)

	With respect to where, when and how Mrs Rowland came by her death a narrative conclusion was recorded on the Record of Inquest as follows: On 27 February 2023 Anne Johnston ROWLAND whilst a resident of a care home in Oxted, Surrey suffered a neck of femur fracture following a collision and fall with another resident who was partially sighted. Mrs Rowland was taken to East Surrey Hospital, Redhill on the same day and on 3 March 2023 she underwent fixation surgery. Her dementia and the immobility caused by waiting for her operation contributed to her developing aspiration pneumonia following surgery. Her condition deteriorated resulting in her death at East Surrey Hospital on 31 March 2023. There was no clinical reason for surgery not taking place until 3 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 Mrs Rowland was clinically fit for surgery following her admission to East Surrey Hospital on 27 February 2023 but that her surgery did not take place because other trauma patients were prioritised ahead of her 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 are prioritised according to clinical need, meaning that is not possible to perform all operations with the timeframe set out in the NICE guidelines. The coroner also heard that theatre capacity has on occasions been compromised by infrastructure failings; the orthopaedic theatres require new air handling and chillers and the construction of a new building to provide a platform for the new plant. That work has yet to be completed. The coroner heard that the Trust is currently applying a metric of 48 hours to surgery from admission and not the NICE recommended guidance.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: Continuing infrastructure risks at East Surrey Hospital have potential to compromise the Trust's ability 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. East Surrey Hospital use a metric of 48 hours within which to conduct such surgery and not the NICE timeframe for hip surgery. Early mobilisation is recommended for hip fracture patients to reduce the risk of complications, including pneumonia. The coroner is concerned that in using a different metric to that in the NICE guidelines and the outstanding infrastructure repairs 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. Mrs Rowland's family
10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated 20th day of March 2024**