ANDREW HETHERINGTON
H M Senior Coroner for Northumberland

County Hall, Morpeth, Northumberland NE61 2EF

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Northumbria Healthcare NHS Foundation Trust**
1	**CORONER** I am Andrew Hetherington, Senior Coroner for Northumberland.
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. http://legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28 September 2023 I commenced an investigation into the death of Eleanor Smith Deceased. The investigation concluded at the end of the inquest on 11 April 2024. The conclusion of the inquest was a narrative conclusion: Died due to an infection the source of which could not be ascertained together with the physiological stress of a surgical procedure contributed to by underlying natural disease and an injury sustained in an accidental fall. It is not possible to say to what extent antibiotics were effectively administered or whether the delay affected the outcome. The cause of death was: 1a. Infection of unknown aetiology

	1b Frailty of old age II Left ventricular systolic dysfunction, Atrial fibrillation, Left neck of femur fracture.
4	**CIRCUMSTANCES OF THE DEATH** On 17 September 2023 within Crossway, 1 Swinhoe Road, Beadnell Eleanor Smith suffered an unwitnessed fall using her walker when she stumbled and fell against the doorpost of the bathroom door. She was conveyed to Northumbria Specialist Emergency Care Hospital where an x-ray identified she had sustained a fracture to the left neck of femur. No infection was identified on admission. She was too unwell to undergo surgery initially and underwent surgical repair of the fracture with insertion of a left dynamic hip screw without complication on 19 September 2023. Postoperatively she developed an infection with a rising white cell count and CRP. There was a significant delay in the administration of intravenous antibiotics which were first administered at 18.00 hours on 23 September 2023 although it is not possible to say to what extent antibiotics were effectively administered or whether the delay affected the outcome. Investigations undertaken were unable to identify the source of the infection and despite treatment she continued to deteriorate and died within Northumbria Specialist Emergency Care Hospital on 24 September 2023.
5	**CORONER'S CONCERNS** 1. It was the concern of the family throughout the investigation that there was a delay in the administration of IV antibiotics and the antibiotics were not administered effectively. The Trust accepted that there was a significant delay in the administration of antibiotics of a period of 24 hours but that it was unlikely that the delay affected the outcome. The family gave evidence that they were present until around 21.00 hours on 23 September 2023 and described difficulties experienced by staff on 23 September 2023 in the siting of a canula. There was an attempt for the

	canula to be placed in one arm, then the other and was eventually sited in the foot. It was the position of Trust that from 17.56 hours on 23 September 2023 there was a working cannula and prescribed medication was administered. I accepted the evidence of the family and I am concerned that the medical records did not accurately record the events and siting of the canula. I am further concerned as to whether prescribed medication on this occasion being antibiotics were effectively administered and what checks there are to ensure the effective administration of medicines.
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 7th June 2024. 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 Eleanor Smith 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.
9	Date 12 April 2024 Signed: A. P Hetherington Andrew Hetherington HM Senior Coroner for Northumberland