MR G IRVINE
SENIOR CORONER
EAST LONDON
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 26837383

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust** **Sent via email: [redacted]** **2. [redacted], Secretary of State for Dept. Health & Social Care** **Sent via email: [redacted]**
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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://www.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 1st March 2024 this Court commenced an investigation into the death of Elizabeth Grace Holder, aged 88 years. The investigation concluded at the end of the inquest on 24th July 2024 when the Court returned a narrative conclusion: "*Elizabeth Grace Holder died in hospital on 24th February 2024 due to complications of*

	a fall that occurred whilst recovering from surgery as an inpatient. At the time of the fall, Mrs Holder was not properly supervised." Mrs Holder's medical cause of death was determined as; 1a Intraparenchymal haematoma 1b Fall II Neck of femur fracture (corrected), intraparenchymal haemorrhage
4	**CIRCUMSTANCES OF THE DEATH** Elizabeth Grace Holder was an 88-year-old woman with co-morbidities, restricted mobility and a history of falls. Elizabeth was admitted to hospital on 29th December 2023 by ambulance following a fall, she was admitted to the trauma unit and underwent a surgical repair of a broken hip. Mrs Holder was noted to be at high risk of falls and had been assessed to require an enhanced level of nursing care, initially requiring 1:1 nursing care. Mrs Holder had a difficult recovery and developed a surgical wound infection. During her inpatient recovery period the patient lost physical reserve and was observed to be increasingly confused, despite this nursing care was reduced to a 1:2 ratio. On 15th February 2024 it was noted that Mrs Holder had declined further, she was markedly confused and underwent diagnostic tests resulting in a queried diagnosis of a transient ischaemic accident. On the evening of 19th February 2024 Elizabeth was observed to be confused and anxious. Mrs Holder had asked to be taken to the lavatory, her request was refused, and she was told to use the commode by a male Health Care Assistant ("HCA"). The HCA did not believe that it was appropriate for him to observe Mrs Holder in the use of the commode and allowed her to proceed unsupervised behind a ward bay curtain. The HCA did not consider alternative, safer strategies, neither asking the female nurse allocated to Mrs Holder on the same shift to undertake supervision, nor offering to supervise use of the commode in the presence of a chaperone. The fall resulted in a fatal intra-cerebral bleed.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The Trust's failure to prevent a predictable and therefore avoidable fall which resulted in death. 2. Despite this incident activating the PSIRF process which resulted in the completion of an After Action Review ("AAR"), the Trust did not identify any sub-optimal aspects to Mrs Holder's care. Accordingly, I have a concern regarding the failure of the Trust's governance systems to; a. Identify and reflect upon failings in care, b. Consequently, the failure of the trust to act in a way to remediate the factors that contributed to Mrs Holder's death.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **20th September 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 Mrs Holder, the Care Quality Commission and to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 25/07/2024 [SIGNED BY CORONER]**