The
Coroner's
Service

North London Coroner's Service,
Barnet, Brent, Enfield, Haringey and Harrow,
Barnet Coroner's Court,
29 Wood Street, London, EN5 4BE
Clerk to the Senior Coroner
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE

DEATHS THIS REPORT IS BEING SENT TO:

[redacted] Chief Executive
North Middlesex University Hospital NHS Trust
Sterling Way
London
N18 1QX
C/O [redacted]

1	**CORONER** I am Mr P. A. Murphy, Area Coroner for the coroner area of the Northern District of Greater 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.
3	**INVESTIGATION and INQUEST** On the 05 July 2023 I opened an investigation touching the death of Maria Francisca Teixeira de Ceita, aged 87 years old. I opened an inquest on the 27 July 2023. The inquest concluded on the 16 February 2024. The conclusion of the inquest was "Maria de Ceita died as a result of brain damage caused by an unwitnessed fall while she was a hospital in-patient on 04 July 2023. The following factors contributed to her death: (a) Not recording that Mrs de Ceita required one to one supervision on the ward; (b) Not recording any update to that plan; (c) Not putting in place on to one supervision on 3-4 July 2023; and (d) Lack of effective communication between staff on the ward.
4	**CIRCUMSTANCES OF THE DEATH** Maria de Ceita was born on 26 March 1935 in Goa, India. She was 87 years old when she died on 04 July 2023 in North Middlesex Hospital, as a result of an unwitnessed fall earlier that day by her hospital bed, which caused her a fatal brain injury. Mrs de Ceita was known by the Hospital to be at risk of falling and at the time of the fall she should have been under one to one supervision by hospital staff.
5	**CORONER'S CONCERNS** **The MATTERS OF CONCERN are as follows. –** In view of Ms de Celta's known risk of falling, staff at the Hospital decided to put in place one-to-one supervision. An omission in recording that plan in Ms de Ceita's medical records by the hospital staff led to that plan being effected, which in turn contributed to Ms de Ceita subsequently falling by her hospital bed and sustaining a fatal brain injury. The matter of concern is therefore the lack of an effective system to document and address the risk of elderly patients falling while in the hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 25 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; - 1. Ms de Ceita's family.
9	**Date:** 31 July 2024