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

The Inquest Touching the Death of Margaret Kathleen Rodgers
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 Rodgers death was opened on 25 July 2024. The inquest was resumed on 27 January 2025 and concluded on 19 February 2025. The medical cause of Mrs Rodgers' death was: 1a.Congestive Cardiac Failure 1b Aortic Stenosis and Urinary Tract Infection 2. Rib and Spinal Fractures, Decubitus Ulcer (operated) and Frailty of Old Age

	A narrative conclusion was recorded at Box 4 of the Record of Inquest as follows: On 3 December 2023, Margaret Kathleen Rodgers had a fall at her home in Warlingham Surrey. She was taken to hospital the same day and found to have sustained rib fractures and spinal fracture and was admitted to East Surrey Hospital. Mrs Rodgers developed hospital acquired pneumonia during her admission for which she was treated. On 14 December 2023 she was found to have an unstageable or advanced sacral pressure ulcer, its development and progress had not been identified until that point. As a result Mrs Rogers required two surgical procedures, on 21 December and 27 December 2023, under general anaesthetic to treat the infected ulcer. Whilst in hospital Mrs Rodgers developed a urinary tract infection and this together with preadmission aortic stenosis and cardiac failure led to her death from congestive cardiac failure on 12 January 2024 at East Surrey Hospital Redhill. Both Mrs Rodgers trauma injuries which resulted in immobility adding to her risk of pneumonia and the development in hospital of the advanced sacral ulcer which required surgery more than minimally contributed to her death in that they impacted on her physical reserves which were already undermined by her existing heart failure and frailty.

5	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion above.
6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: The court heard that whilst the Trust has implemented a number of recommendations arising out of the patient safety review following Mrs Rodgers death, a number have yet to be resolved in particular: a. NICE and the National Wound Care Strategy guidance is that patients admitted to hospital have a pressure ulcer risk assessment within 6 hours of admission. This means that the first assessment will often need to be undertaken in the Emergency Department (ED). The court heard that the work to ensure that the ED completes such assessments is ongoing and not yet embedded and that there are practical difficulties, for example when ED patients were located on corridors. b. The court also heard that in December 2023 to January 2024, the period of Mrs Rodgers admission, the hospital was experiencing a high level of operational pressures and that on occasions the ward itself had insufficient nursing staff levels to meet the demand of acutely ill patients with high dependency needs. The Trust is undertaking a review of the staffing template for the ward, but that work is not complete and not yet incorporated into the budget.

	The coroner is concerned that in not completing the above recommendations arising out of the patient safety review, the Trust is placing 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 Rodgers family

10	**Signed:** **Susan Ridge** **S K Ridge** **H.M Assistant Coroner for Surrey** **Dated this 19th day of February 2025**