ANDREW HETHERINGTON
HM Senior Coroner for Northumberland

County Hall Morpeth Northumberland NE61 2EF
Tel 01670 623136
Email [redacted]

Date: 18 March 2025 Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: CHIEF EXECUTIVE, NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST.

CORONER

1 I am Mr Andrew Hetherington for Northumberland

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

3 On 1 May 2024 I commenced an investigation into the death of Renate MARK. The investigation concluded at the end of the inquest . The conclusion of the inquest was died as a result of a head injury sustained in an unwitnessed fall.

CIRCUMSTANCES OF THE DEATH

The deceased had considerable underlying natural disease. Within her home address on 20 April 2024 she suffered an unwitnessed fall. She was conveyed to Northumbria Specialist Emergency Care Hospital where a CT head scan showed age related atrophy and ischaemic changes but no other injuries.

4 She was assessed as a level 3 falls risk meaning she was to be kept under line of sight in case of falling. She was stable and the plan was for discharge home with additional care support.

At approximately 03:10 hours on 24 April 2024 she suffered an unwitnessed inpatient fall in the bathroom of room 25 on ward 9. She was not under direct observation despite her level 3 falls risk assessment.

A CT brain scan identified she had sustained significant injuries including a cervical spinal fracture and a subdural haematoma as a result of the fall. Surgical intervention was not appropriate and that she

received palliative care until her death within Northumbria Specialist Emergency Care Hospital at 22:25 hours on 25 April 2024.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. -

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) The deceased was assessed as a level 3 falls risk meaning she was to be kept under line of sight in case of falling. Witness statements served in advance of the inquest stated the fall was witnessed. It was however eventually accepted in evidence that the fall was in fact unwitnessed. The precise circumstances of the fall could not be determined. All of the investigations undertaken by the Trust relied upon the incorrect understanding that the fall was witnessed and observations were in line with Trust falls policy, when they were not.

(2) The inquest heard that it is practice within the Trust that a Nursing Assistant is to be located centrally in the corridor on ward 9 to oversee patients assessed as at risk of falling and for the patients to be within staff's peripheral vision. The inquest heard that on 24 April 2024 8 patients were assessed as level 3 falls risk and 1 patient was assessed as level 4 falls risk. I am concerned as to the number of patients at risk of falls being observed in this way. I am further concerned that there is a misunderstanding of what is meant by peripheral vision and what constitutes a witnessed or unwitnessed fall.

(3) I am concerned there is not greater scrutiny of witness accounts as part of the Trust's investigation process in particular given the concerns raised by the deceased's family early in the investigation and the other witness accounts to provide earlier learning to prevent future events.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you CHIEF EXECUTIVE OF NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 May 2025. 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons being the deceased's family.

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.
18 March 2025

9 Signature 

Andrew Hetherington HM Senior Coroner for Northumberland for