COUNTY OF DEVON, PLYMOUTH AND TORBAY CORONER AREA

REPORT ON ACTION TO PREVENT OTHER DEATHS
MARY MARGARET POMEROY

HM AREA CORONER
NICHOLAS LANE

	REGULATION 28 – REPORT ON ACTION TO PREVENT OTHER DEATHS THIS REPORT IS BEING SENT TO: 1) [redacted] (Interim Chief Executive Officer) and [redacted] (Chief Nursing Officer) **- University Hospitals Plymouth NHS Trust (UHP NHS)** *Via email:* [redacted] *(instructed external legal representative at inquest for UHP NHS) and* [redacted] *(deputy legal manager, UHP NHS)*
1	CORONER I am Nicholas Lane, HM Area Coroner for County of Devon, Plymouth and Torbay coroner area.
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: e http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 25 March 2022 an investigation was commenced into the death of Mary Margaret Pomeroy. The investigation concluded at the end of the inquest hearing on 25 March 2025 at Exeter Coroner's Court, in the County of Devon, Plymouth and Torbay Coroner Area.
4	CIRCUMSTANCES OF THE DEATH Mary Pomeroy was a frail 89 year old female who suffered fatal traumatic injuries that were inflicted upon her (following being pushed over and falling to the ground) by a fellow in-patient on their shared ward at Derriford Hospital, Plymouth in March 2022. Section 2 of the Record of Inquest (which recorded the medical cause of Mary Pomeroy's death) was determined as: *1a – combined physiological effects of bilateral humeral fractures in an elderly patient* *1b – traumatic fall to ground following being pushed over* Section 3 of the Record of Inquest (which answered how, when and where Mary Pomeroy came by her death) was determined as: *'Mary Pomeroy was an in-patient at Derriford Hospital, Plymouth when, on 3 March 2022, she was pushed over on to the floor by a fellow patient who had been suffering with psychotic symptoms and cognitive and behavioural problems. Mary suffered fractures as a result of this trauma. Mary's condition deteriorated after, and as a direct result of, this incident, and she died on 15 March 2022 at Derriford Hospital, Plymouth.*

	There was a lack of assessment and management of the patient who pushed Mary over and this materially contributed to the incident occurring and therefore to Mary's death.' Section 4 of the Record of Inquest (which provided the conclusion as to Mary Pomeroy's death) was determined, in narrative form, as: *'Mary Pomeroy died from injuries suffered following being pushed over by a fellow patient on the same ward in hospital – this fellow patient had psychiatric, behavioural and cognitive difficulties and wasn't being closely supervised on the ward.'*
5	<u>CORONER'S CONCERNS</u> During the course of the investigation and 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: Derriford Hospital in Plymouth is the main acute hospital site managed by UHP NHS. UHP NHS carried out a Root Cause Analysis (RCA) investigation in respect of the circumstances which led to Mary Pomeroy being pushed to the ground by a fellow patient on a ward at Derriford Hospital, Plymouth and her death thereafter. This investigation culminated in a written investigation report which was given executive sign off on 14 July 2022, by the SI panel chair and chief nurse of UHP NHS. The main body of the investigation report concluded that the incident which led to Mary Pomeroy being pushed to the ground by a fellow patient was 'a rare and devastating accident for which could not have been foreseen'. The summary of the SI Panel Meeting Review, chaired by the Chief Nurse on 4 July 2022, stated that 'overall it was considered that [the patient who pushed Mary Pomeroy] was managed appropriately during his admission to UHP NHS and concluded that this was a deeply unfortunate accident, but not one that could have been anticipated and therefore prevented by staff.' The inquest heard evidence that the patient who pushed Mary Pomeroy to the ground on 3 March 2022 had done almost exactly the same thing to another patient on the ward only two days previously, on 1 March 2022 – this incident was discussed in the main body of the RCA investigation report, but not referred to at all in the SI Panel Meeting Review summary. The inquest also heard evidence that the patient who pushed Mary Pomeroy had been involved in a number of incidents where he had used physical force on staff members on the ward in February 2022. At the inquest, the author of UHP NHS's investigation report (who was the Matron of the relevant ward) accepted, in evidence, that the patient who pushed Mary Pomeroy should, on 3 March 2022, have been subject to enhanced observations of care – this was on the basis that previous assessments in November 2021 and January 2022 had shown that this was required for him owing to his psychiatric and behavioural presentation (which had become more concerning by the end of February/beginning of March 2022) and also because of very recent and specific concerns regarding his behaviour which should have been obvious to ward staff following the incident on 1 March 2022. The Matron accepted, in evidence, that had enhanced observation and care been in place for the patient (which could have taken a number of forms following assessment, depending on what would have been most clinically and therapeutically appropriate at the time) then he should have been prevented from being in a position where he was able to push Mary Pomeroy to the ground on 3 March 2022. The Matron accepted, in evidence, that UHP NHS's RCA report had been incorrect to conclude that the type of incident that occurred on 3 March 2022 could not have been foreseen. The Deputy Chief Nurse of

	UHP NHS accepted, in evidence, that the SI Panel Meeting should have interrogated the relevant facts and chronology more. The inquest determined that the incident on the ward on 3 March 2022 was foreseeable, based on the concerns about the patient's behaviour, the likely triggers for him becoming distressed and aggressive and the almost identical incident that had occurred on 1 March 2022. The inquest also determined that the lack of assessment and management of this patient's behaviour and needs materially contributed to the incident which led to Mary Pomeroy suffering injuries and led to her death. It is unfortunately clear, when comparing the evidence heard at the inquest with the findings of UHP NHS's RCA report, that there was inadequate analysis of this serious incident by UHP NHS, with concerning circumstances surrounding the care provided not being identified – therefore appropriate recommendations to inform future care provision were not given consideration as part of the RCA investigation/report. If UHP NHS do not identify concerning matters when carrying out internal investigations and do not take steps to try and learn from serious incidents when they occur, then there is an obvious, significant and continuing risk of future deaths occurring arising out of healthcare provision provided.
6	<u>ACTION SHOULD BE TAKEN</u> In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action (for the reasons set out in paragraph 5, above).
7	<u>YOUR RESPONSE</u> Your organisation is under a duty to respond to this report within 56 days of the date of this report, namely by **27 May 2025**. I, the coroner, may extend this period. If any request is to be made for this period to be extended, please ensure this is made in writing at least 14 days prior to the above required response date. 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	<u>COPIES AND PUBLICATION</u> I have sent a copy of my report to Mary Pomeroy's sons and the Care Quality Commission. I have also sent a copy of my report to the Chief Coroner. 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: 1 April 2025 Signature:  **Nicholas Lane** **HM Area Coroner** *County of Devon, Plymouth and Torbay*


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