MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

Date: 17 June 2025

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Rotherham NHS Foundation Trust

1. CORONER

I am Simon Tait, Assistant Coroner for South Yorkshire East

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 6 February 2025 I commenced an investigation into the death of Hazel Gambles. The investigation concluded at the end of the inquest . The conclusion of the inquest was a narrative conclusion that:

The deceased died as a result of naturally occurring frailty of old age. Her pre-existing Alzheimer's disease, coronary artery atherosclerosis and chronic obstructive pulmonary disease contributed to her death, as did a head injury sustained during an in-patient fall while in hospital.

1a Extreme frailty of age

1b

1c

II Alzheimer's disease, chronic obstructive pulmonary disease, coronary artery atherosclerosis, recent head injury

4. CIRCUMSTANCES OF THE DEATH

Hazel Gambles suffered a fall at home on 10 January 2025. She was admitted to Rotherham District General Hospital. She had not sustained any injuries in the fall at home but was felt to have community acquired pneumonia and was admitted for investigation. A falls risk assessment was done on admission identifying her as a falls risk, but the falls prevention

measures section of the assessment was not completed, and no such measures were put in place.

On 11 January at 00.18 Mrs Gambles was transferred to Ward B4. According to the Trust guidelines, a further falls assessment should have been done within six hours of admission to the ward but that did not take place. At 20.00 she had an unwitnessed fall and was noted to have injuries to her face. At 23.50 a falls risk assessment was done. The falls prevention measures section of the form was not completed.

At 01.04 Mrs Gambles was reviewed by a doctor. The assessment should have taken place sooner given the injuries to her face and the fact that she was on anticoagulation. The request for medical review is recorded in the records but not timed as it should have been. Following medical review, a CT scan was undertaken and Mrs Gambles was found to have suffered a small bleed on her brain. This bleed had been sustained in the in-patient fall. Her family were told of the fall but were not told about the result of her CT scan, or that she had suffered the bleed. Contrary to Trust policy there was no Datix report submitted in respect of the fall, meaning that the fall was not reviewed or investigated at the time.

On 23 January 2025 Mrs Gambles was discharged to a care home. The discharge letter did not mention the in-patient fall. She died on 27 January 2025. The head injury sustained in the in-patient fall more than minimally contributed to her death.

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 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. –

There are several areas of concern around failures in documentation and failures to follow Trust policy, namely:

1. Lying and standing Blood Pressure was not recorded on admission.
2. There was no documentation of any falls prevention measures at the time of the first falls assessment.
3. There is no evidence of falls prevention measures being put in place following the first falls assessment.
4. There was no falls assessment done at the time of transfer to ward B4. There should have been a falls assessment within six hours of transfer but that did not happen. The assessment took place some 23 hours after admission to the ward, by which time Mrs Gambles had already fallen.
5. Following the in-patient fall there was a delay of over 5 hours before a medical review took place. The note recording the request for medical review is not timed.
6. There was no discussion with Mrs Gambles' family explaining the findings of the CT scan and they were not told about the bleed on the brain.
7. No Datix report was done following the in-patient fall leading to a delay in investigation.
8. The in-patient fall is not mentioned on the Discharge letter.

I am concerned that these failures suggest a lack of awareness of, and lack of compliance with, the Trust's processes on falls assessment and record keeping.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 the 12th August 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.

8. COPIES and PUBLICATION

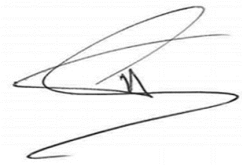
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted].

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.

17 June 2025

Signature



for South Yorkshire East