Miss K J Gomersal LLB | Acting Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

[redacted]

Case Ref: **13567700**

26 May 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: North Cumbria Integrated Care NHS Foundation Trust

1) CORONER

I am Margaret Taylor HM Assistant Coroner for Cumbria

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 12 November 2024 I commenced an investigation into the death of Sarah Kathleen HILL. The investigation concluded at the end of the inquest on 13 May 2025 . The conclusion of the inquest was a narrative conclusion that Sarah Hill

Died as a consequence of the recognised complications of a necessary medical procedure .

I found that her cause of death was:

1a Systemic Inflammatory Response Syndrome

1b Common bile duct perforation and Pancreatitis

1c Gallstones

II Coronary Artery Atherosclerosis

4) CIRCUMSTANCES

Mrs Hill was a 78 year old lady who was admitted to the Cumberland Infirmary on 5 November 2024 for an elective ERCP procedure for the removal of gallstones .Small stones and fragments were successfully removed during the ERCP but the largest stone could not be removed as it was impacted at the level of sphincterotomy . A stent was inserted to enable bile duct patency and the procedure abandoned . Mrs Hill complained of nausea , vomiting and pain post procedure . Approximately seven hours later a CT scan and bloods were ordered to rule out any significant pathology . A decision was made to admit her due to pancreatitis which is a recognised complication of ERCP . The CT did not show evidence of perforation . On 6 November blood results revealed an increase in amylase and Mrs Hill developed a temperature suggesting her pancreatitis was worsening . On 7 November she became tachycardic and short of breath . She collapsed whilst going to the toilet . A further CT scan demonstrated a significant worsening of the pancreatitis , a new acute collection , air in the retroperitoneum , ascites and a new pleural effusion . She was referred to the surgical team who decided she was not for escalation . At approximately 17.00 hours she had an unwitnessed fall at a time when she was meant to be closely observed . She was helped to a chair and whilst observations were attempted she became unresponsive . At 17.54 hours she went into cardiac arrest . Blood results demonstrated multi organ failure . Her prognosis was poor due to the response to pancreatitis and perforation . A DNACPR was agreed and a plan made for end of life care . Mrs Hill died in the early hours of 8 November 2024 .

5) CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern about the standard of nursing care provided to Mrs Hill. 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. –

(1) There was a lack of evidence suggested appropriate falls risk assessments had been undertaken and a failure to report falls / collapses on the ward .

(2) There was a lack of documentation about the use of cot sides and the placement of the call bell within Mrs Hill's reach .

(3) There was a lack of frequent recorded observations necessitated by Mrs Hill's deteriorating condition.

(4) Mrs Hill was placed in a side room where she was not easily observed without consideration given for the need for additional monitoring which led to her being left alone for extended periods of time.

(5) I was advised that the ward was understaffed and under pressure .I was told that despite this being appropriately escalated nurses were caring for 10 patients when the expected allocation would be 6 patients for each nurse on duty .No further help was provided to the ward following escalation . The evidence presented to me was that this was not an unusual situation on the ward .

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you North Cumbria Integrated Care NHS Trust 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 22 July 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

The family of Mrs Sarah Kathleen Hill

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.

26 May 2025

Signature 

Margaret Taylor HM Assistant Coroner for Cumbria