




Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Chief Executive - County Durham & Darlington NHS Foundation Trust
1	CORONER I am Rebecca SUTTON, Assistant Coroner for the coroner area of County Durham and Darlington
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.
3	INVESTIGATION and INQUEST On 03/03/2025 16:39an investigation was commenced into the death of Victor Jackson HUTCHENS 17/05/1939. The investigation concluded at the end of the inquest on 23/07/2025 12:50. The conclusion of the inquest was that On 27 February 2025 at the Darlington Memorial Hospital the deceased died as a result of an accidental fall. On 20 February 2025 the frequency of care rounds provided to the deceased was reduced, in error, from hourly to four-hourly. It cannot be said, on a balance of probabilities, that the error contributed to the deceased's death.
4	CIRCUMSTANCES OF THE DEATH The deceased died due to a head injury, caused by an accidental fall in hospital.
5	CORONER'S CONCERNS During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: On 20 February 2025, a week before the deceased's death, the frequency of care rounds was reduced, in error, from hourly to four-hourly. The member of staff responsible for the error is unaware of how the error occurred. That being the case, there is a concern that the error could occur again and could cause or contribute to a future death.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 October 02, 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	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>[REDACTED]</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 07/08/2025</p> <p></p> <p>Rebecca SUTTON Assistant Coroner for County Durham and Darlington</p>