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 **Ms Rebecca Sutton, Assistant Coroner** for the coroner area of **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 08 May 2025 an investigation into the death of Susan Elizabeth SAMSON aged 78 was commenced. The investigation concluded at the end of the inquest on 12 February 2026. The conclusion of the inquest was that: On 7 May 2025 at her home address in Darlington, the deceased died due to an accidental fall down the stairs. The death was caused by an accident, which was contributed to by an unsafe discharge home from a rehabilitation placement.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a recent history of falls and had been admitted to hospital on 27 February 2025. She was using a wheeled walking frame to mobilise and experienced difficulty when attempting to use stairs. It was identified on 12 March 2025 that the deceased would benefit from a second banister rail on her discharge from hospital. There was an attempt to discharge the deceased home on 19 March 2025, which was unsuccessful, as her legs were buckling on the stairs. It was decided that it was not safe for the deceased to stay at home and she was admitted to Rydal Care Home for a six-week period of rehabilitation. Between 19 March 2025 and 1 May 2025 there were numerous attempts to assess whether the deceased was safe to use stairs without assistance. The first time that the deceased managed to successfully complete the stairs without requiring prompting was on 28 April 2025. There was a second successful attempt on the stairs on 30 April 2025. The deceased was discharged home on 1 May 2025 (at the end of the six-week rehabilitation period). An Occupational Therapist accompanied the deceased home and observed the deceased using her own staircase. By that time the second banister rail had not been installed. The Occupational Therapist deemed the deceased to be safe using her stairs. On 7 May 2025 the deceased fell down her stairs and died due to the injuries sustained in that fall.
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: (brief summary of matters of concern) The Occupational Therapist involved in the deceased's discharge on 1 May 2025 gave evidence that for someone to be assessed as safe to use the stairs on their own, it was not

	sufficient for them to have managed to complete a set of stairs without assistance on one occasion; it was necessary for the person to demonstrate that they could consistently complete the stairs without assistance. The Occupational Therapist stated that the two successful attempts in the Care Home seemed to be enough to achieve consistency and indicated that if similar circumstances arose today the patient would still be discharged home at the end of the six-week rehabilitation period. I found as a fact that prior to the deceased's discharge on 1 May 2025 the deceased had not demonstrated that she was able to consistently complete a flight of stairs without assistance. I am concerned by the evidence that if similar circumstances arose today the patient would still be discharged. I am concerned that there may be occasions in the future that patients will be discharged before they are able to consistently complete a flight of stairs and that, as a result, a death may occur.
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 April 10, 2026. 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 have also sent it to who may find it useful or of interest. 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 23rd February 2026** [redacted] **Ms Rebecca Sutton** **Assistant Coroner for** **Durham and Darlington**