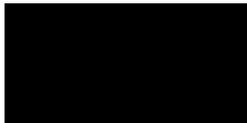




REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Chief Executive of Darlington Borough Council</p>
1	<p>CORONER</p> <p>I am Rebecca Sutton, senior coroner/area coroner/assistant coroner, for the coroner area of County Durham and Darlington.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>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.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>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.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the</p>

	<p>circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>I heard evidence that:</p> <ol style="list-style-type: none"> 1. On 18 March 2025 (via an email timed at 16:19) a request was made by staff at Sedgefield Community Hospital to Darlington Borough Council (who were the landlord of the property where the deceased lived) to fit a second banister rail in the deceased's home. 2. On 10 April 2025 a further request, by an Occupational Therapist working at the Rydal Care Home, was made to Darlington Borough Council to fit a second banister rail in the deceased's home. 3. An appointment was made to fit the second banister in the deceased's home on 6 May 2025. 4. For reasons unknown the appointment was changed from 6 May 2025 to 9 May 2025. <p>I am concerned by the length of time between the requests for a second banister and the first appointment arranged to fit a second banister.</p> <p>I am concerned that, if similar circumstances arose today, or in the future, a Darlington Borough Council tenant could be exposed to a potentially avoidable risk of death while awaiting the installation of a second banister.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 April 2026. I, the coroner, may extend the period.</p> <p>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.</p>
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></p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</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. 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: 2 March 2026</p> <p></p> <p>Ms Rebecca Sutton Assistant Coroner for Durham and Darlington</p>