REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Dr Leslie Hamilton, Assistant Coroner, for the Coroner area of Durham and Darlington.
2.	**DATE OF REPORT:** 4 May 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. Darlington Borough Council (Lifeline Service) 2. Family of Mr Connell You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 June 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** Mr Connell had a contract with the Lifeline Service provided by Darlington Borough Council. He had a fall and activated his pendant. Due to technical problems (which could not be explained) he was not connected to the service and so had a "long lie" before he was found the next morning.
6.	**ACTION SHOULD BE TAKEN** In my opinion, unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 18 February 2026, I commenced an investigation into the death of Leonard Stuart CONNELL aged 86 years. **The medical cause of death was:** 1a Multi Organ Failure 1b Intra-abdominal Sepsis Resultant from Traumatic Perforated Diverticulum 2 Fracture Neck of Femur, Pathological Spinal Fracture, Frailty of Old Age, Chronic Kidney Disease. **How, when and where**: He was an 86 year old man who died on 11 January 2026 at Darlington Memorial Hospital. He had a history of ankylosing spondylitis (2016), type 2 diabetes (on insulin) and significantly impaired left ventricular function

	midnight on the 2nd January, he fell down the stairs at home and was found about 5am the next morning. On admission he had evidence of a "long lie". CT scan showed pathological fractures to spine (L1 to 4) on the background of ankylosing spondylosis, a fractured neck of femur, right posterior rib fractures and evidence of perforated diverticular disease. After an MDT discussion, it was felt he was not fit for surgery and he was managed with end of life care. **Conclusion**: Accident
8.	**CIRCUMSTANCES OF DEATH** [Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words] See above

9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: Although in his case I found that the "long lie" (due to him not being connected to the Lifeline service) did not contribute to his death, I have concerns that other clients may experience problems with connection to the service (as the problem could not be explained in his case) and so suffer a "long lie" (which usually results in muscle damage leading to release of compounds into the blood stream which in turn leads to acute kidney injury and increased risk of mortality) which may contribute to their death. There had been a previous incident on 28th October 2025, where Lifeline were aware of a fault with his equipment but failed to act upon it - this was a 'missed opportunity'.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Darlington Borough Council (Lifeline Service) 2. Family of Mr Connell I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE [redacted]