	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 29 June 2022 I commenced an investigation into the death of Joan Rossington born on 26 September 1937. The investigation concluded at the end of the inquest on 7 November 2022. The conclusion of the inquest was:- On 16 June 2022 Joan Rossington was an inpatient at the Royal Hallamshire Hospital. She required support with a number of her cares and her own carers were providing her with support during the day throughout her admission. After her carer had left for the day Joan stood from her chair and attempted to move across the ward. She was unable to sustain her balance and fell banging her head. She sustained significant injuries as a result of this fall and died as a result of those injuries at the Royal Hallamshire Hospital on 17 June 2022 She died as a result of an accident. The medical cause of death was: 1a: Traumatic subarachnoid, intracerebral and subdural haemorrhage 1b: Multifactorial fall 2: Old age and frailty, suspected dementia
4	**CIRCUMSTANCES OF THE DEATH** Joan Rossington was an inpatient at the Royal Hallamshire Hospital. Whilst an inpatient she was supported by her own care staff. Those staff were present with her during the day and provided routine support to her including assistance with her eating, drinking and personal hygiene. Joan had a number of care plans and risk assessments which applied to her on the ward including appropriate care plans relating to her risk of falls. Those care plans and risk assessments were not discussed with or shared with her own care staff delivering support to her on the ward. On 16 June 2022 despite these plans being in place, once her care team had left the ward for the day; Joan suffered a fall in hospital. As a result of this she sustained head injuries which proved to be fatal.

5	**CORONER'S CONCERNS** 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 circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Joan was in receipt of support on the ward from her own care staff. These staff were not included in, or aware of, the risk assessments or care plans which were in place on the ward to support Joan. This had the potential to place Joan at risk of those staff delivering care which was contrary to that which was indicated by medics and clinicians responsible for her. Involvement in care planning and delivery of those supporting Joan would have made this a safer environment for her and the roles and responsibilities of those involved in care should be made clear.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. I would ask that your responses specifically consider the following:- 1. The role of family and carers not employed by the Trust where they have a role in supporting interventions with those in hospital
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th February 2023. 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: Joan Rossington's family members and Sheffield Teaching Hospitals NHS Foundation Trust. 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 other 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.

9	**22nd November 2022**  Abigail Combes **Assistant Coroner**