Hull University Teaching Hospitals NHS Trust

[redacted]

Date 25 March 2024

Miss Lorraine Harris
HM Area Coroner for Hull & the East Riding of Yorkshire
The Coroner's Court & Offices
The Guildhall
Hull
HU1 2AA

Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

Dear Miss Harris,

Re: Death of Sylvia Linda White – Response to Regulation 28 Report to Prevent Future Deaths

I write in response to the Regulation 28 Report to Prevent Future Deaths (the Report), dated and received on 30 January 2024, issued as a result of the concluded inquest into the death of Ms Sylvia Linda White.

I would like to take this opportunity to express my sincerest condolences to the family of Ms White for their loss.

As confirmed within the Report, the Trust was not an interested party in this matter, nor was evidence requested from the Trust prior to the inquest hearing, and therefore we first became aware of the inquest and circumstances on 30 January 2024.

The Report states that upon receipt of evidence from the Care Manager of Hale Care, your statutory duties under regulation 28 were triggered. It is stated that the Care Manager provided oral testimony suggesting that information contained within a patient's discharge summary does not provide appropriate information to risk assess a patient, and that this was not only the case for Ms White but that this happens regularly; thus leading to the concerns detailed within the report.

Unfortunately, as the Trust was not present at the inquest, we are only able to comment on the information contained within the Report. It does not seem that the discharge process has been fully

explained in the course of the inquest. Information regarding a patient's frailty and mobility is detailed in a form known as a Trusted Assessor Referral Form (TARF) not the patient's discharge summary, as suggested by the Care Manager. This form is sent from the hospital to the Local Authority, who risk assess the patient's needs within the community. Trusted Assessor schemes are a national initiative designed to reduce delays when patients are ready for discharge from hospital. This approach allows adult social care providers to adopt and use assessments carried out while patients are still in hospital, promoting safe and timely discharges.

On review of Ms White's records, I can confirm that a TARF was appropriately completed and submitted to Social Services on 04 October 2023, and our system show that this was acknowledged by them on the same day. This details that during her admission she was able to walk to the toilet and back with minimal supervision, and with the use of a Zimmer frame. I would also like to confirm that on review of Ms White's discharge summary, there is a request to her GP to follow up her lying and standing blood pressure in a week due to risk of falls within the community.

I am sorry that this information was not made available to you by those who were party to the inquest. I hope that this letter provides both you and Ms White's family with further clarity and assurance regarding the discharge process and risk assessment of a patient from the hospital into social care.

Yours sincerely

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Interim Group Director of Quality Governance