ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hull University Teaching Hospital** **2. NHS England** **3. Care Quality Commission** **4. CSC (providers of Lorenzo)**
1	**CORONER** I am Sally Robinson, Assistant Coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 7th March 2023, an inquest was opened and adjourned into the death of Ethel Doreen Reed aged 93 years. The investigation concluded at the end of the inquest on January 26th, 2024, The conclusion of the inquest was Accidental Death. Box 3 of the Record of Inquest read: Ethel Doreen Reed died at Holy Name Community Rehabilitation Centre, Hall Road, Hull from a chest infection which developed from fractured ribs following an unwitnessed fall at home. Her medical cause of death was recorded as: **1a** Chest infection **1b** Rib fractures **1c** **II** Fall, Chronic Obstructive Pulmonary Disease, Hypertension, Transient Ischaemic Attack, Ischaemic Heart Disease, Atrial Fibrillation
4	**CIRCUMSTANCES OF THE DEATH** Ms Reed had a fall at her home address on 22nd January 2023. She was taken to Hull Royal Infirmary and she was seen in A&E, the Acute Medical Unit, Frailty Assessment Unit for assessment but was deemed too poorly for that ward and was transferred to Ward 90.She had sustained rib fractures which had caused a pneumothorax and she had other co morbidities which were treated on Ward 90. The rib fractures caused an infection to develop in her lungs and Mrs Reed developed pneumonia. Whilst on ward 90 she began physiotherapy and was mobilising and able to eat and drink with minimal support. She was assessed as medically fit for discharge on 3rd February 2023, but she required more physiotherapy and support and so was transferred to a new no criteria to reside ward, Ward H130E in Hull Royal Infirmary. Whilst on Ward H130E Mrs Reed contracted Covid-19. (positive PCR 19/02/23, negative 23/02/23)

	and this set her discharge back as she had been planned for discharge to a residential rehab setting on 19/02/23. Mrs Reed was seen by the medical team on 24/02/23 as nursing staff had concerns. Mrs Reed was visibly dehydrated, drowsy, tachycardic and her blood tests showed signs of infection. She was assessed as now not medically fit for discharge however instead of being transferred on to a medical ward she was discharged on 26th February 29023 to Holy Name Community Rehab Centre in Hull. She was not medically fit for discharge and indeed should not have been discharged. The fact that she was very poorly was recognised as such upon arrival at the centre. The centre staff requested an urgent medical review and Mrs Reed was placed on end of life care and very sadly died on 2nd March 2023 in the centre.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) H130 is on the 13th floor of Hull Royal Infirmary. It has an East and a West wing and spans the full floor. It was opened in response to winter pressures. At that time, in January 2023, Hull Royal Infirmary was placed under significant pressure in terms of admissions and staffing. The ward been open only a matter of some two weeks by the time Mrs Reed was transferred to that ward. Despite being medically fit for discharge upon arrival on that ward Mrs Reed's condition worsened and family raised concerns as best they could but they reported that the ward was chaotic and that staff would tell them they had only just found out they were working on the ward before their shift started and there was no consistency of nursing staff on the ward. Mrs Reed was dehydrated and family report that there was a paucity of personal care afforded on that ward. There was a risk of cross infection as patients' personal effects such as toiletries were not with the right patients and had to be located by family. There was no established cohort of permanent staff on the ward at that time and no signposting to the ward sister or matron and therefore no way of patents, their friends, or their families being able to have a clear escalation pathway to ventilate concerns. Although HUTH now have an established team and leadership chain on Ward H130 there is a real concern that wards opened in response to winter pressures in the future in any busy hospital may give rise to the same peripatetic staffing regime, that is to say, agency staff and no fixed team in place and a lack of visible leadership. This could lead to the deterioration of patients not being recognised if there is no continuity of care by the same team of nursing staff. (2) An issue with the Lorenzo electronic patient record keeping system has been identified in respect of the system not auto populating the identification of the author of any changes made in the immediate discharge letter (IDL) after it has been finalised. This could lead to miscommunication of critical issues and difficulties in establishing who made what decisions which could lead to delays in treatment in the next post discharge setting which in turn could lead to future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 8th April 2024. 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: • The family of Ethel Doreen Reed, • Hull University Teaching Hospitals • Community Health Care Partnership as well as the agencies identified at the top of this report. I am also under a duty to send the Chief Coroner a copy of your response. 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	**[DATE]** **[SIGNED BY CORONER]** ***8th February 2024*** ***Sally Robinson, Assistant Coroner***