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:** Hull University Teaching Hospitals NHS Trust
1	**CORONER** Miss Lorraine Harris, Area Coroner, 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 3rd November 2023 I commenced an investigation into the death of Sylvia Linda WHITE, aged 92 years. The investigation concluded at the end of the inquest on 26th January 2024. The conclusion of the inquest was: *Accident* The following findings of fact were made: • Sylvia Linda WHITE was 92 years of age, she was partially sighted but maintained a level of independence at home with the assistance of carers. • Mrs White had been discharged from hospital recently (day before her birthday, which would have been 04/10/2023), but evidence heard that the discharge papers did not report the increase in her frailty and the decrease in her mobility. At the beginning of the inquest it was unknown that the issue of discharge summaries may be relevant. Manager of the care company raised concerns that it was not uncommon for discharge summaries to be inadequate in assessing the ongoing care changes. The carer felt that the risk assessments should have changed after hospital but they were not. • Carer attended on the evening of Thursday 12th October 2023, Mrs White was in bed. She was given medication but did not wish to use the commode. • Mrs White was capable of getting out of bed and using the commode

	herself. • The commode should have been placed next to the bed. Notes said it should have been placed within reach but were not specific about locations. • The following morning Friday 13th October 2023 a carer attended and discovered Sylvia pinned to the floor by an upturned wardrobe. • The commode looked to have been placed in the corner of the room, but was upturned. • The wardrobe had never shown signs of instability. • Mrs White had never moved the commode herself in the past. There was no reason to think that she had moved it herself on this occasion. • A coroner is unable to deal with what is possible, and it would be unsafe to say what definitely happened as Mrs White had no recollection, but it is likely that Mrs WHITE has slipped, possibly while using the commode, and as she fell inadvertently pulled the wardrobe down on top of her. Her dressing gown was hung on the door handle and she may have pulled on this. • Mrs White wore a lifeline device but the position of the wardrobe meant she was unable to activate it. • I note that, on discovery, the carer lifted the wardrobe, called emergency services and the family, while reassuring Mrs White and keeping her warm and stable. • Mrs White had sustained a significant head injury but was unsuitable for surgical intervention. Box 3 of the record of inquest read: Sylvia Linda WHITE was 92 years of age and partially sighted. She maintained a level of independence at home with the assistance of carers. On 13th October 2023 at 0758 a carer discovered Mrs White pinned to the bedroom floor by an overturned wardrobe which she appeared to have accidently pulled down on top of herself during some form of fall or slip. Mrs White was conveyed to Hull Royal Infirmary and found to have a traumatic subdural haemorrhage. The bleed progressed and Mrs White was placed on palliative care. She died on 28th October 2023. Her medical cause of death was recorded as: 1a Traumatic Subdural Haemorrhage 1b Unwitnessed fall 2 Frailty of great old age, cognitive impairment, chronic kidney disease, congestive cardiac failure
4	**CIRCUMSTANCES OF THE DEATH** Sylvia Linda WHITE was 92 years of age. She maintained her independence at home but had carers visit 4 times a day. She was mobile but used aides. She

	was partially sighted, having problems in both eyes. As outlined above Mrs White was found by a carer on the morning of Friday 13th October 2023 pinned to the floor by a wardrobe. She sustained a head injury and died on 28th October 2023 in hospital. There was no issue with her care in hospital leading to her death.
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. – 1. The main issue of this inquest was to try to ascertain exactly how the wardrobe came to be on top of Mrs White and evidence was heard on the subject. As the evidence neared its conclusion a comment was made regarding discharge summaries and the role they play in updating risk assessments for carers. 2. I am fully aware that the hospital did not have the opportunity to put forward any information on this point, however it is my statutory duty to make a report to prevent future death, and the evidence in this case was that this was an issue that occurred regularly. 3. Prior to this incident occurring Mrs White had been in hospital and discharged on 4th October 2023. A manager for the care home outlined that the paperwork provided to carers known as the "Discharge Summary" is often inadequate in providing suitable information. In this instance I was informed it did not provide any information on Mrs White's increased frailty and decreased mobility. This means that information provided is inappropriate for ongoing risk assessments. 4. The manager did outline a particular form that they prefer, I make no comment regarding the format of the information required, merely the need for appropriate information to allow risk assessments to take place. 5. The manager stated that a social worker should be completing a risk assessment prior to discharge but this often does not happen. In many cases a doctor or another member of staff will complete a discharge summary. The information in these is often lacking to safeguard the welfare of the person concern with regard to their care needs. The manager stated they often have to alert safeguarding at the local authority of the deficit. 6. Bearing in mind the importance of a discharge summary in providing the foundation information for the ongoing safe care of patients as they leave the hospital environment, this is an issue where either a structured approach is required or training to those who are failing to complete them correctly is required.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/organisation have 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 Tuesday 26th March 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 family of Sylvia Linda WHITE • The Chief Coroner • Hale Care • The Safeguarding Department of the Local Authority • The CQC • The ICB for Humber • NHS National England Director 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	**[DATE]** **[SIGNED BY CORONER]** ***30th January 2024*** ***Lorraine Harris***