MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

[redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], OBE Chief Executive, Doncaster Royal Infirmary

1. CORONER

I am Sarah Louise Slater, Area Coroner for South Yorkshire East

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 8 August 2022 I commenced an investigation into the death of Robert Fuller, age 71. The investigation concluded at the end of the inquest on the 21st March 2024. The conclusion of the inquest was that Mr Fuller died in Doncaster Royal Infirmary on the 22nd July 2022 as a result of natural causes.

1a Cerebrovascular disease and ischaemic heart disease

II Hypertension and type II diabetes mellitus

4. CIRCUMSTANCES OF THE DEATH

Mr Fuller was admitted to Doncaster Royal Infirmary on the 11th June 2022 with increased confusion. Investigations revealed that he had suffered a transient ischemic attack. He was medically fit for discharge by the 13th June 2022 but the discharge was delayed due to him needing social care involvement prior to discharge. Mr Fuller was transferred to Mallard Ward within the frailty unit on the 14th June 2022. This ward is a locked ward because between 50 and 75% of the patients suffer with dementia of varying degrees together with some experiencing challenging and unpredictable behaviour.

On the 10th of July Mr Fuller was transferred out of his shared room due to a verbal disagreement with a fellow patient (Patient A). On the 3rd July 2022, Patient A kicked Mr Fuller's feet whilst he was sleeping in a chair on the corridor. This caused no injuries. On the 10th July 2022, Mr Fuller was walking down the corridor when Patient A punched him at the side of the head causing him to fall, hitting his head on the radiator before coming to rest on the floor. Investigations immediately after the incident revealed a new small traumatic bleed in the brain. Mr Fuller was transferred to a different

ward.

Mr Fuller's condition fluctuated over the next few days but then deteriorated further due to a number of factors including covid, severe longstanding cerebrovascular disease and delirium. The pathological evidence confirmed Mr Fuller had suffered a new large stroke in the days prior to his death on the 22nd of July 2022. The pathology evidence confirmed that the injuries Mr Fuller sustained in the assault and subsequent fall did not cause or contributed to his death. Therefore, a conclusion of natural causes was recorded.

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. There was evidence of poor record keeping on the ward. This included behaviour charts, enhanced patient supervision records and daily evaluation charts not being consistently recorded. There was either no or poor documentation of other professionals entering the ward and evaluating patients, and the outcome of such assessments not being recorded. Some of the documentation was also described as not fit for purpose within the frailty unit due to the needs of the patients. This insufficient record keeping prevented any patterns of challenging behaviour to be assessed and managed accordingly putting other patients, staff and visitors at risk of harm.
2. This poor record keeping also lead to poor/inaccurate communication following the incident with the family.
3. There is no system in place for agency staff, who frequently work on the Frailty Unit to access and communications , reminders or new policies and procedures.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Mr Richard Parker 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 the **28th May 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 [redacted] and DAC Beachcroft solicitors.

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.
2nd April 2024

9. Signature

for South Yorkshire East