**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Hull University Teaching Hospital**<br>2. **NHS England**<br>3. **East Riding of Yorkshire Council Adult Social Care and Health**<br><br>**I am also sending this to Yorkshire Ambulance Service and Humberside Police Right Care Right Person lead as it may be of interest to these agencies and the family of Mr Colin Wiles.** |
| 1 | **CORONER**<br><br>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**<br><br>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**<br><br>On 11th April 2023 an inquest was opened and adjourned into the death of Colin Wiles aged 79 years. The investigation concluded at the end of the inquest on 25th October 2024, the conclusion of the inquest was a narrative conclusion.<br><br>Conclusion: Narrative - Colin Wiles died at Hull Royal Infirmary following admission for a collapse at home. Multifactorial issues led to a worsening of pre-existing health conditions and hypothermia which were contributed to by self-neglect.<br><br>His medical cause of death was recorded as:<br><br>1a. Type 2 Respiratory Failure<br>1b. Chronic Obstructive Pulmonary Disease and Hypothermia<br>2. Frailty and Chromic Kidney Disease; Paranoid Schizophrenia |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Colin Wiles lived alone in a home he owned. He had a history of diagnosed mental health and was concordant with medication for Schizophrenia. He enjoyed a good relationship with his mental health nurses and GP and was deemed capacitous throughout his treatment in recent years.<br><br>Colin had a good and loving relationship with his daughter and with his sister.<br><br>Colin elected to live in a house which did not have fully functioning mains services due to a variety of reasons. He received advice on his living situation from various agencies, but he appeared to be content in his way of life. This self-neglect however meant that he |

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| | did not always keep his house warm although he did have a coal fire and access to oil heaters, and he did cook his own meals when not at family members' houses.<br>There had been attempts at helping Colin access repairs for his house following various admissions to hospital and a safeguarding referral was made by the Safeguarding Adults team at Hull Royal Infirmary on 13th February 2023 as Colin was about to be discharged home from hospital and his house needed work. The Independence and Advice Hub were to screen that referral, but Colin was discharged home before contact was made with him.<br><br>On 6th March 2023 Colin was assigned a social worker and support was offered. Colin was offered alternative living arrangements for a short while but declined with capacity to make his own decisions.<br><br>On the 7th March 2023, the social worker once again visited Colin, and this time support was accepted from the Red Cross. On 8th March Colin was discharged home. Due to ongoing concerns a Vulnerable Adults Risk Management (VARM) meeting was suggested.<br><br>The Red Cross did support Colin but raised concerns about his house. Colin declined further support on 10th March 2023 but said he knew what to do if he needed support in the future.<br><br>A VARM meeting was not held, which was an accepted missed opportunity by East Riding Adult Social Care and Health.<br><br>Colin's hospital admissions prior to his death concerned a general decline and hypothermia and he was warmed up at hospital.<br><br>Colin's daughter arranged to visit Colin on 26th March but upon attendance there was no response to knocking or phone calls. She rang the police with a concern for welfare call. She was advised this was a health concern and as such under the Right Care Right Person Policy she should ring for an ambulance which she duly did at 17:57. The call was answered at 17:59 which constituted a delay of 1 minute and 50 seconds.<br><br>The call was coded as a Category 3 call, which on the information provided was the correct category. The caller was advised the service was extremely busy but was not advised how long the delay was likely to be.<br><br>Calls were made to the patient, but the line was constantly engaged as reported by his daughter.<br><br>At 03:35 on 27th March 2023 an ambulance arrived at Colin's house. This was response time of 9 hours and 38 minutes was accepted by Yorkshire Ambulance to be an excessive response time.<br><br>Colin was seen through the window collapsed and the fire and rescue service were summonsed by ambulance to attend and effect entry which they did at 04:00 hours. Colin was critically unwell when the ambulance crew assessed him, and he was conveyed under blue lights and sirens Hull Royal Infirmary who were pre alerted by the ambulance that he was en route.<br><br>Despite best efforts at Hull Royal Infirmary, Colin sadly passed away at 15:00 hours on the 27th March at Hull Royal Infirmary.<br><br>Due to excessive handover times at Hull Royal Infirmary on that date Colin was not handed over to Emergency Department staff until 05:48 hours, having arrived at the emergency Department at 04:27 hours. This was a delay of 1 hour and 21 minutes.<br><br>At 02:58 on 27th March 2023 the CSP level was escalated to Level 3, as Category 3 response times had increased to 10 hours and 5 minutes. A total of 160 ambulance hours were lost on that date waiting for patient transfer at Hull Royal Infirmary which equates to 16 x 10 hr ambulance shifts. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) No Vulnerable Adult Risk Management meeting was held despite multifactorial concerns with Mr Wiles' comorbities and self neglect leading to poor living conditions and increased risk to his safety<br><br>(2) It does not seem clear whether callers are advised to call the emergency services back if they continue to have concerns.<br><br>(3) The waiting times for ambulances to hand over patients at Hull Royal Infirmary were excessive that day leading to 160 hours of lost ambulance time.<br><br>(4) There appears to be an issue with no criteria to reside patients and the ability to hand over patients into ED in Hull Royal Infirmary who arrive in emergency ambulances. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd January 2025. I, the coroner, may extend the period and acknowledge it is the Christmas and New Year period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: the family Colin Wiles, Yorkshire Ambulance Service and Humberside Police as well as the agencies identified at the top of this report.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>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]**<br><br>***24th November 2024*** ***Sally Robinson, Assistant Coroner*** |
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