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

email: [redacted]

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

Tel: (01302) 737135
Fax: (01302) 736365

Date: 12 December 2024

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, City of Doncaster Council

1. CORONER

I am Ms N J Mundy 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 5 July 2024 I commenced an investigation into the death of Jean MULLEN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Accidental death.

1a Fracture of neck and subdural haemorrhage

1b Fall from height

4. CIRCUMSTANCES OF THE DEATH

This case relates to the unexpected death of an 87 year old woman who was found collapsed at her home address. The death has been referred by South Yorkshire Police, who have confirmed that there are no suspicious circumstances.

According to the referral, Mrs Mullen's pendant alarm triggered at 03:21hrs on the 22nd June 2024. It is noted that the alarm company heard Mrs Mullen scream at 03:31hrs. She was last heard speaking at 03:38hrs. The alarm responders attended at the address but they were unable to gain access. Paramedics attended and forced entry. Mrs Mullen was found faced down at the bottom of the stairs. The police have described her as having her bottom in the air, in a foetal like position and noted a small cut on the upper left side of the scalp and a visible fracture to the left forearm.

According to the referral, the attending Paramedics commenced full ALS, but they were unable to save Mrs Mullen.

[redacted] advised that in March 2024, her Mother suffered a fall at home, which resulted in her being admitted to Doncaster Royal Infirmary. [redacted] confirmed that her Mother sustained some bruising, but no significant injuries. [redacted] informed me that she lives in Shropshire, so she is not able to directly support her Mother. [redacted] advised that following her Mother's fall, in March, she travelled to Doncaster. [redacted] advised that she visited her Mother's address and noted that her Mother was not coping very well. The property was untidy, with food left out. At this point, [redacted] realised that her Mother needed more support.

[redacted] advised that whilst in Hospital, her Mother underwent a needs assessment via the local authority. An occupational therapist also assessed her Mother. [redacted] advised that her Mother was discharged from Hospital on the 22nd March 2024 with a care package in place. [redacted] advised that 1 x Carer would attend in a morning and 1 x Carer at night to assist her mother. [redacted] advised that this was to assist with getting up, going to bed and showering. [redacted] advised that her Mother was a strong willed woman and she would not always accept help. [redacted] advised that her Mother would also do things that she wasn't supposed to, such as coming downstairs on her own. [redacted] advised that her Mother's bedroom and bathroom were upstairs, but she would use a commode downstairs during the day. [redacted] advised that she thought that the stairs were becoming too much for her mother, which she had communicated to social care, but [redacted] was advised that her Mother had completed a stairs assessment which she had passed. [redacted] advised that she thought her Mother should have been placed into a care home, but the Local Authority advised that her Mother was not yet ready for this.

I have spoken with Doncaster Royal Infirmary, who have provided a copy of the discharge letter relating to the last admission - see attached. According to the letter, Mrs Mullen was admitted to Doncaster Royal Infirmary on the 20th March 2024 following a fall from bed and long lie. The letter notes that Mrs Mullen was managed with IV fluids for raised CK levels. X rays confirmed no acute injuries, but there was evidence of long standing osteoarthritis changes. The urine culture was negative. No postural hypotension was noted - ECG Sinus rhythm. The letter confirms that Mrs Mullen was discharged on the 22nd March 2024.

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. –

During the course of the inquest I heard evidence regarding communications between various departments of Adult Social Care and Home First and in particular STEPS. There had been an assessment by the therapist at Doncaster Royal Infirmary regarding Mrs Mullen returning to a safe home environment and what support and equipment would be required to allow that to take place. This included an assessment in the home with social workers present. A care package was provided by STEPS and it quickly became apparent that long term care and support would be required in the home and thus an application was completed on the 12th April. Mrs Mullen's family referred to them being informed that a grab rail would be required at the top of the stairs near the bathroom to help Mrs Mullen navigate to the bathroom thus reducing the risk of falls. This was not provided.

A fall occurred when Mrs Mullen was in the shower but the carers failed to escalate this and made no referrals for any further assessment to take place in relation to Mrs Mullen's mobility and ability to continue living safely at her home address. Further this was a missed opportunity to assess whether any other aids or equipment were needed to support her. Had this taken place it is likely that the absence of the grab rail would have been identified. This was a further missed opportunity.

Finally, the care and support placement referred to in the second exhibit to [redacted]'s report made no reference to the issue of stairs and the risk of falling that they presented.

In order to reduce the risk of such a situation occurring in the future I invite you to consider the following:

(1) The training of staff regarding the importance of recording instances such as falls and escalating same.

(2) Following up on recommendations for aids and equipment required to ensure a safe home environment for elderly persons such as Mrs Mullen.

(3) The importance of full and accurate record keeping.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 **6th February 2025**. 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]. I have also sent it to Doncaster Royal Infirmary who may find it useful or of interest.

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.

12 December 2024

9. Signature

Ms N J Mundy LL.B (hons) Senior Coroner for South Yorkshire East