REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Department of Health & Social Care**
1	**CORONER** I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk
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 19 July 2024 I commenced an investigation into the death of **David Thomas BENDELL** aged **79.** The investigation concluded at the end of the inquest on 03 June 2025. The conclusion of the inquest was: **Narrative Conclusion - Accidental death, contributed to by underlying ill health.** The medical cause of death was confirmed as: **1a Large Right Traumatic Subdural Haematoma** **1b** **1c** **1d** **2 Chronic Myelomonocytic Leukaemia, Thrombocytopenia, Stroke, Frailty**
4	**CIRCUMSTANCES OF THE DEATH** **David Bendell's death was recognised at 02:49 on 13th July 2024, at The West Suffolk Hospital, Bury St Edmunds in Suffolk.** **On the evening of the 12th July 2024 David had been found by his carers (who attended four times daily), injured and slumped on the sofa, so the emergency services were summonsed.** **David told his carers he had fallen whilst trying to use the commode and shortly after saying this, David became unresponsive and began having seizures.** **A CT scan undertaken on David after his arrival at the West Suffolk Hospital identified that he had a large bleed to his brain, which was not survivable.** **David suffered from a blood cancer (leukaemia) which made his blood less able to clot (thrombocytopenia), which would have increased the severity of the bleed to his brain.** **David had been discharged from hospital on the 8th July 2024 following a recent**

	stroke, and although deemed able to transfer (move from his bed to a commode and return) he was unable to walk. **At the time David fell in his home accommodation (warden-controlled housing) no rehabilitation support staff, or carers were present or immediately available to assist him.**
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. At inquest it was heard in evidence David was discharged from hospital once he was able to transfer from a hospital bed to a commode, and back to the bed. It was acknowledged that David could not walk unaided.** **2. David was discharged on the 8th July 2024 under the Stroke Early Supported Discharge Team, that was to provide physiotherapy support in his home on a daily basis. David also had carers to attend four times a day (this being the maximum support available).** **3. David's family described how the ambulance team that brought David home considered taking him straight back to hospital as they did not think he would be able to manage at his home. In addition, one of the first physiotherapists to see David reportedly said 'this is not going to work' to family members on seeing David in his accommodation.** **4. In evidence it was heard that David's condition was such that he was not a candidate for hospital-based rehabilitation on a specialist stroke rehabilitation ward. This meant that the only available treatment option for David was to treat him at home.** **5. The court was told that there is no step-down community rehabilitation facility to act as a 'half way house' for patients like David, if like David they are not eligible for inpatient rehabilitation, but are in reality not physically capable of keeping themselves safe when alone at home.** **6. I am therefore concerned that with the current rehabilitation options available being either in a specialist hospital ward or at home, other individuals in David's situation who are not deemed suitable for in-patient hospital, will also be placed at risk by being sent home when it is not safe to do so.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your 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 July 31, 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 who may find it useful or of interest. 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	**Dated: 05/06/2025** **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**