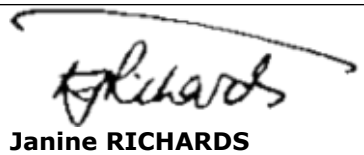
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted]
1	**CORONER** I am Janine RICHARDS, Assistant Coroner for the coroner area of County Durham and Darlington
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 30/12/2024 14:54an investigation was commenced into the death of Esther Jane Lancaster BYRNE 06/02/1932 00:00:00. The investigation concluded at the end of the inquest on 02/06/2025 00:00. The conclusion of the inquest was that Esther Jane Lancaster Byrne, aged 92 years, died at her care home on the 18th of December 2024. The deceased had a diagnosis of vascular dementia and was extremely frail. She deteriorated subsequent to an accidental fall which occurred on the 1st of November 2024 when she sustained a neck of femur fracture, which in the light of her frailty and some doubt as to the presence a fracture or whether this was, in fact, an osteophyte curtain, by the treating physician, was treated conservatively. The deceased was readmitted on the 4th of December 2024 due to increased hip pain and when the fracture sustained had become displaced, possibly due to a further fall. This was operated upon on the 5th of December 2024 and the deceased was discharged back to her care home and subsequently deteriorated to her death..
4	**CIRCUMSTANCES OF THE DEATH** Esther Jane Lancaster Byrne, aged 92 years, died at her care home on the 18th of December 2024. The deceased had a diagnosis of vascular dementia and was extremely frail. She deteriorated subsequent to an accidental fall which occurred on the 1st of November 2024 when she sustained a neck of femur fracture, which in the light of her frailty and some doubt as to the presence a fracture or whether this was, in fact, an osteophyte curtain, by the treating physician, was treated conservatively. The deceased was readmitted on the 4th of December 2024 due to increased hip pain and when the fracture sustained had become displaced, possibly due to a further fall. This was operated upon on the 5th of December 2024 and the deceased was discharged back to her care home and subsequently deteriorated to her death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern)

	1. Poor communication and liaison with family generally, and in particular with a family member who held a health and welfare power of attorney, led to important information being incorrect, including about such issues as the deceased's baseline presentation which was pertinent to safe discharge planning and risk assessment. It was accepted that there was no communication with the family member who held power of attorney regarding diagnosis and treatment options, the rationale for these, or the discharge plan. 2. There were numerous discrepencies in the evidence demonstrating a misunderstanding by various medical staff as to the deceased's baseline presentation, and the extent to which she had or had not mobilised whilst an inpatient which were pertinent to care planning upon discharge and to any handling required to be risk managed by the care home. 3. It was accepted that a follow up appointment should have been arranged for the deceased after discharge and there was no explanation for why this was not arranged. 4.The treating consultant physician expressed considerable doubt as to the quality and accuracy of radiological reporting provided by the outsourced out of hours service (which is understood to be outside the UK) and accepted that this issue, amongst others, contributed to his doubt that the deceased had sustained a fracture. The Inquest heard that there was no ability to discuss the findings with the reporting radiologist.
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 29, 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 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 by the Chief Coroner.
9	**Dated: 03/06/2025**

	 **Janine RICHARDS** **Assistant Coroner for** **County Durham and Darlington**